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.
Background information

University Hospitals Plymouth NHS Trust is the largest hospital trust in the south west peninsula. It is an NHS teaching trust and works in partnership with the Peninsula College of Medicine and Dentistry. The trust provides healthcare to people living in the south west peninsula and visitors to the region, and provides training and education for a wide range of healthcare professionals.

The trust has an integrated Ministry of Defence Hospital Unit on the Derriford Hospital site, which has a tri-service staff of approximately 220 military personnel working within a variety of posts. This includes consultants, doctors, nurses, and trainee medical assistants.

The trust provides services for patients at main sites and through clinics at other local hospitals and care centres. The largest range of the trust services are provided at Derriford Hospital.

Below is a list of the acute hospital sites at the trust, with the details of the services provided:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Centre</td>
<td>Damerel Cl, Devonport, Plymouth PL1 4JZ</td>
<td>ENT; Minor Injuries Unit, Sexual Health, X-ray</td>
<td>Plymouth</td>
</tr>
<tr>
<td>Derriford Hospital</td>
<td>Derriford Road, Crownhill Plymouth Devon PL6 8DH</td>
<td>Emergency Department; stem cell transplant; kidney transplant; pancreatic cancer surgery; neurosurgery; cardiothoracic and vascular surgery; bone marrow transplant; thoracic and upper gastro-intestinal; surgery; hepatobiliary surgery; neonatal intensive care and high-risk obstetrics; plastic surgery; liver transplant evaluation and stereotactic radiosurgery; Acute Assessment Unit</td>
<td>Plymouth, East Cornwall, North and South Devon</td>
</tr>
<tr>
<td>Launceston General Hospital</td>
<td>College Rd, Launceston PL15 9JD</td>
<td>Adult and paediatric outpatient clinics, X-ray services.</td>
<td>Launceston and the surrounding area</td>
</tr>
<tr>
<td>Liskeard Community Hospital</td>
<td>Clemo Rd, Liskeard PL14 3XD</td>
<td>Adult and paediatric clinics; minor plastic surgery; X-ray services</td>
<td>Liskeard and the surrounding area</td>
</tr>
<tr>
<td>Mount Gould Hospital</td>
<td>200 Mount Gould Rd, Plymouth PL4 7QD</td>
<td>Outpatient clinics; X-ray services</td>
<td>South Plymouth locality</td>
</tr>
<tr>
<td>Plymouth Dialysis Unit</td>
<td>184 Plymbridge Road, Plymouth PL6 7FL</td>
<td>Haemodialysis; peritoneal dialysis and chronic kidney disease</td>
<td>Plymouth</td>
</tr>
<tr>
<td>Royal Cornwall Hospital</td>
<td>Treliske, Truro TR1 3LJ</td>
<td>Trauma and orthopaedic paediatric outpatient clinic</td>
<td>Cornwall and the Isles of Scilly</td>
</tr>
<tr>
<td>South Hams Hospital</td>
<td>Plymouth Rd, Kingsbridge, Devon TQ7 1AT</td>
<td>Outpatient clinics; satellite dialysis unit; Minor Injuries Unit; X-ray services</td>
<td>South Hams and the</td>
</tr>
</tbody>
</table>
(Kingsbridge Hospital) | Hospital Rd, Stratton, Bude EX23 9BR | Outpatient clinics; minor plastic surgery | surrounding area
---|---|---|---
Stratton Hospital | Stratton and the surrounding area
Tavistock Hospital | Spring Hill, Tavistock PL19 8LD | Outpatient clinics; day case surgery; Minor Injuries Unit; X-ray services | Tavistock
Tavistock Clinic | 70 Plymouth Road, Tavistock, Devon, PL19 8BX | Sexual health services | Plymouth, East Cornwall, North and South Devon

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

Is this organisation well-led?

Leadership

Leaders had the integrity to run the trust. They understood and managed the priorities and issues the trust faced. They supported staff to develop their skills and take on more senior roles. However, they were not always visible and approachable in the trust for patients and staff and did not all have the skills and abilities to challenge effectively.

During the previous 12-months there had been several changes to the board, including a new chief nurse, a new director of finance, a new director of integrated care and partnerships and a new non-executive director. The board was more balanced in terms of gender as a result and we found renewed energy and determination across the board.

The trust’s chairman had just started his eighth year in the role and his term was due to end in 2020. The chairman was experienced, capable, full of commitment and compassion. He was approachable and undertook planned walkabouts to different areas of the hospital to see care being delivered and meet with staff. We were told the chairman spent lots of time visiting the neonatal intensive care unit (NICU) and was fundraising for them in support of the ‘keep me close’ appeal, which provided accommodation for the families of babies being cared for in the NICU. The chairman had also spent some time with the care of the elderly team – an experience he described as “emotional and very humbling”.

The Chief Executive had also just started her eighth year at the trust and was well-known throughout the organisation. Staff told us the Chief Executive was approachable and highly visible across the organisation. In addition to leading the trust, the Chief Executive also had significant responsibilities in the Sustainability and Transformation Partnership (STP).

The trust had a new chief nurse who was highly regarded by all staff we spoke with and was having a positive impact in several critical areas. Despite only being in post for five months, he was well-known in the trust and was described as “personable and approachable” and “a breath of fresh air”, while also taking a firm line and setting clear expectations. The deputy nursing director support was being strengthened to build greater strength in the nursing leadership team and to allow the chief nurse to operate more strategically than operationally.
The new director of finance was ambitious and confident. Again, they had only been in the role for about five months, but they had a clear understanding of the trust’s financial position and the challenges surrounding this. They were well-connected and active in the STP.

The trust’s medical director had been very heavily involved in the STP and staff felt his visibility within the trust had reduced. However, two new deputies had been appointed to support the medical director with their duties, including taking a more external focus so the medical director could increase their internal focus.

The trust also had a new director of integrated care and partnerships, who had started in April 2019. They were dedicated, knowledgeable and enthusiastic about tackling some of the trust’s challenges and leading the development of greater integration.

The remaining executive directors had been with the trust for several years and had a clear understanding of the challenges facing the trust. Their visibility across the trust varied, but most staff we spoke with said they would feel able to contact the executive team and raise concerns if needed.

Although we found the non-executive directors to be a committed and passionate group, we were concerned about the skills, experience and knowledge of those with a non-clinical background. Throughout our interviews and focus groups there was an apparent lack of understanding and/or appreciation of the trust and the risks to patient safety, quality and performance. While some articulated general points, particularly around risks, there was a lack of detail in their responses and we were not assured they had a firm grip on what was happening in the organisation and how they could challenge and influence the trust’s approach.

We were told by several board members that both formal and informal conversations between board members had evolved and were cohesive and collaborative. Although we observed and heard that the non-executive directors were consistently supportive of their executive colleagues (one executive director questioned if they got too much support), we also observed and heard that challenge could be strengthened. Several executive directors and other board observers told us there was room for greater challenge, and three executive directors told us they would like to get more challenge from their non-executive colleagues.

One executive director told us the non-executive directors were good at drilling down into data, but often tried to fix ‘problems’ rather than challenge the executive directors to fix it. Additionally, we were told the non-executive directors did not always fully understand regulatory implications and pressures, particularly in relation to financial targets and performance.

One non-executive director told us not enough progress was being made in relation to risks on the board assurance framework (BAF) because the trust had been “firefighting CQC issues” and their ambition in their role was to get CQC “off our backs”. This did not reflect a positive leadership stance with an understanding about CQC inspections being focused on quality and safety, which should be the focus of the trust anyway.

There was a board development plan, which included 360-degree feedback, in-depth interpersonal relationship discussions, psychometric evaluation, and relationship development supported by an external provider.

Executive and non-executive directors, including the Chairman and Chief Executive, were recruited in accordance with the Fit and Proper Persons Regulations. Although we noted two minor gaps in two personnel files (signatures missing to confirm the interview), these were rectified immediately following our inspection.

Although there was an agreed process, the trust did not have a formal policy or standard operating procedure for managing Fit and Proper Persons. The trust’s ‘Recruitment and Selection Policy’ included a short paragraph confirming directors would be recruited with checks made to adhere to the regulation, but did not include any further detail. We asked the HR Director about this and they
confirmed there was no policy, but a paper had been presented to the board and agreed in May 2015, and this was later updated in January 2019. These board reports included the process that would be followed, including self-declaration and required background checks. However, there was no policy or standard operating procedure subsequently written and made available to formalise the process.

The trust had continued the appointment of an interim chief pharmacist to enable consistency and there was a plan to develop the leadership team, although this was not yet embedded. Staff told us that whilst they felt supported by the department they were unsure if the wider trust fully understood the pressures and impact on the department. The resilience of the department was still low with some of the management team not feeling supported because there was a lack of a stable structure.

Across the organisation we found management processes needed strengthening to ensure teams, specialties, care groups etc were able to fully monitor and improve their services alongside trust governance processes. We noted the trust had recently introduced a ‘manager passport’, which it was hoped would strengthen the skills of new and existing managers.

**Vision and strategy**

*The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood the trust’s vision and strategic direction.*

There was a clear vision to provide outstanding integrated care, supported by a strategy. The trust’s strategy had just been refreshed and was due to be signed off at the board meeting the week after our inspection. Internally, the trust had publicised their strategic direction with posters, cardboard pyramids and computer screensavers across the organisation. However, the non-executive directors felt there had not been a detailed discussion about what the strategy really meant and how it could be implemented effectively.

There were four strategic objectives:

- Valuing our people
- Delivering safe, high quality services
- Providing services in a sustainable way
- Working with partner across our communities

From these objectives, three priority improvement challenges had been agreed:

- Reducing avoidable admissions of frail elderly patients by seven a day
- Increase scanner utilisation and theatre session utilisation to 85%
- Reduce outpatient routine follow-up appointments physically seen in a hospital setting by 35%

Each of these priority areas had an executive director leading and a weekly executive meeting reviewed actions and progress.

The interim chief pharmacist had led a staffing review and was developing a new structure to give more stability to the department. Staff said they felt they had seen success in recruiting to junior
roles in the department but wanted to now see this feeding through into more senior roles. Some of the staff members were not clear about the direction of travel of the pharmacy department.

There was a broad equality, diversity and inclusion framework for 2019/20 with a vision to “create an environment that values difference and fosters an inclusive workplace culture where colleagues from all backgrounds can give their best, are treated fairly, are valued for their contributions, and can progress their careers.” There were several principles and areas of focus included, but these were quite broad and there was no apparent strategy sat alongside the framework to ensure delivery and monitoring.

The trust did not have a digital strategy, but we were told it “desperately wanted and needed one”. There was a recognition that ‘digital’ did not have the focus it needed, although this was improving. Across the sustainability and transformation partnership (STP) there was a vision to implement a single patient administration system, which would be used by all the acute providers. A national proposal had been submitted, but there was no clear timeframe for when implementation would take place. We were told there were two systems being looked at – one could potentially be implemented within a couple of years, while the other would be closer to six years. One of the key considerations of either system was how it could interoperate with other systems within the trust and across the wider health system.

There was no patient experience strategy, although there was a workplan. By the end of 2019 it was expected there would be a two-year workplan to ensure patient experience was fully considered and reported, with a strategy being planned at a later date.

Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust provided opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear. The trust was increasing its focus on promoting equality and diversity in daily work.**

There had been a very strong focus on culture throughout the trust since our last inspection, which was having a positive impact. A new ‘ACE’ event (appreciation, civility and excellence) had taken place earlier in 2019 and was reported to be a huge success. One director told us it was “the best ‘study day’ we’ve had”, with similar comments being made by staff. The event had focused on recognising and reporting excellence and thanking staff. The trust’s wellbeing team held events to promote wellbeing in the workplace, and support was being provided in areas where the culture could be improved. The trust recognised there was still more work to do, but progress was being made.

The trust had a strong and focused group of three Freedom to Speak-up Guardians, with a non-executive director as lead. The guardians were very accessible and approachable. They felt well supported by the board in raising concerns and saw actions taken as a result. Staff knew who the guardians were and how to access them if needed. The guardians met the chief executive once a month and met as a group every week. The key themes from speak-up contacts related to management style and bullying and harassment. However, the number of contacts relating to these areas were decreasing, which was thought to be a result of improved manager training through the managers’ passport and ‘just culture’ training.

The trust had an ‘Equality, Diversity and Human Rights’ policy, designed to support the creation of a fair, diverse and equal culture. Additionally, as part of the board development programme a session was run in February 2019 covering equality, diversity and inclusion. The trust had also
held several events to raise the profile and understanding of equality and diversity, and to encourage staff to speak-up. These included events during Disability Awareness Week, Equality, Diversity and Human Rights Week and at the Plymouth Respect Festival.

Every Thursday morning the executive directors met to discuss any areas of concern, which included feedback from staff surveys, freedom to speak-up, conversations with staff etc. If issues were identified, a ‘Your Voice’ visit could be planned as part of the trust’s approach to creating a healthy culture. The visit was undertaken by an executive director with organisational development support and targeted promotion of freedom to speak-up. The aim was to talk with staff to understand some of the challenges and help identify cultural improvements.

The trust’s complaints process was very formal and at times felt quite impersonal, although this was in the process of being changed. The trust was using a standard letter template for the majority of its complaint responses, which was then amended to include information relevant to the complaint. However, there was a standard opening paragraph which was not changed, and we saw in one instance a complainant had asked for further information following the trust’s initial response and they were sent the same standard opening paragraph. The trust was moving away from a standard letter template and was encouraging more ongoing interaction between the complainant and the investigator, either through telephone calls or meetings.

Complaint responses were rarely signed by the Chief Executive unless they had specifically asked to be the signatory, usually because they had been involved with the complaint in some way. Most responses were signed by the chief nurse, although of the eight complaints we reviewed one response was signed by the service line manager, one was signed by the deputy chief nurse, and one was signed by the director of integrated care and partnerships. We were told any available executive director would sign complaints in the chief nurse’s absence, rather than there being a link to their area of responsibility.

The interim chief pharmacist recognised the pharmacy department was not yet through the cultural change. However, staff said there was an improvement and they felt they could now speak without fear of repercussion. Staff also said they felt middle managers lacked support as the structure was not yet fully in place. The pharmacy department was carrying out integrated pilots and these were having a positive effect on the outcomes for patients, especially in relation to discharge and to take away (TTA) medicines. Staff told us the senior team were open to suggestions for working in different ways, although this sometimes felt like re-inventing the wheel because they were going back to doing things as they were done before. The team had introduced a ‘Star of The Week’ award, which was commented on positively.

The trust used patient stories at their board meetings to enable the board to hear first-hand about the experiences of patients. However, we were told there was not a balance between positive and less positive stories, with more positive patient experiences being brought to the board. We were also told the stories were often presented by the care group, rather than the patients themselves. This was something the trust was aware of and looking to address.

We were told by several leaders and staff that “OPEL four had become normalised” and OPEL three was considered a “respite”. OPEL refers to the national operational pressures escalation levels, which ranges from OPEL one (demand/pressures and capacity are aligned, no additional support required) to OPEL four (demand/pressures significantly outstripping capacity with increased potential for suboptimal care and safety. Support required). The culture around escalation had therefore shifted to a ‘business as usual’ approach even at the highest escalation levels, leaving staff feeling tired, unsupported and unsure of how things would be able to improve.
Furthermore, regular meetings were being cancelled as a response to the heightened escalation and as a result nobody was able to clearly explain what the strategic or possible solutions were.

**Board Diversity**

Of the executive board members, one member did not disclose their ethnicity. None of the other seven members identified as Black and Minority Ethnic (BME). A quarter of the board members were female.

Of the non-executive board members, five members did not disclose their ethnicity. Of the other four members, one identified as being BME. A third of the non-execute board members were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>-</td>
<td>25.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>-</td>
<td>33.3%</td>
</tr>
<tr>
<td>All board members</td>
<td>-</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Board tab)*

**Staff Diversity**

As of December 2018, University Hospitals Plymouth NHS Trust employed 7,145 people, of which 490 were BME staff (6.9%).

*(Source: Routine Provider Information Request (RPIR) – P102 WRES-template)*

The trust provided the following breakdowns of clinical and non-clinical staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Non-clinical staff (%)</th>
<th>Clinical staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>96.7%</td>
<td>91.0%</td>
</tr>
<tr>
<td>BME</td>
<td>1.4%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – P102 WRES-template)*

The trust acknowledged they were not as diverse as they wanted to be across all staffing groups, but particularly at more senior levels. However, it was unclear how the trust was tackling this.
The trust’s 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Immediate managers
- Staff engagement

There were no themes where the trust’s scores were significantly lower (worse) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators
are available for all trusts. For example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.

- The questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors.

<table>
<thead>
<tr>
<th>WRES Indicators from ESR (HR data)</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 6+</td>
<td>1.1%</td>
<td>3.7%</td>
<td>●</td>
</tr>
<tr>
<td>1b. Proportion of non-clinical staff in senior roles, band 8+</td>
<td>0.0%</td>
<td>7.2%</td>
<td>○</td>
</tr>
<tr>
<td>2. Proportions of shortlisted staff being appointed to positions</td>
<td>13.2%</td>
<td>27.1%</td>
<td>-12.7%</td>
</tr>
<tr>
<td>3. Proportion of staff entering formal disciplinary processes</td>
<td>0.4%</td>
<td>1.2%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>4. Proportion of staff accessing non-mandatory training and CPD</td>
<td>85.9%</td>
<td>80.5%</td>
<td>Not assessed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WRES Indicators from the NHS staff survey</th>
<th>Proportion of respondents answering “Yes”</th>
<th>Are there significant differences between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust 26.3% White staff 26.9% All staff 26.6%</td>
<td>BME and White staff? This trust and its peer group? Last year and this year? (BME)</td>
</tr>
<tr>
<td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust 26.1% Peer group 24.7%</td>
<td>24.9%</td>
</tr>
<tr>
<td>7. Staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust 70.1% Peer group 85.8%</td>
<td>84.5%</td>
</tr>
<tr>
<td>8. Staff experiencing discrimination at work from a manager / team leader or other colleague?</td>
<td>Trust 17.3% Peer group 6.9%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust staffing numbers</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. (BME Voting Board Members) and Board compared to overall staff demographic</td>
<td>[0]</td>
<td>[0]</td>
</tr>
</tbody>
</table>

**Key**
- Statistically significant or negative finding
- Not statistically significant
- Positive finding
- Statistical analysis not undertaken as less than 30 BME staff responded
- Statistically significant improvement
- No statistically significant change
- Statistically significant deterioration

As of 31 March 2018, two of the electronic staff record (ESR) staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between white and BME staff:

1a. In 2018, BME candidates were significantly less likely than white candidates to hold senior (band eight and above) clinical roles (1.1% of BME staff compared to 3.7% of White staff). This had increased (improved) by 0.3% compared to the previous year.

2. In 2018, BME candidates were significantly less likely than white candidates to get jobs for which they had been shortlisted (13.2% of BME staff compared to 27.1% of white staff). This had decreased (got worse) by 12.7% compared to the previous year.

Of the four indicators from the NHS staff survey 2018 shown above (indicators five to eight), the following indicators showed a statistically significant difference in score between white and BME staff:

7. 70.1% of BME staff believed the trust provided equal opportunities for career progression and
promotion (2018 NHS staff survey), which was significantly lower when compared to 85.8% of white staff. The score had decreased (got worse) by 4.4% when compared to the previous year.

8. 17.3% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey), which was significantly higher when compared to 6.9% of white staff. The score had increased (got worse) by 2.2% when compared to the previous year.

One of the eight voting board members did not disclose their ethnicity. Of the seven who did, none identified as BME. This was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

The trust’s equality and diversity leads recognised this position and told us that although the gaps were closing, particularly in relation to the percentage of staff experiencing bullying and harassment from patients and the public, there was still a lot of work to do.

Friends and family test

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 95.6% and 97.5% between June 2017 and May 2019.

The response rate ranged from 31.0% - 48.2% for the trust.
Sickness absence rates
The trust’s sickness absence levels from March 2018 to February 2019 were similar to the England average. The rates at the trust followed a similar trend to that nationally with higher sickness absence in the winter months.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey
In the 2018 General Medical Council Survey the trust performed the same as expected for all indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance
Leaders did not always operate effective governance processes throughout the trust and with partner organisations. Staff were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the trust.

Governance processes and systems in the trust were under review, being led by the chief nurse. Several changes had already been made, and the trust recognised there was more to do to strengthen governance further and to reduce duplication. We found leaders were sometimes unclear about the governance structures because there were different “owners” of different parts of governance – for example, quality, safety, performance. There had not been an external review of governance in recent years.

A public board meeting was held bi-monthly, rather than monthly as is more common. In the intervening months, the board focused on board development activities. While this was an uncommon arrangement, the board felt it worked well and provided sufficient balance between meeting in public and developing the board. However, we observed the board papers were exceptionally long, which meant there was a risk items would not always be discussed in detail during public board. We were told the length of the board packs was greater because the board met less frequently. Several non-executive directors commented the amount of board papers were “too much”.

We were told several of the issues identified in our 2018 inspection had been known about at board level, but there had been a failure to join up what was being identified at various sub-committees and through other sources of intelligence, therefore the seriousness of those issues was not fully understood. There was also an acknowledgment some issues in the trust had become ‘normalised’ and as such had lost the board’s attention to the detail.

Minutes of the trust’s board meetings and sub-committees were clear and documented reasonably well a summary of the discussions that took place. However, there was limited evidence of challenge in the minutes, which aligned with the feedback we had from a number of directors that there was often not enough challenge from non-executive directors. There were multiple examples in minutes where the chair had invited discussion, but none took place: “The Chairman invited questions. There were none.” and “There was no further discussion” were two examples.

The trust was looking to strengthen how the sub-committees improved their assurance to the board and functioned collectively. One director told us there was “sometimes a risk that a methodical approach to assurance was not there”. They gave the trust’s response to CQC’s section 29A warning notice last year as an example, suggesting there was a sense of “panic” around it.

The trust had a reasonably traditional governance structure of board sub-committees, which took reports appropriate to their area of focus and reported upwards to the board as required.

We were told the length of the agendas at the safety and quality committee meant there was a focus only on high-level assurance in some key areas, with “not always as much discussion about quality and performance metrics as there could be”. We were also told the agenda length meant there was not as much challenge in the committee as there could be. One executive director felt the sub-committees focused more on business than assurance.

Each care group had a governance meeting, which we were told during our inspection fed into the safety and quality board sub-committee. It had been identified there was a need to set clearer expectations of and provide development to the care group leadership teams to help them better prepare and present at sub-committees to help more focused assurance discussions take place. However, following the inspection the trust informed us the care group governance committees did not report to the safety and quality sub-committee, although did not inform us where the governance meetings reported to. It was therefore unclear how the governance structures worked between care group and the board, and whether or not this was understood by staff.

Key board reports such as the annual safeguarding and infection prevention and control reports were presented to the board by the executive and/or non-executive leads. However, report authors felt they were given no opportunity to present their work, engage with the board and answer any questions.

Governance surrounding incident grading needed to be strengthened. The trust used an electronic incident reporting system, which required the reporter to rate the level of harm. Although there were processes in place for the investigator to review and amend the rating, in the 13 incidents we reviewed rated ‘No harm’, ‘Low harm’ or ‘Moderate harm’, there was no evidence the rating had been reviewed and confirmed as correct or any rationale for changes to the rating following the investigation. In four cases, the investigation either did not address the issues raised in the report or lacked evidence of findings and actions. Fields in the electronic reporting system were not always completed during and at the end of investigations, including dates, feedback and action plans, meaning the trust had limited oversight of incidents. For serious incidents, however, the trust had changed the decision-making process to ensure all incidents were appropriately graded. The new process involved a 24-hour review meeting within the care group to agree the level of
investigation required and make a recommendation based on that assessment. There were clear terms of reference for this meeting to ensure the correct decision was made. The recommendation was then signed off by the chief nurse. In the chief nurse’s absence, the medical director or by exception another executive director completed this sign off.

The governance and oversight of complaints was adequate, although the board received little detail about the complaints. The board received complaints metrics as part of the integrated performance report, for example numbers of complaints, Patient Advice and Liaison Service contacts, and Parliamentary and Health Service Ombudsman referrals, but there was no regular reporting of themes and triangulation of data with other patient experience metrics. The complaints team were aware of this and were working towards producing a quarterly patient experience report which would be presented to the board and would address the current detail gap.

When appropriate, concerns were handled outside the formal complaints process by the Patient Advice and Liaison Service (PALS), especially if the patient was still in the hospital. However, it was unclear how the board were sighted on these concerns. Where formal complaints were received, they were allocated to the service line for investigation. We were told the chief nurse was copied into all investigation allocations, so they were aware of the nature of the complaints. Once allocated to the service line, the service line manager oversaw the investigation process and approved the draft response. The complaints team then checked the response answered the complainant’s concerns and completed a quality check, including two proof-reads. The final draft was then sent to the executive directors for sign-off.

The complaints team attended care group governance meetings at least quarterly, where they were able to share learning from other care groups and provide information on complaint themes. At the time of our inspection, the agenda item was focused on access and waiting, which made up 40% of all PALS contacts.

We were told the trust was going to commission an independent financial governance review to ensure there was a sound understanding of the reasons for the underlying deficits and the challenges facing the organisation in effectively managing the financial position.

Development of the pharmacy board had been positive and now had involvement from the trust board. There was now a clear reporting pathway from the pharmacy board through to the trust board.

There was an equality, diversity and inclusion work group. Equality and diversity reported through the people and culture committee, although relevant items could also be taken to the safety and quality committee.

**Board Assurance Framework**

The trust provided their Board Assurance Framework (BAF), which detailed five strategic objectives and accompanying risks. A summary of these is below.

1. Improve quality
2. Develop our workforce
3. Improve our financial position
4. Create a sustainable future
5. Maintain strong governance

The Board Assurance Framework set out 22 risks to the trust’s strategic objectives. All the risks on the BAF were categorised as red or amber. However, many had assurance assessments which reflected a lower RAG rating based on the outcome of mitigating actions.
We were told the BAF needed to be strengthened. There was a desire to shorten the BAF and increase the focus on the risks and impact of actions being taken. It was felt doing this would raise greater debate at board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, they did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

There was a consistent and clear message from all leaders that demand, patient flow and performance were the key risks and challenges for the trust. These were well-understood, but actions to address the impact were limited or in early stages of implementation. While there were some clear priorities which appeared to have some pace behind them, there were also concerns expressed to us about the capacity of individuals and teams to sustain implementation and delivery. The trust was in discussion with regulators about some project management support to help them deliver their priorities.

Staffing was another risk consistently raised during our interviews with leaders and staff. The trust had 200 nursing vacancies and a relatively junior workforce, with many recruits being newly qualified from the local university. The trust had recently recruited 140 new nurses who were due to start over the coming four months, many whom had been recruited internationally. It was felt this would give the trust some “headroom” while they focused on a recruitment and retention strategy that would not only attract staff from other areas of the country, but also support existing employees to stay.

Some of the performance and operational pressures and risks within the trust related to their specialist services, including being a major trauma centre. As the peninsula’s specialist centre, the trust provided a significant number of additional services, most of which were running over capacity and having a knock-on effect in the rest of the hospital. One director told us the trust had “possibly bitten off more than it could chew” and another confirmed work was ongoing across the Devon and Cornwall sustainability and transformation partnerships to look at how the work could be better shared out to reduce the burden on the trust.

The trust’s performance with regards to waiting times for assessment and treatment was recognised, monitored and being managed. In August 2019 there were over 100 patients waiting more than 52-weeks for treatment to start and just under 30,000 people on waiting lists. There was a clear risk assessment and harm review process, which was overseen by the medical director and chief nurse who met every Monday to review any safety incidents. However, the trust was not confident in its ability to address the waiting lists and improve performance because of the emergency, non-elective pressures being experienced, workforce shortages (exacerbated by national challenges around pensions for higher paid staff) and financial investments being required within a difficult financial envelope. One example we were given was in urology where about 11 clinical sessions per week were being lost because clinicians were not undertaking additional work because of the pension rules.

The trust’s Freedom to Speak-up Guardians provided a quarterly report to the board, which they presented in person.

The pharmacy department was working with NHS England and NHS Improvement to look at its use of resources and to bring the department up to standard levels in comparison with other...
similar trusts. The interim chief pharmacist was involved in the regional chief pharmacist network and looking at their staffing structures. There was a trained medication safety officer, although due to long-term sickness the role was being covered by another individual without the title. This had resulted in a perception the role was not covered.

While each care group had its own risk register, it was not clear who owned these and how risks were escalated corporately when appropriate to do so. We were told by one director that ownership and actions needed to be improved, as did ownership of compliance.

**Finances overview**

The trust’s financial position was extremely challenged and although there were projections for a break-even position at the end of the financial year, there remained a significant underlying deficit. The end of year projection relied on additional income, for example sustainability funding, which was only guaranteed if the trust achieved certain standards. As this additional income was non-recurrent, an underlying deficit of around £42million existed even in a year-end break-even position.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£507.8m</td>
<td>£509.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£3.4m</td>
<td>(£27.2m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£504.4m</td>
<td>£537.0m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£3.1m)</td>
<td>(£3.8m)</td>
</tr>
</tbody>
</table>

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

**Trust corporate risk register**

The trust provided a document detailing their 23 highest profile risks. Each of these had a current risk score of eight or higher. The below risks all had a risk status of ‘red’.

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Operational pressures</td>
<td>Operational pressures which may affect ability to treat patients safely. Includes national standards, ED crowding delayed diagnosis/treatment.</td>
<td>25</td>
<td>March 2019</td>
</tr>
<tr>
<td>Q2</td>
<td>Follow-up backlogs</td>
<td>Patients may come to harm as a result of a failure to provide timely follow-up appointments.</td>
<td>15</td>
<td>February 2019</td>
</tr>
<tr>
<td>Q3</td>
<td>Quality governance</td>
<td>Failure to adopt robust quality governance arrangements resulting in avoidable harm to patients. Includes a number of specific risks such as failure to report, investigate and learn from incidents.</td>
<td>15</td>
<td>December 2018</td>
</tr>
<tr>
<td>Q4</td>
<td>CQC compliance</td>
<td>Failure to maintain compliance with CQC registration requirements leading to poor patient care.</td>
<td>15</td>
<td>April 2019</td>
</tr>
<tr>
<td>W1</td>
<td>Safe staffing</td>
<td>Failure to ensure that we have the sufficient staff leading to potential harm or poor clinical outcomes for</td>
<td>25</td>
<td>April 2019</td>
</tr>
<tr>
<td>Code</td>
<td>Category</td>
<td>Issue Description</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>W2</td>
<td>Culture and staff experience</td>
<td>Failure to provide an open and rewarding environment in which to work leading to staff dissatisfaction, the potential loss of key staff and a negative impact on the trust’s culture.</td>
<td>April 2019</td>
<td></td>
</tr>
<tr>
<td>F1</td>
<td>Financial performance</td>
<td>Failure to generate the income or control expenditure to deliver the agreed budget.</td>
<td>March 2019</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>Financial sustainability</td>
<td>Failure to develop a financial plan which is consistent with commissioner assumptions and regulatory expectations leading to an inability to deliver services on a continuing basis.</td>
<td>January 2019</td>
<td></td>
</tr>
<tr>
<td>S1</td>
<td>System transformation</td>
<td>Insufficient leadership and/or focus leading to a lack of clear plans and pace in delivering the level of transformation required to address the operational and financial challenges within the health and social care community.</td>
<td>March 2019</td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>Physical infrastructure</td>
<td>Inadequate physical infrastructure and/or resources leading to inadequate care being provided to patients.</td>
<td>June 2017</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Board assurance framework)

**Information management**

The trust did not always have reliable data. Staff could not always find the data they needed easily, in easily accessible formats, to understand performance, make decisions and improvements. However, the information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust was a significant outlier for their HSMR and SHMI performance and we were told the trust could not understand the position. We were told the trust’s deaths review process was not identifying any concerns and it was felt the outlier status was being driven by recording and reporting functions in the trust’s IT systems. The trust had made some changes in April 2019 and believed this would have a positive impact on the HSMR and SHMI data, but it would take some months to play through the update cycle.

The trust felt the quality of data going to the sub-committees needed strengthening and this was an area of work being taken forward by the chief nurse as part of the overall governance review.

There was a long-established integrated performance report covering performance, finance and quality. There was mixed feeling amongst the board about the effectiveness of the report – some felt it was comprehensive and met their needs, while others felt it had too much information that was not used or lacked enough detail to be useful. Whilst the report had largely moved away from red, amber and green (RAG) ratings and was using run charts for most of its measures, it was not yet using statistical process controls. RAG ratings are being used less in performance reports because they show a ‘snapshot’ at the time the data was reported and do not show deterioration or improvements clearly. Run charts are better because they show performance over time and allow trends to be identified. Statistical process controls are recommended by NHS England and
NHS Improvement as the best standard for performance monitoring. They look like run charts but include upper and lower tolerances (‘controls’), which help identify areas to examine in greater detail.

The service line performance dashboards had been revised to include performance metrics around deaths. Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicators (SHMI) performance, crude mortality data and the numbers of deaths that had gone through the mortality screening process were all included and updated monthly. This provided service lines with better oversight of their mortality data and enabled investigation when performance was poor. It also provided the trust with greater oversight of mortality performance and actions being taken to address areas of concern, including a quarterly ‘learning from deaths’ board report.

The trust’s performance information team were integrated into services. They provided thorough tracking information for waiting lists and the trust was “very confident” in the data provided.

Information relating to pharmacy was collected and reviewed to provide feedback on performance and identify where improvement was needed. A pilot on Hexworthy ward had reduced the numbers of patients going home without medicines and overall the trust had seen a reduction of 66% in this area. Clear monitoring processes existed for critical medicines on discharge.

There was a recognition lots of data around equality and diversity was available, but it needed to be used more effectively to proactively manage, promote and ensure equality and diversity for staff and patients.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The trust had a long-standing patient experience committee who were very active and engaged with the trust’s engagement programme. The committee was chaired jointly by the chief nurse and one of the trust’s volunteers in their role as a patient representative. Alongside the committee, patient experience ambassadors (affectionately known as PEAs) worked across the hospital to engage with patients and families about their experiences, and to help improve experiences through small gestures, such as making tea or being a listening ear.

The trust’s head of communications worked across staff, patient and stakeholder groups to support communication and engagement with these groups. Initiatives included ‘walking in my shoes’ exercises, communication boards on every ward, and participation in the Pride of Plymouth awards.

The chief nurse spent half a day every week in uniform working on the wards. There was a commitment for all the senior nursing team to work clinically one day a fortnight to engage with staff and really understand how the hospital is operating.

In pharmacy, engagement was still being developed through the move to more ward-based staff teams. The chair of the patient engagement group was included in the attendees on the pharmacy board terms of reference, but had not yet attended because it was felt the pharmacy structure needed to be more stable first.

Equality and diversity work with patients was developing, with some established work already taking place. The trust’s equality and diversity leads had used groups already available within the
trust to gather feedback, and intelligence was being received from different sources. The leads were planning to reach into community groups to get further understanding of what it is like as a patient or visitor in the hospital. One positive example of ongoing engagement was with the Plymouth Deaf Club, including the Patient Advice and Liaison Service (PALS) attending to talk about services for the death at Derriford Hospital.

Equality and diversity work for staff was not yet embedded but was developing. Some events had taken place, for example ‘big conversations’ relating to what good looks like for equality and diversity, but others were needed to keep momentum. There was a plan to introduce four networks which would have sponsorship by executives, and to start to embed equality and diversity within care groups. The four proposed networks were: LGBT, BME, disability, and women’s development. However, without any dedicated resource (the equality and diversity leads undertook the roles alongside their ‘day jobs’), it was unclear how this was going to be achieved.

Learning, continuous improvement and innovation

Staff did not always have a good understanding of quality improvement methods and/or have the skills to use them. However, staff were committed to continually learning and improving services. Leaders were starting to encourage more innovation and participation in research.

There was an inconsistent message from board members about the level of learning that took place at board. While some board members felt learning was well-embedded, others were “less convinced” that learning really took place. Not everyone felt the issues in diagnostic imaging and pharmacy identified at our last inspection had really been looked at to ensure the same issues could not occur again somewhere else in the trust.

More project management resource was required to deliver an effective quality improvement (QI) programme at the trust. We were told that with additional resources, the trust would be about 18-months away from delivering quality improvement really well. It was acknowledged the trust was behind some others in its improvement journey, but there was confidence it was not years away from catching up with the sector leaders in QI. There was a concerted effort to form a strong methodology, which the trust called ‘Putting People First’, but there was a concern that putting everything the trust needed to do through this would not be the right way to go. Similarly, there was some hesitance about just rolling training out to staff and letting them get stuck in without any clear strategic direction or joined-up working between care groups. The trust was working hard to strengthen its QI capacity and methodology, including strengthening its Quality Academy, established in 2017, introducing the ‘Executive Wall’, creating stronger collaboration with partners and building greater confidence and support for staff to deliver QI projects.

As part of the Putting People First programme, the trust had an ambition to train 600 staff in quality improvement methodology by the end of 2019 and a further 1,000 over the next two years. The learning and development team felt this was achievable and the resources required to deliver the training were available, including support from NHS England and NHS Improvement.

The trust’s incident reporting process did not evidence learning taking place and being shared where appropriate, or feedback being given to the reporter in all cases. We reviewed 13 randomly selected no, low and moderate harm incidents and found feedback was not evidenced in nine of the incidents, and evidence of learning was either not recorded or shared in seven of the incidents.

Not all deaths were being reviewed. The trust had a structured process for learning from deaths, but only 50-60% of deaths were being screened. We were told this was due to capacity, but with
the introduction of the medical examiner role in 2020 the trust would be able to move to screening 100% of deaths. The trust used a screening tool to identify any deaths where learning may be possible. If any areas of care had potential for learning, a structured judgement review was completed. Structured judgement reviews were completed by five clinicians who were members of the trust’s mortality review group. It was acknowledged more clinicians were required to improve the timeliness of the reviews, but due to operational pressures additional resources were not available. In the case of child deaths, the trust followed the Child Death Overview Panel process and did not duplicate any of this work through separate review processes. All deaths of patients with learning disabilities were subject to a structured judgement review and did not go through an initial screening process.

While quality improvement was still being embedded across the organisation, there were examples where quality improvement methodology had been used with positive effect. In one example, we were told patients were often not ready when porters arrived to take them for scans which led to delays and inefficiencies. Following a quality improvement project, cards had been introduced which were placed on patients’ beds with the date and time of any scans. These ensured staff knew when patients needed to be ready for and had reduced delays.

The trust had been allocated STP funding for new hybrid theatres (£26.2million) and for urgent and emergency care (£29.7million). NHS England and NHS Improvement were working with the trust to ensure compliant business cases were developed. Additionally, the trust had received funding earlier in the year to improve its imaging capacity. Further funding had also meant the emergency department had already had some work completed, including an expanded and upgraded resuscitation area and expanded and upgraded children’s area.

Serious incidents were appropriately investigated, and lessons learned were shared with the teams involved, and wider where necessary.

The trust’s complaints process was designed to ensure learning took place, but shared learning across the organisation was an area that was being improved. We found in most cases we reviewed there was clear evidence of the lessons learned being shared with complainants in response letters, and information about how learning within the trust would be shared was captured in action plans. We were told more work was needed with the care groups to ensure the governance teams shared learning more widely, including better use of patient stories.

The trust had invited several complainants to talk about their experiences as part of the complaints training programme, and another complainant was due to talk at the nurse preceptorship training. We were told this had been impactful for staff, helping them understand the importance of the complaints process, engaging with complainants and ensuring learning took place.

In pharmacy, people were given opportunities to learn and there was a developing culture to allow staff to give open feedback.

There was a strong research culture, which was aligned to the trust’s strategy. The research team was made up of 85 full time positions. The trust was engaged in local, national and international research, and worked closely with the local university through a joint research committee. There were 560 research studies ongoing, being both academically and commercially-led, and during the 2018/19 financial year, 4,900 patients were recruited into research trials.

Accreditations
NHS trusts can participate in several accreditation schemes. The services provided by trusts 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 they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) when the service will need to be re-assessed to continue to be accredited.

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Derriford Hospital anaesthetic department May 2015</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Cellular and Anatomical Pathology, (Including Histology, Cytology, Neuropathology and Mortuary) September 2018, date of last visit (SU1 March 2019)</td>
</tr>
<tr>
<td></td>
<td>Combined Laboratory</td>
</tr>
<tr>
<td></td>
<td>Haematology &amp; Coagulation, Biochemistry (Automated &amp; Special Investigations), Molecular Biology, Immunology (Diagnostic and Histocompatibility &amp; Immunogenetics), Transfusion Laboratory - September 2018, date of last visit (SU1 April 2019)</td>
</tr>
<tr>
<td></td>
<td>Microbiology (Serology and Bacteriology) October 2016, date of last visit (SU3 Dec 2018)</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>The Mustard Tree, August 2018</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditation tab)
Derriford Hospital provides a range of medical care services across 20 wards and nine outpatient or day case units. The hospital provides medical care services for the local population of Plymouth and the surrounding areas of Devon and Cornwall. The hospital is a major trauma centre a specialist hospital responsible for the care of the most severely injured patients involved in major trauma. It provides 24/7 emergency access to consultant-delivered care for a wide range of specialist clinical services and expertise. The hospital is also a regional centre for stroke services in the South Western Peninsula.

The trust had 58,600 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 26,253 (45.3%), 1,850 (3.2%) were elective, and the remaining 30,497 (52.0%) were day cases.

Admissions for the top three medical specialties were:
- general medicine – 22,389
- gastroenterology – 8,363
- clinical oncology – 7,955

(Source: Hospital Episode Statistics)

We inspected the following ward areas:
- Acute ambulatory care unit (AAU)
- Thrushel and Tavy medical assessment units (MAU)
- Tamar short stay ward and discharge lounge
- Endoscopy unit
- Torcross, Coronary Care Unit
- Marlborough, gastroenterology and hepatology ward
- Monkswell, Shipley and Hartor and Hembury Healthcare of the Elderly wards
- Meldon, general medicine ward
• Burrator general medicine ward Merrivale Acute Stroke and Neurology ward Mayflower, renal ward
• Honeyford, respiratory ward
• Bracken, stem cell transplant unit
• Birch, haematology day unit

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:
• spoke with eight patients who were using the service.
• spoke with 93 staff including the managers or acting managers at most of the wards we visited. We also spoke with doctors, nurses, support staff and therapists.
• observed multidisciplinary meetings, staff interactions and care on the wards.
• reviewed 38 patient records relating to physical health.
• reviewed 6 patient records in relation to management of mental health needs.

We inspected the service as part of our routine inspection programme. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to staff. However, systems to make sure everyone completed it needed to improve. Not all nursing and medical staff were up to date with mandatory training.

**Mandatory training completion rates**

This information is routinely requested by CQC within the universal provider information request spreadsheets, to be completed within a standard template, before our inspection. The trust has stated that the 'Trust update' module encompasses the following:

• Equality, Diversity & Human Rights
• Health, Safety & Welfare (including Medical Gases, Medical Devices)
• NHS Conflict
• Fire safety
• Infection, Prevention & Control
• Moving & Handling
• Safeguarding Adults (including Mental Capacity Act)
• Preventing Radicalisation
• Safeguarding Children
• Resuscitation
• Information Governance
The trust set a target of 95% for completion of mandatory training.

Nursing staff did not always keep up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 for registered nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>516</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>510</td>
</tr>
<tr>
<td>Trust Update</td>
<td>485</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>477</td>
</tr>
<tr>
<td>Child Protection Level 3</td>
<td>3</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for one of the five mandatory training modules for which registered nursing staff were eligible. Data from the trust at the time of inspection showed 91.6% registered nurses in the medicine care group had completed the trust update module. We reviewed the performance dashboard on Thrushel ward and saw that basic life support training was below the trust target. The ward sister explained that staff were booked in to complete this training.

Medical staff received mandatory training, and most staff had completed it, but compliance with updates to training needed to improve. A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>156</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>156</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>153</td>
</tr>
<tr>
<td>Trust Update</td>
<td>128</td>
</tr>
</tbody>
</table>

In medicine the 95% target was not met in any of the mandatory training modules for which medical staff were eligible. Data from the trust at the time of inspection showed 57.7% of medical staff in the medicine care group had completed the trust update module and 68.4% had completed safeguarding level 2. We discussed medical staff mandatory training compliance with the medicine care group leads who told us human resources staff and practice educators were working to improve mandatory training compliance for medical staff.

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

The mandatory training was comprehensive and met the needs of patients and staff. Nurses we spoke with told us they had enough time to complete mandatory training. Staff could complete online mandatory training from home if needed. Managers released nurses for two days a year for ‘block training’ so staff were able to complete mandatory training.

Clinical staff had training to recognise and respond to patients with mental health needs, learning disabilities, autism and dementia. However, staff described the mental health content as minimal. Training on mental health, learning disabilities and autism was included in the mandatory trust annual update training.
Staff we spoke with had a basic understanding of how to support patients with mental health needs. Some nurses told us they wanted more training on supporting patients with mental health needs. The mental health liaison team did not provide formal mental health training to staff in the hospital due to its insufficient capacity, but the team did offer advice and support.

Staff told us they needed more training to support patients with mental health and mental capacity difficulties. Staff on Tavy medical admissions unit told us they had not had training in mental health, dementia, restraint, breakaway or learning disabilities.

The learning disabilities team offered training to staff. An independent mental capacity advocate worked with the team one day per week. The team offered ad hoc training for trainee doctors. However, there was no mandatory learning disability training for staff. We heard there were three slides about vulnerable patients in safeguarding training dedicated to learning disabilities.

Staff had access to training in safe restraint methods. All security staff, including ‘bed watch’ (security staff employed to observe a patient) and enhanced observation staff were trained in restraint. The restraint training used by the trust was healthcare approved in line with reduction networks training standards. Restraint training was offered to all frontline staff. However, we heard that it was challenging for staff to find time to attend the training. For staff in the medicine care group, 171 staff had received restraint training, but the trust did not state how many staff were eligible for this training. The trust had identified this as a risk and a business case for investment in a physical intervention training team had been approved at the time of the inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers monitored mandatory training compliance through monthly performance reports. Ward managers discussed performance reports with matrons every month at performance reviews to address gaps in staff mandatory training.

Staff’s awareness of sepsis had improved since our last inspection. Staff we spoke with were aware of the signs of sepsis and how to begin treatment using the ‘sepsis six’ pathway. Sepsis training was included with the roll out of national early warning score 2 (NEWS2), a tool to detect patient deterioration.

**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. However, not all staff were up to date with safeguarding training.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training. The trust included safeguarding adults and safeguarding children in the trust update training module.

Nursing staff received training specific for their role on how to recognise and report abuse. However, not all staff had completed updates to safeguarding training. A breakdown of compliance for safeguarding training courses from 16 May 2018 to 15 May 2019 at trust level for registered nursing staff in medicine is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>516</td>
</tr>
<tr>
<td>Trust Update</td>
<td>485</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for the safeguarding training module for which registered nursing staff were eligible.

Not all medical staff had completed training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses from 16 May 2018 to 15 May 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>156</td>
</tr>
<tr>
<td>Trust Update</td>
<td>128</td>
</tr>
</tbody>
</table>

In medicine the 95% target was not met for the two safeguarding training modules for which medical staff were eligible.

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

The trust safeguarding lead confirmed mandatory training included female genital mutilation (FGM) and child sexual exploitation.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with understood how to recognise safeguarding concerns for example, self-neglect and domestic abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with understood how to make a safeguarding referral through the electronic system.

**Cleanliness, infection control and hygiene**

The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection most of the time. They kept equipment and the premises visibly clean. However, cleaning records were not always up-to-date and hand sanitiser gel was not always available at the entrance to wards.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean, although some corridors were cluttered with equipment.

Cleaning records were not always up-to-date to show that all areas were cleaned regularly. On Mayflower renal unit and Tavy medical assessment unit we saw cleaning checklists for bays that were not completed daily.

Hand sanitiser gel was not always available for patients and visitors to use at the entrance to wards. On Tavy medical assessment unit two dispensers were empty and at the entrance to the endoscopy ward one dispenser was empty.
Staff followed infection control principles, including the appropriate use of personal protective equipment (PPE) most of the time. Staff washed their hands before and after contact with patients. However, we saw staff walking through corridors with urine bowls wearing gloves but no aprons on Thrushel medical assessment unit.

Isolation rooms for patients with infections were clearly labelled and cleaning staff we spoke with understood cleaning procedures for these rooms. Infection control lead nurses told us there were enough side rooms for patient isolation in the hospital and the electronic patient information system could run reports on use of side rooms in the hospital.

An infection prevention and control team and governance structure ensured oversight of practice and reporting of compliance, ensuring compliance with the NICE quality standard QS61 to reduce infection rates and prevent avoidable deaths from healthcare associated infections. The trust-wide infection control sub-committee reviewed cleanliness assurance group reports every month. We reviewed the cannula care audit for the medicine care group (February to July 2019) and found overall compliance was consistently above the 95% target.

Senior nurses completed monthly observational hand hygiene audits. Results were displayed on each ward, so staff, patients and visitors could see their performance. For example, we saw Bracken ward scored 100% in all areas in July 2019. We reviewed hand hygiene audit results for the medicine care group between 1 February 2018 and 31 July 2019 and found compliance was consistently above the target of 95%.

The infection prevention and control team delivered infection prevention control education and teaching to both clinical and non-clinical staff.

National guidelines were followed for the screening of patients admitted to the medicine care group. High risk patients were screened for MRSA in line with relevant criteria. The service monitored hospital-acquired infections, including, MRSA through monthly service line performance dashboards. However, performance for some wards did meet trust targets. For example, Marlborough ward compliance for MRSA screening of non-elective inpatients was below 70% April to June 2019. This did not meet the trust target of 95%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff labelled equipment with dated ‘I am clean’ stickers to show it was clean and ready for use. On Bracken ward staff were aware of how to manage spillages of cytotoxic waste and a spillage kit was available in the treatment room.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. However, staff did not always carry out safety checks of specialist equipment and wards did not always meet the needs of patients when six beds were used in five-bed bays.

Patients could reach call bells and staff responded quickly when called. On Thrushel and Tavy medical admission units, staff checked patients had access to call bells as part of the ‘call don’t fall campaign’ to prevent falls.

The design of the environment followed national guidance most of the time, but the service did not always provide suitable facilities to meet the needs of patients. At the last inspection we found wards where patients were looked after in six-bedded bays, which were designed for five bed spaces. Due to reduced space between patient’s beds there was an increased risk of cross contamination, compromised patient privacy and less space for clinical staff in emergencies. This
had not improved. We saw patients in six-bedded bays designed for five bed spaces on Tamar short stay ward, Honeyford, Meldon and Marlborough ward. Staff on Marlborough ward told us these ‘escalation beds’ were used most of the time. Staff had raised incidents relating to the infection control risk. The service had recorded risks relating to this for Marlborough and Monkswell ward but not the other wards.

The service had recorded risks relating to use of six beds in five bed bays on Marlborough and Monkswell wards. These were infection control risks associated with restricted access to handwashing sinks. On Marlborough ward the risk was being mitigated by having bins for removal of aprons and gloves outside the bay and additional hand sanitiser gel. There was evidence of regular review of this risk, but the service was unable to remove the additional beds due to operational pressures in the hospital. On Monkswell ward the risk assessment noted an increased falls risk due to clutter, such as bins in the corridor and lack of space in the bay for a nurse to observe patients at their desk. The risk on Monkswell had been open since April 2015, and on Marlborough since April 2019.

There was some evidence of increased *c. difficile* infection rates following use of 6 beds in 5 bedded wards. Between April 2018 and March 2019 there were no reports of *c. difficile* on Marlborough ward. Since April 2019 there were two cases in April, two cases in May and two cases in July.

Staff did not always store equipment safely. On Burrator ward disinfectant tablets were left on the windowsill in the sluice. This increased the risk of a patient eating a hazardous substance accidentally or to self-harm as the sluice was not locked. On Honeyford respiratory ward two oxygen cylinders not stored securely in the corridor. There was a risk staff or patients could trip over the oxygen cylinders.

Staff did not always carry out daily safety checks of specialist equipment. At our last inspection we found emergency equipment was not checked every day in line with trust policy. This had not improved. On Tamar short stay unit ten days were not checked in June 2019 and seven days were not checked in May 2019. On Burrator ward four dates on records were missing in July 2019 and eight dates on records were not completed in May 2019. Emergency equipment was stored in tamper-evident trolleys with numbered tags.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to the equipment they needed for patients including specialist equipment such as pressure relieving mattresses. Equipment was safe and ready to use. We checked five pieces of electrical equipment on Monkswell ward and they were all in date for servicing. We checked five consumable items each on Bracken and Burrator wards and they were all in date.

Staff disposed of clinical waste safely. We saw waste was separated and stored appropriately on wards we visited. Staff signed and dated sharps bins and stored them appropriately.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the quality of handovers when patients moved wards, and recording of venous thromboembolism VTE assessments needed to improve.**

Staff did not always follow consistent processes to share key information to keep patients safe when handing over their care to others. The situation, background, assessment, recommendation (SBAR) model was used when patients moved between wards. At the time of our inspection the
service was moving to an electronic handover process from the medical assessment unit on the wards. Staff could handover patients who were medically stable using only the electronic form. Patients who were not stable needed a verbal handover in person or by telephone, in addition to the electronic form. However, paper SBAR forms we reviewed were not completed consistently. We reviewed five SBAR forms across Meldon and Marlborough wards and found in all five SBAR forms they were not consistently dated and signed by the person giving and receiving the transfer. For example, on Marlborough ward a SBAR form we reviewed was signed by the nurse providing transfer but not by person/doctor receiving the patient and another SBAR form had no date or signatures.

We observed a patient being handed over from the medical admissions unit to Marlborough ward. Ward staff were not expecting the patient on the ward even though the patient had been allocated to the ward through the electronic system. There was no medical handover of the patient and the SBAR transfer form was not completed.

Shift changes and handovers included all necessary key information to keep patients safe. Doctors and nurses attended daily morning safety briefings to ensure important information was shared between staff. We reviewed records of daily safety briefings on Thrushel, Torcross and Marlborough wards and found the safety briefing included discussion of: staffing levels, acutely unwell patients, infection control risks, falls risks, pressure care risks, incidents and concerns. Records of safety briefings were available to staff. Doctors and nurses attended the morning safety briefing.

Staff ensured patients had enough information to manage their condition if it deteriorated after they left hospital. For example, on Bracken stem cell unit patients were given alert cards and encouraged to ring the unit 24/7 if they had concerns patients can be admitted directly to the unit rather than emergency department.

Staff completed risk assessments for each patient on admission or arrival and updated them when necessary and used recognised tools. Nursing staff completed risk assessments on admission. These included: falls risk, pressure ulcer risk, malnutrition risk. We saw nursing risk assessments were completed in all the 38 patient records we reviewed. Patients who were more acutely unwell or had been assessed as higher risk (for example for falls, pressure ulcers) would be accommodated in level one care bays or areas closest to the nursing station.

Staff knew about and dealt with any specific risk issues, this included:

Deteriorating patients and sepsis

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score 2 (an updated version of the tool) to monitor and identify deteriorating patients. Nursing staff we spoke with could access medical review for patients in a timely way from doctors working on the ward or the acute care team. We reviewed the NEWS2 audit for the medicine care group 1 April 2019 to 31 July 2019 and found compliance with the tool was above 95% in all areas every month.

At our last inspection we found the sepsis protocol and care bundle for managing patients with suspected sepsis was not used consistently across inpatient wards and not all staff could remember if they had received training on sepsis. While staff awareness had improved, we were not assured the sepsis protocol was fully embedded as compliance with the sepsis six pathway needed to improve.
Nurses we spoke with could describe the signs of sepsis and were aware of the sepsis six care bundle. Wards had sepsis link nurses. We spoke to a sepsis link nurse on Tavy medical assessment unit and they explained their role was to staff to improve their awareness of sepsis.

Completion of sepsis audits needed to improve. The service audited compliance with sepsis pathway timelines for medical patients, including the administration of antibiotics within one hour. Data collection for sepsis pathway audits needed to improve. The hospital used a paper system for recording NEWS2 scores which meant data collection took more time than if an electronic system was used. The percentage of patients who presented with severe sepsis and were administered intravenous antibiotics within one hour of diagnosis of sepsis in April 2019 was 91% on Thrushel MAU and 44% on Tavy MAU. Performance for May 2019 was 100% on Thrushel MAU and 57% on Tavy MAU and performance for June 2019 was 100% on Thrushel MAU and 80% on Tavy MAU. Brent and Hexworthy, the two other high-risk areas included in the sepsis audit, had not been collected in the past three months. The trust stated deterioration in data collection across all wards and assessment areas had been due to availability of the ‘military sepsis team’ (a team of staff employed by the ministry of defence working at the hospital who were supporting with sepsis audits) to complete weekly ward audits. The service had a trust-wide sepsis improvement plan, but no ward level actions were included to address poor performance on specific wards or units.

Venous thromboembolism

At our last inspection we found not all patients were risk assessed for venous thromboembolism (VTE) on admission to hospital and reassessed within 24 hours of admission or whenever the clinical situation changed. This had not improved.

We reviewed 22 medicines charts and found risk assessments were not always fully completed for 24-hour VTE assessment and there was not always evidence of review of the VTE assessment. Where risk assessments were incomplete step one or step six were sometimes not completed. In four of the VTE assessments we reviewed step one (mobility assessment) was not recorded. In five of the VTE assessments we reviewed step six was not recorded. The trust was using VTE risk assessment based on out of date NICE guidance. Clinical leads told us risk assessment documentation would be aligned with current NICE guidance when recording of VTE assessment is part of electronic prescribing.

The trust audited VTE risk assessments being completed against a 95% target. The trust audited four medicines charts from all wards every month. The target was consistently met between February and July 2019. The service monitored compliance with VTE assessment at the thrombosis committee.

Falls

Nurses worked to reduce the risk of patient falls by placing patients at the highest risk of falls in bays where they could most easily be observed. Thrushel MAU had introduced a ‘call don’t fall’ campaign, with posters displayed on wards encouraging patients at medium risk of falls to call for help. Nurses on Thrushel MAU had started a ‘baywatch’ system where a nurse wearing a red lanyard constantly observed patients in the bay. The ‘baywatch’ approach was being shared with the rest of the wards in the care group and we saw it working well on Shipley ward. Senior nurses audited the completion of falls risk assessments. We reviewed the falls risk assessment audit for 1 February 2019 to 31 July 2019 and found compliance was above 95%.

Staff completed a frailty score for each patient on an electronic system on admissions. Frailty scoring was used to assess older people’s mobility and ability to live independently and complete
the tasks of daily living. The frailty team reviewed the care of patients scoring five or six (mildly to moderately frail) on the frailty score to prevent future frailty-related admissions to hospital.

Mental Health

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). The service had plans for the mental health liaison service to be a 24-hour service by April 2021. The hospital had a mental health liaison service, provided by the local mental health community trust, but staff told us that they had a variable response from the team. Staff told us the mental health liaison team would sometimes not visit until the patient was medically fit. However, staff told us the response had improved and that they were better able to negotiate with the team about patients’ individual needs, despite ongoing ill health. We saw evidence of wards chasing mental health liaison to see patients, including a patient that required a section 5.2 of the Mental Health Act, which is used to keep patients in hospital temporarily if a doctor considers they need to be formally assessed for a mental health problem.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff said they did not always get a verbal handover from psychiatric liaison and they did not always write in the patients’ medical notes, so staff were not always clear on the outcome of the mental health liaison assessment. Staff told us they got telephone advice and support but that the psychiatric liaison team could not always attend in person, especially out of hours, due to the service capacity. Staff found this a challenge, particularly if patients were expressing suicidal ideation. They told us supporting these patients was time-consuming, they hadn’t received adequate mental health training and that they felt under pressure. Staff on Tavy ward told us they used the alcohol withdrawal assessment scoring guidelines and the clinical opiate withdrawal scale to assess the risks to patients, as required.

Staff told us about an enhanced observations team of mental health trained healthcare assistants whose staff carried distraction kits which enabled them to reassure and redirect patients who needed additional support. Staff advised that they could also request a ‘bed watch’ service provided by security staff. At the time of inspection medicine care group leaders were reviewing the use of security staff for ‘bedwatch’ due to considerations about what is clinically appropriate and most cost effective. While there were clear criteria for accessing bed watch or the enhanced care team, staff told us they requested bed watch for patients in accordance with the guidelines, but the request was sometimes declined, and they did not know why. Staff advised that the bed watch service had also been under review since the new enhanced observation team had been set up.

Nurse staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe most of the time. However, some wards, including Marlborough and Burrator acute medicine ward had a high number of nurse vacancies. Nurses were regularly moved around the hospital to cover gaps and maintain safe staffing levels. There was a focus on recruitment, with international nurse recruitment in the pipeline to improve vacancy rates. Retention strategies included ensuring the preceptorship programme was high quality and developing a pilot for an 18-month rotation for
band five nurses. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. A live acuity tool was used to ensure safe deployment of staff and to manage the organisational staffing resources on a day to day basis. The service used a nationally recognised staffing acuity tool (the Shelford acuity tool) and staff reviewed and updated the system with the current acuity of patients. This worked on a red, amber, green (RAG) rating basis, identifying where there was cause for concern. This tool was combined with professional judgement to ensure safe care was being provided to patients. Daily safe staffing meetings were held between care groups, overseen by the head of nursing. Real time data of actual staffing levels and patient acuity could be viewed, and staff redeployed as required.

Due to a lack of nurse staffing, the stroke ward was not able to provide a designated hyperacute stroke unit and staffing would be adjusted to provide this. The stroke ward was staffed as an acute stroke unit at the time of inspection, with a reduced number of beds, and nursing establishment was reviewed every year. Stroke consultants we spoke with told us additional nurses were needed to meet national standards and safely staff the unit as a hyper acute stroke unit rather than an acute stroke unit. At the time of our inspection designated level one beds (for the sickest patients with a higher nurse to patient ratio) and funding for appropriate staffing of these beds had been agreed.

The trust considered recommended benchmarks to plan staffing levels. The head of nursing reviewed nursing staffing establishment every year. The National Institute for Health and Care Excellence Safe staffing for nursing in adult inpatients wards in acute hospitals, recommends the registered nurse to patient ratio should not be greater than eight patients per registered nurse during the day shift. Data in the October 2018 staffing review showed this ratio was met during the day across all wards except Mayflower renal ward and Monkswell elderly care wards which were funded to a 1:9 nurse to patient ratio.

We attended the 9.15 am matrons’ staffing meeting for the medicine care group. Nurse and health care assistant staffing was discussed for the late and evening shifts that day. Late shifts were covered by moving nursing staff around and six registered nurse shifts, and four healthcare assistant shifts went out to be covered by agency staff.

The medicine care group held a risk relating to the high numbers of staff vacancies. There was a recruitment plan to address this and new starters planned to begin in September 2019.

We discussed nurse staffing with matrons. Challenges included the impact of high nurse vacancies in surgery (as nurses from the medicine care group were moved to fill shifts on surgical wards) and covering nurse staffing at night. Matrons acknowledged that the need to move nurses around to cover shifts in different speciality areas lowered staff morale. Matrons increased twilight cover of healthcare assistants and nurses to minimise the risk of reduced nurse staffing at night.

The ward manager could adjust staffing levels daily according to the needs of patients. However, ward managers and nurses told us it was sometimes difficult to get extra healthcare assistants for one to one care. To address this the service had a pool of registered mental health nurses and mental health care assistants that could be called upon to observe patients with mental health needs. At the time of our inspection, the service was developing an enhanced care team of healthcare assistants with experience of managing challenging behaviour.

Patients’ mental health needs were included and considered in assessing the staffing needs for wards. For example, the head of nursing requested the matron reviewed the needs of mental
health patients on the medical admissions unit to inform decisions about appropriate staffing. However, staff on Marlborough ward we spoke with told us it was difficult to access extra staff to provide one to one observation of mental health patients.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers most of the time on the wards we visited. However, at the time of our inspection Marlborough, Tavy and Honeyford wards were short one nurse against planned numbers. For example, at the time of inspection and during a follow up visit Marlborough ward was short one nurse during the day and night. We reviewed the frequency of intentional rounding (regular nursing observations of patient’s vital signs) on this ward and reviewed four patient records. Intentional rounding had not been completed within recommended time frames for all the patient records we reviewed. This indicated nurses did not have time to complete essential tasks to keep patients safe. Nurses reported difficulties staffing level one observation bays on Thrushel, Tavy, Honeyford and Marlborough wards. The nurse staffing for these areas was not protected to ensure that staffing levels for the level one areas was always maintained so the sickest patients in the level one beds were not always observed by a nurse.

The trust was using alternative staffing roles to improve staffing levels. For example, advanced care practitioners on the acute assessment unit. Advanced practitioners worked to speed up the process for imaging, reading blood results.

The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>None</td>
<td>None</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1655.2</td>
<td>11.1%</td>
<td>7.6%</td>
<td>4.9%</td>
<td>67,510 (6%)</td>
<td>34,299 (3%)</td>
<td>185,160 (18%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>657.4</td>
<td>16.3%</td>
<td>9.2%</td>
<td>4.8%</td>
<td>67,510 (6%)</td>
<td>34,299 (3%)</td>
<td>185,160 (18%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within this core service were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy or bank staff usage.

Vacancy rates

The service had stable vacancy rates and overall nursing vacancy rates were 16%.

Turnover rates

The service had stable turnover rates and overall nursing turnover was 9%.
Sickness rates

The service had an increasing sickness rate.

Monthly sickness rates over the last 12 months for qualified nurses shows an upward trend from May 2018 to October 2018.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

We discussed increased nursing sickness rates with medicine care group leads. They told us an increase in sickness was due to a combination of short and long-term sickness. Human resources staff supported ward managers to complete a monthly walkthrough to support with recruitment, retention and performance management. Matrons encouraged ward managers to have open conversations with staff about wellbeing at work encourage staff to access wellbeing support and occupational health services.

Bank and agency staff usage

The service had reducing rates of bank and agency nurses used on the wards.

Agency hours

Monthly ‘agency hours’ over the last 12 months for qualified nurses, health visitors and midwives shows a shift from January 2019 to June 2019.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Managers were not always able to fill nursing shifts during the day or night across most wards. Managers limited their use of bank and agency staff and requested staff familiar with the service. Ward managers tried to fill shifts with existing staff or regular bank staff. Data from the March 2019 staffing review which reported on February data showed nursing shifts were not always filled:

<table>
<thead>
<tr>
<th>Medical care ward area</th>
<th>Average registered nurse % fill rate during the day</th>
<th>Average registered nurse % fill rate during the night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tavy AMU</td>
<td>83%</td>
<td>74%</td>
</tr>
<tr>
<td>Thrushel AMU</td>
<td>85%</td>
<td>83%</td>
</tr>
<tr>
<td>Bickleigh (cardiology)</td>
<td>80%</td>
<td>77%</td>
</tr>
<tr>
<td>Bracken stem cell unit</td>
<td>67%</td>
<td>91%</td>
</tr>
<tr>
<td>Brent</td>
<td>81%</td>
<td>95%</td>
</tr>
<tr>
<td>Burrator acute medicine ward</td>
<td>64%</td>
<td>68%</td>
</tr>
<tr>
<td>Hartor (elderly care)</td>
<td>75%</td>
<td>81%</td>
</tr>
<tr>
<td>Hembury (elderly care)</td>
<td>83%</td>
<td>73%</td>
</tr>
<tr>
<td>Hexworthy (respiratory)</td>
<td>75%</td>
<td>96%</td>
</tr>
<tr>
<td>Honeyford (respiratory)</td>
<td>80%</td>
<td>99%</td>
</tr>
<tr>
<td>Marlborough (gastroenterology)</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>Mayflower (renal)</td>
<td>110%</td>
<td>87%</td>
</tr>
<tr>
<td>Meldon (general medical)</td>
<td>83%</td>
<td>99%</td>
</tr>
<tr>
<td>Merrivale Acute Stroke and Neurology ward</td>
<td>82%</td>
<td>81%</td>
</tr>
<tr>
<td>Monkswell (elderly care)</td>
<td>97%</td>
<td>79%</td>
</tr>
<tr>
<td>Shipley (elderly care)</td>
<td>81%</td>
<td>100%</td>
</tr>
<tr>
<td>Tamar (shorty stay ward)</td>
<td>97%</td>
<td>99%</td>
</tr>
<tr>
<td>Torcross (cardiology)</td>
<td>101%</td>
<td>99%</td>
</tr>
</tbody>
</table>

Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff we spoke with confirmed they received an orientation to the ward before they started work.

**Medical staffing**

Some medical care specialities had a shortage of medical staff to meet the needs of the service. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Some medical care specialities had a shortage of medical staff to meet the needs of the service. The shortages in medical staff were reviewed regularly and specialty leads felt there had been proactive work to recruit to vacancies. At the time of our inspection only four healthcare of the elderly consultants were employed by the trust against an assessed need of 10, this risk was recorded on the medical care risk register. At weekends there was only one healthcare of the elderly consultant. This meant fewer patients were seen at the weekend and increased workloads on Friday to prepare. Recruitment was ongoing and eight elderly care consultants would be employed by February 2020.

The service had enough medical staff to keep patients safe during the week, but weekend cover needed to improve. The service always had consultants on call during evenings and weekends.
There was consultant presence on all wards Monday to Friday, and we saw evidence in the 38 records we reviewed that consultant wards rounds were completed daily. There were arrangements for doctors to see new or unwell patients, or cover was provided by the on-call medical team. The acute care team supported medical staffing out of hours. They were able to review patients and appropriately refer to the registrar or specialist team. However, staff told us it was difficult to arrange timely medical review of medical patients on non-medical wards at weekends.

There were arrangements for medical staff to review medical patients who were placed on other non-medical wards due to the lack of available beds, but these needed to improve to ensure patients received a timely review at weekends. These patients were known as medical outliers. There was an outlier rota led by a dedicated outlier consultant supported by junior doctors, who would rotate on a weekly basis. The number of junior doctors was determined by the number of outlying patients. Outlier ward rounds were only completed Monday to Friday. Over the weekend outlier patients were reviewed as required by the on-call team. The outlier team stopped working each Friday at 5 pm and did not recommence until 8 am the following Monday morning. This meant that should a medical patient be admitted to a surgical ward at 5:30 pm on a Friday, they would not be seen again until the following Monday unless their review was assessed as urgent. We saw the medical outliers were discussed during board rounds. We visited a surgical ward where patients were outlying and confirmed review had been completed daily by the medical team.

The service was working to recruit more doctors. The July 2019 medical care clinical governance meeting included an update on junior doctor staffing. There were 14.2 whole time equivalent vacancies from August 2019 to December 2019 which was the lowest it had been for the last few years according to the meeting minutes. The trust was using recruitment agencies to recruit junior doctors into posts. Seven foundation level three (F3) trust doctors were due to start in August 2019, with a further four starting in February 2020. Junior doctor exception reporting (on patient safety and rostering concerns) was reviewed at the monthly medicine care group board meeting.

The trust was not able to supply medical staff locum usage data. We requested this at the time of inspection, but the data was the same as what was supplied in the routine provider information request.

The table below shows a summary of the medical staffing metrics in medicine at compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>1655.2</td>
<td>11.1%</td>
<td>7.6%</td>
<td>4.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>235.9</td>
<td>6.3%</td>
<td>1.0%</td>
<td>0.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
Medical staffing rates within this core service were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover or agency use.

**Vacancy rates**

The service had a low medical vacancy overall at 11% but had an upward trend since November 2018.

Monthly vacancy rates over the last 12 months for medical staff shows an upward trend from November 2018 to April 2019.

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

**Turnover rates**

The service had stable turnover rates for medical staff at 1% overall.

**Sickness rates**

Monthly sickness rates over the last 12 months for medical staff shows an upward trend from May 2018 to September 2018.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*
Staffing skill mix
Staffing skill mix was similar to the national average.

In February 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 229 whole time equivalent staff working in medicine at University Hospitals Plymouth NHS Trust

<table>
<thead>
<tr>
<th>Staffing Skill Mix</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>20%</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 (01/02/2019 – 28/02/2019)

Bank and locum staff usage
The service submitted data on use of bank and locum staff used on the wards, but we were unable to determine the figures from this data as it was incomplete.

Managers could access locums when they needed additional medical staff. For example, the sister on Meldon ward told us was covered by four long term locum staff.

Records
Staff kept detailed records of patients’ care and treatment. Records were up-to-date and available to staff. However, the clarity and organisation of record keeping needed to improve. Records were not always stored securely on wards.

Patient notes were comprehensive, and all staff could access them. However, the quality of record keeping needed to improve. Staff used paper records for medical and nursing notes. We reviewed 26 patient nursing and medical records to review the quality of completion. We also reviewed six records in relation to the care of patients with mental health conditions.

At the last inspection we found – Medical staff did not always ‘print’ their name, role/GMC number (identification number from the General Medical Council) although most medical staff added their bleep number. This meant it was at times difficult to trace the person who made the entry if more information was required. This had not improved.

At the last inspection we found patients’ names and identification numbers had mostly been added but did not clearly state the location of the patient on each page. This meant that it was difficult to follow the patient journey and the reasons for moving patients to a different ward. This had not improved.
When patients transferred to a new team, there were no delays in staff accessing their records. Patients nursing, and medical notes moved with them when they moved wards. Staff used a handover document to inform the new ward of the patients’ needs but this was not used consistently.

Records were not always stored securely. Staff stored medical records in lockable trolleys. However, on Burrator and Tavy short stay and Marlborough wards we saw that staff did not always lock the trolleys after accessing notes. Nursing notes were kept at the end of patient’s beds or in lockable trolleys.

Senior nurses audited the quality of completion of records every month using the fundamentals of care audit.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, recording and storing medicines. However, processes for administering medicines safely were not always followed. At our last inspection we found on Mayflower renal unit the administration of intravenous fluids was not always prescribed for patients receiving haemodialysis in line with national guidance. This had not improved. We reviewed medicine charts on Mayflower renal unit and found administration of intravenous fluids did not have a standard prescription or patient group direction. We discussed with a senior nurse and consultant who confirmed that intravenous fluids were administered then prescribed on the medicine chart.

We observed a medicine round on Monkswell ward and found nurses checked the patient’s name and identification band for their date of birth. Nurses observed patients taking medicines before signing medicine charts.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. A pharmacist visited wards daily to review prescriptions and advise medical staff when doses needed to be revised. We observed that although initial VTE assessments were completed, not all stages of the risk assessment were always recorded and the 72 hour follow up assessment was not seen to be completed on the majority of charts we reviewed. Patients were prescribed appropriate anti-coagulation in accordance with the Trust policy.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Records showed that daily checks of medicines stock on the resuscitation trolleys had been performed to ensure that they were fit for use in accordance with trust policy. Medicines fridge records showed that temperatures had been maintained in the recommended range.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff knew how to report incidents or near misses via the
trust’s electronic reporting system. Staff we spoke with felt confident in raising an incident should they need to.

**Incidents**

Staff did not always directly receive feedback from the incidents they reported, and timeliness of incident investigations needed to improve. However, staff recognised and reported incidents and near misses and managers investigated and shared learning.

All staff knew what incidents to report and how to report them. Staff knew how to report incidents through the electronic system. For example, staff told us they had reported incidents relating to falls, staffing levels and medicine administration errors.

Staff reported all incidents that they should report. Staff we spoke with told us they were encouraged to report incidents.

**Never Events**

The service had no never events on any wards.

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 April 2018 to March 2019, the trust did not report any never events in medicine.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (Sis) in medicine which met the reporting criteria set by NHS England from April 2018 to March 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>13</td>
<td>72%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with understood the principles of duty of candour.

Staff did not always directly receive feedback from investigation of incidents, both internal and external to the service. Most staff we spoke with did not always directly receive feedback on the incidents they reported. This meant staff were less involved in learning from incidents and could discourage staff from reporting in future.
Staff met to discuss the feedback and look at improvements to patient care. However, review of incidents at governance meetings needed to improve. Senior nurses discussed learning from incidents with staff at daily safety briefings. Medicine care group governance meetings did not have standard agendas and did not always include review and discussion of serious incidents.

There was evidence that changes had been made as a result of feedback. For example, following an increase in falls among patients’ risk-assessed as medium rather than high risk of falls, nurses were focusing on preventing falls in this patient group. We saw the ‘call don’t fall’ campaign in action on Thrushel and Tavy wards with yellow posters displayed to encourage patients to call for help and yellow signs next to call bells.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed the last three serious incident investigations and saw that duty of candour was followed and discussions with next of kin recorded. Root cause analysis investigations identified learning and included action plans to share learning at ward level and across the medicine care group were included.

However, root cause analysis investigations were not always completed in a timely manner. For example, the three incidents we reviewed took 145 days, 95 days and 70 working days to complete, against a target of 60 working days. Delays to investigating incidents could lead to delays in sharing essential learning and changes to practice to ensure patient safety. At the time of inspection, the trust had recently changed the serious incident review process to improve timeliness. The new process included an initial review of the incident within 24 hours which would be used to inform the 72 hour investigation report.

Managers debriefed and supported staff after any serious incident. Staff we spoke with told us they had a debrief following a recent serious incident and support was available from occupational health following distressing incidents. A member of staff told us about an incident they were involved in and were positive about support from occupational health, including a supported return to work from sickness.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see.

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.

The safety thermometer data showed the services achieved over 95% harm-free care for the last 12 months.

Staff used the safety thermometer data to further improve services. We saw that data on harm free care was shared with staff and the ward manager on Thrushel MAU was proud of maintaining harm-free care.

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 32 new pressure ulcers, 31 falls with harm and 11 new urinary tract infections in patients with a catheter from May 2018 to May 2019 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at University Hospitals Plymouth NHS Trust**

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1. **Total Pressure ulcers (32)**

2. **Total Falls (31)**

3. **Total CUTIs (11)**

---

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

*(Source: NHS Digital – Safety Thermometer)*

We discussed the results of the safety thermometer audits with the matron for harm-free care and the lead nurses for tissue viability, falls prevention and infection prevention and control.

Senior nurses used safety thermometer results alongside incident reports to look at themes and compared safety thermometer results with other hospitals.

The service was addressing a rise in pressure ulcers with a trust-wide pressure ulcer reduction action plan. The service thought a rise in pressure ulcers was due to changes in recording of ungradable and unstageable pressure ulcers and an increase in acuity on the wards. The tissue viability nurse supported wards to tailor their action plans.

**Falls prevention campaigns**

The service worked to prevent patient falls. For example, the service had a falls action week in June 2019 across all patient areas. Call to action posters were displayed in all patient areas – working towards encouraging staff to have the conversation about falls risks with patients. The falls action week encouraged staff to talk about how they felt when falls happened.

Senior nurses reviewed falls across the service to look for themes. We reviewed the minutes of the June 2019 Harm-free care meeting and saw that there was a detailed analysis of falls incidents broken down by ward.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed clinical guidelines on the intranet and found staff had access to local policies based on national guidance and links to National Institute of Clinical Excellence (NICE) guidance. We saw that most guidelines were up to date, for example clinical guidelines on aortic dissection, implantable devices and hyperglycaemia in acute coronary syndrome (ACS) non-invasive ventilation and asthma. Some guidelines were out of date and marked ‘expired’, but these were still available to staff. As a result, there was a risk staff could access and follow out of date clinical guidelines.

The service had local audit programmes to monitor compliance with national guidance. We reviewed the audit programmes for haematology, oncology and immunology and found that details of successes, concerns and actions taken following the audit were recorded for most audits.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. For example, we saw on Marlborough ward mental health needs, including patients under section 2 of the Mental Health Act were included on the safety briefing.

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 needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw that patients had a choice of meal options and were regularly offered drinks throughout the day. Staff were attentive to patient’s nutritional needs. For example, we observed a housekeeper was careful to check which patients were ‘nil by mouth’ or had specific nutritional needs while offering drinks and snacks. Easy to eat finger foods were available for patients living with dementia.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed 26 nursing records and found that fluid and nutrition charts were completed appropriately.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nurses used the malnutrition universal screening tool (MUST) and we saw that MUST scores were recorded and reviewed in all the patient records we reviewed.

Specialist support from staff, such as dieticians and speech and language therapists, were available for patients who needed it. Staff made referrals to therapy staff through an electronic referral form. We saw evidence in medical notes of input from dietitians and speech and language therapists who reviewed patients as needed. For example, we saw that a patient was reviewed by a dietitian when they were at risk of malnutrition.
Pain relief

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

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff regularly reviewed patients’ pain needs during intentional rounding. Nurses used the Abbey Pain Scale for patients with cognitive impairments who could not verbalise their pain needs.

Patients received pain relief soon after requesting it. Patients we spoke with were positive about how their pain was managed.

Staff prescribed, administered and recorded pain relief accurately. Nurses reviewed patients’ pain as part of regular observations.

The service completed pain audits. Documentation of pain scoring was included in the fundamentals of care audit. Data showed between 1 May 2019 and 31 July 2019, 92% of patients had pain scores recorded every time nurses completed observations of the patient.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed similarly to national averages in national clinical outcome audits. Where performance was below national averages or expected outcomes, managers used the results to improve services further.

Examples of accreditation for the service included:

- The endoscopy service was accredited by the joint advisory group on gastrointestinal endoscopy (JAG). At the time of our inspection the endoscopy unit was completing improvement work to comply with recommendations made by JAG at their last visit in March 2019. This included works to extend the check-in and waiting area and building a door to separate the reception and waiting area from clinical areas.

- Bracken stem cell transplant unit was accredited by the joint accreditation committee (JACIE) the accreditation body for haemopoietic stem cell transplantation and cellular therapy. They were accredited in 2017.

Relative risk of readmission

From February 2018 to January 2019, patients had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions, when compared to the England average.

Elective Admissions– Trust Level

Overall, the service had a similar to expected risk of readmission for elective care than the England average.

- Patients in clinical oncology had a similar to expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
Non-Elective Admissions – Trust Level

Overall, the service had a lower than expected risk of readmission for non-elective care than the England average.

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in clinical oncology had a lower than expected risk of readmission for non-elective admissions
- Patients in nephrology had a lower than expected risk of readmission for non-elective admissions

(Source: Hospital Episode Statistics – HES – Readmissions (01/02/2018 – 31/01/2019))

From February 2018 to January 2019, patients at Derriford Hospital had a similar risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Derriford Hospital

- Patients in clinical oncology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions

Non-Elective Admissions – Derriford Hospital

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in clinical oncology had a lower than expected risk of readmission for non-elective admissions
- Patients in nephrology had a lower than expected risk of readmission for non-elective admissions
Managers carried out a comprehensive audit programme. Each speciality took part in local and national audits and took action to improve performance in audits.

**Sentinel Stroke National Audit Programme (SSNAP)**

Derriford Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, October to December 2018. Performance within domains two and eight had been persistently poor since December 2017.

**Derriford Hospital**

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

**Overall Scores**

<table>
<thead>
<tr>
<th></th>
<th>Dec 17 – Mar 18</th>
<th>Apr 18 – Jun 18</th>
<th>Jul 18 – Sep 18</th>
<th>Oct 18 – Dec 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>B</td>
<td>B</td>
<td>C↓</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>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
</tr>
</tbody>
</table>

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

We discussed performance in the SSNAP audit with the stroke leads. Improvements in the past two years included an increase in consultant staffing and the employment of an additional stroke specialist nurse. At the time of inspection, a business case to recruit extra band eight and seven therapists to enable the delivery of a seven-day service across therapies had been approved, with interviews scheduled in September 2019.

Senior leaders reviewed stroke performance at the trust stroke group chaired by the medical director. We reviewed the July 2019 acute stroke performance data and found the following metrics were reviewed every month: Percentage and number of thrombolysis patients, arrival to thrombolysis treatment (median), percentage of stroke patients screened for safety of swallowing in four hours, non-direct admissions to acute stroke unit (with reasons), direct admission to acute stroke unit in four hours breaches. Data showed in July 2019 there were seven delayed admissions to the acute stroke unit. The service did not meet its own target of 90% in the past year and compliance ranged between 45-72% against a national average of 55%.
We reviewed the SSNAP action plan for January to March 2019 and found performance was monitored every week through breach meetings and monthly performance reporting. There were actions against each standard that was below the target standard. The action plan included the following actions: workforce plan being developed to protect staffing to ringfence two acute stroke beds, adding an icon for referral to occupational therapy on the electronic patient system so referral times could be monitored and seeking funding for a band four assistant psychologist to carry out cognition and mood screening.

**Lung Cancer Audit**

The table below summarises the trust’s performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>66.7%</td>
<td>Does not meet the audit aspirational standard</td>
<td>No</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>39.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>14.5%</td>
<td>Within expected range</td>
<td>Yes</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>58.7%</td>
<td>Within expected range</td>
<td>No</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>62.9%</td>
<td>Within expected range</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit)

One out of four national standards were met in the national lung cancer audit. We discussed the lung cancer audit with a governance manager who told us the service was in the process of reviewing the lung cancer pathway to reduce delays for imaging. The oncology specialist nurse
staffing establishment had recently increased, and this would help improve performance with the metric ‘crude proportion of patients seen by a cancer nurse specialist.’

**National Audit of Inpatient Falls**

The table below summarises Derriford Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) <em>(Having a vision assessment is indicative of good practice in falls prevention)</em></td>
<td>34.5%</td>
<td>Red</td>
<td>No</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) <em>(Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</em></td>
<td>15.4%</td>
<td>Red</td>
<td>No</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) <em>(Having an assessment for delirium is indicative of good practice in falls prevention)</em></td>
<td>6.9%</td>
<td>Red</td>
<td>No</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) <em>(Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</em></td>
<td>82.1%</td>
<td>Green</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: National Audit of Inpatient Falls)

We discussed falls prevention with the harm-free care matron and falls prevention lead nurse. Falls prevention work included the ‘call don’t fall campaign’ and using ‘baywatch’ to ensure falls risks patients were continually observed.

**Chronic Obstructive Pulmonary Disease (COPD) Audit**

The table below summarises Derriford Hospital’s performance in the 2019 Chronic Obstructive Pulmonary Disease Audit. The service met one out of the six national standards.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission? <em>(Specialist input improves processes and outcomes for COPD patients)</em></td>
<td>58.9%</td>
<td>Worse than the national aggregate</td>
<td>No</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%)</td>
<td>99.6%</td>
<td>Better than the national aggregate</td>
<td>No</td>
</tr>
</tbody>
</table>
(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)

<table>
<thead>
<tr>
<th>Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</th>
<th>26.1%</th>
<th>Better than the national aggregate</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</td>
<td>45.3%</td>
<td>Worse than the national aggregate</td>
<td>No</td>
</tr>
<tr>
<td>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</td>
<td>79.4%</td>
<td>Better than the national aggregate</td>
<td>Yes</td>
</tr>
<tr>
<td>Percentage of patients with spirometry confirming FEV1/FVC ratio &lt;0.7 recorded in case file (A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</td>
<td>44.3%</td>
<td>Worse than the national aggregate</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Chronic Obstructive Pulmonary Disease Audit)

The service started submitting to the COPD audit in November 2018. Before this the service did not submit to the audit due to a lack of nursing and administrative time. A business case was approved to fund 25 hours of band six specialist nurse time and a full-time band three audit facilitator to collect data from COPD and asthma patients.

The service did not have a formal action plan to improve performance in the COPD audit. The service was working to improve identification of asthma and COPD patients in a timely way. The service started collecting data for the audit in March 2019 and from March to September 2019 data was submitted from 500 patients.

National Audit of Dementia

The table below summarises Derriford Hospital’s performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for)</td>
<td>55.6%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
<tr>
<td>while in hospital)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of staff responding</strong> “always” or “most of the time” to the question “Is your ward/service able to respond to the needs of people with dementia as they arise?” <em>(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</em></td>
<td>84.4%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium</strong> <em>(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</em></td>
<td>45.3%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Multi-disciplinary team involvement in discussion of discharge</strong> <em>(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</em></td>
<td>55.9%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

*(Source: National Audit of Dementia)*

Managers used information from the audits to improve care and treatment.

There were engagement meetings follow-up of audit outliers. The service engaged positively with the CQC outlier review process. However, there were some delays to responses. At the time of inspection, the service had two audit outliers that we were following up. We spoke with a consultant involved in the review of the audit outlier for coronary atherosclerosis. Cases were reviewed internally, and no major themes were found.

**Competent staff**

The service made sure staff were competent for their roles. However, completion of appraisals needed to improve to appraise staff’s work performance and provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff completed competencies relevant to the ward specialty and staff role during their induction training and an ongoing basis. We saw examples of these competencies on the wards we visited, for example, on Mayflower renal unit staff completed a comprehensive range of competencies relevant to dialysis and stroke nurses completed STAR training – (stroke training and awareness resources).

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with staff who had started their role in the last year and they told us the induction process
prepared them for the role and support from managers was good. Junior doctors we spoke with who had recently started at the trust were positive about the induction process.

**Appraisal rates**

Not all staff were supported to develop through yearly, constructive appraisal of their work.

From 16 May 2018 to 15 May 2019, 81% of staff within the medicine core service received an appraisal, compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>16 May 2018 to 15 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>254</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>41</td>
</tr>
<tr>
<td>Registered Nursing staff</td>
<td>369</td>
</tr>
<tr>
<td>Administrative and Clerical Staff</td>
<td>150</td>
</tr>
<tr>
<td>Additional Scientific and Technical Staff</td>
<td>17</td>
</tr>
<tr>
<td>Allied Healthcare professionals</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>851</td>
</tr>
</tbody>
</table>

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

The trust submitted updated data for medical staff completion of appraisals. For the period 1st June 2018 to 31st May 2019, 183 out of 198 (92.4%) medical staff in the medicine care group had received an appraisal.

There were enough clinical educators to support staff learning and development. The service used clinical educators well and staff were positive about them. For example, on Mayflower ward the practice educator had done some training on use of medical devices following some incidents. The service also supported student nurses well. Shipley ward was part of the collaborative learning in placement (CLIP) project to support student nurses.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, on the endoscopy unit staff started lists slightly later to allow time for staff training once a month. Staff on the medical assessment units were positive about the practice development nurse and access to simulation training based on how to respond to a range of clinical emergencies.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Most staff we spoke with were positive about access to training and development. For example, a nurse on Thrushel medical admissions unit had been supported to complete a master’s module in mental health.

Managers made sure staff received any specialist training for their role. For example, on Meldon ward two nurses had been funded to complete a masters level diabetes module. Staff had access to undergraduate and masters level training modules on dementia care.

Managers identified poor staff performance promptly and supported staff to improve. Human resources attended wards every month to support ward managers with staff performance issues.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers we spoke with on Thrushel medical admissions unit felt well-supported by the trust.
The trust provided volunteers with seven days of training, which included training relevant to their role.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Board rounds we observed were attended by the multidisciplinary team and everyone engaged to ensure the care was co-ordinated. Patients had their care pathway reviewed by relevant consultants and specialist nurses and therapists. Doctors we spoke with were positive about multidisciplinary working. For example, on Monkswell a multidisciplinary whiteboard designed to incorporate persons family links and brief background of their personal social situation to aid discharge planning and communications.

Staff worked across health care disciplines and with other agencies when required to care for patients. Ward staff worked with services in the hospital and in the community, including a hospital drug and alcohol service, a community Parkinson’s nursing service, the local mental health inpatient hospital, a community crisis response team, the community mental health team and community eating disorder services. Most wards had a discharge coordinator. We spoke with the discharge coordinator on Marlborough ward who explained their role included making referrals to community services and raising safeguarding alerts as required.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We reviewed seven records of patients with mental ill health and saw evidence that staff referred patients for mental health assessment as required. Referrals were made to the hospital psychiatric liaison service.

Patients had their care pathway reviewed by relevant consultants during the week but review of medical patients on non-medical wards at weekends needed to improve. The on-call manager or acute care team at night worked to ensure that patients were placed on the most appropriate ward. However, placing patients on the most appropriate medical ward was a challenge due to a shortage of beds. Monitoring of patients on the most appropriate wards was improving and the service had weekly root cause analysis meeting to explore the reasons why patients were not placed on the most appropriate ward.

**Seven-day services**

**Key services were available seven days a week to support timely patient care. However, consultant review of patients at weekends needed to improve.**

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. However, patients on non-medical wards were not always reviewed at the weekend as the outlier team worked Monday to Friday.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The rapid response therapy team provided a seven-day service 8am – 7pm Monday to Friday and 8am to 16:45 at the weekend.

The stroke service had plans to provide seven-day therapy services (including physiotherapy, occupational therapy and speech and language therapy) by the end of October 2019.
The trust participated in mandatory audit of performance against the seven-day standards. Data from the report presented to board in July 2019 showed:

- Standard 2: consultant review within 14 hours of decision to admin was met over 95% of the time.
- Standard 5: access to diagnostics was met.
- Standard 6: consultant directed interventions available locally or within a defined care pathway was met.
- Standard 8: once or twice daily review where required was not met overall. The standard was met Monday to Friday but not at weekends.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on wards. For example, on Hartor ward information on how best to support someone living with dementia was displayed.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff completed smoking and alcohol risk assessments on admission. The endoscopy service participated in a bowel cancer screening programme to support the early detection of bowel cancer. Cancer patients had access to a range of complementary therapies, such as massage and manicures at the Mustard Tree cancer centre.

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

**Consent was not always recorded in line with relevant guidance and legislation. There was a lack of consistency in how people’s mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation.**

Staff understanding of how and when to assess whether a patient had the capacity to make decisions about their care needed to improve. Staff we spoke with on Burrator ward had mixed views as to who was responsible for completing capacity assessments. Not all staff were confident in how to assess capacity or the process to follow if they had concerns about a patient’s capacity. Some nurses we spoke with were aware of the ‘acid test’ for deprivation of liberty (is the person free to leave and are they subject to continuous supervision and control).

Staff gained consent from patients for their care and treatment in line with legislation and guidance most of the time. However, records of Mental Capacity Act assessments were included in care records that they were not always completed. Although capacity is always assumed, the form included a tick box to indicate if a patient had capacity to consent to their nursing assessment and this was not always completed. The learning disabilities team provided Mental Capacity Act support to consultants.

Senior nurses completed monthly audits of treatment escalation plans and do not attempt cardiopulmonary resuscitation paperwork. We reviewed the audit for April 2019 and found performance did not meet the trust target for completion of mental capacity assessments (86%) or discussion of do not attempt cardiopulmonary resuscitation orders with patient’s next of kin (87%).

Staff clearly recorded consent in the patients’ records. We reviewed two consent forms for endoscopy procedures and found that consent was recorded clearly. Records we reviewed included details that patients had consented to care and treatment.
Mental Capacity Act and Deprivation of Liberty training completion

Mental Capacity Act and Deprivation of Liberty training was not a separate training module, it was included in the ‘trust update’ module under Safeguarding Adults (including Mental Capacity Act). Compliance for the ‘trust update’ module did not meet the trust target for nursing or medical staff.

Nursing and medical staff received mandatory training in Deprivation of Liberty Safeguards and this provided basic information about where and when to seek help and advice. However, it was doctors who made applications for Deprivation of Liberty Safeguards most of the time.

The mental capacity lead had completed a training needs analysis and identified significant gaps in training and was working to provide more robust training for medical and nursing staff in the Mental Capacity Act.

Not all nursing staff were confident to complete Deprivation of Liberty Safeguards applications. Nursing staff on Tavy medical assessment unit had had minimal Deprivation of Liberty safeguards (DoLs) training that covered how to complete paperwork. Staff found the DoLS paperwork challenging and the process confusing and they were unsure where to get advice. The junior sister on Thrushel medical admissions unit had created a folder for staff that contained information, examples and processes for applying for Deprivation of Liberties Safeguards to help staff navigate the process.

Staff did not have a good understanding of relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff understanding of the Mental Health Act had improved since our last inspection. Nurses only had a working knowledge of the Mental Capacity Act and Deprivation of Liberty safeguards where they used it regularly. The mental health liaison team provided support and advice for patients with mental health difficulties. The on-call manager or acute care team at night site management team came to support detention processes and read patients’ rights. The learning disability team provided care plans for patients with learning disabilities. Staff knew they could request an independent mental capacity advocate for patients that required them.

Managers monitored the use of Deprivation of Liberty Safeguards. Managers quality checked Deprivation of Liberty safeguards applications and an audit was underway at the time of our inspection. A central team supported doctors to make Mental Health Act assessments, processed section paperwork and ensured patients received their rights.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could access support from the mental capacity lead or the safeguarding team, but staff awareness needed to improve.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The trust was preparing for Liberty Protection Safeguards to develop a new process. The mental capacity lead was working with the clinical commissioning group, social care and other organisations in preparing for Liberty protection Safeguards to ensure a joined-up approach.

Staff did not always implement Deprivation of Liberty safeguards in line with approved documentation. We reviewed three DoLs applications, one was well completed but we found Mental Capacity Act assessments did not always identify the specific decision being made or mental capacity assessments.
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff taking time to talk to people, offering them choices and reassurance when they were in pain or confused. Staff told us they enjoyed the work they did and were proud to be given the opportunity to spend time with people. Staff introduced themselves and were supportive and encouraging.

Patients said staff treated them well and with kindness. Patients we spoke with knew how to seek help and felt listened to by the staff on the wards. We observed people approaching staff for support and staff listening before responding to the requests. During a physiotherapy session we saw the therapist encouraging and enabling people to build and maintain their independence while on the ward.

Staff followed policy to keep patient care and treatment confidential. Patients we spoke with were happy that their privacy and dignity was respected. Staff pulled curtains around patients when giving personal care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Ward staff regularly checked on patients’ wellbeing during nursing observations and showed a non-judgemental approach. For example, we saw a healthcare assistant supporting a patient living with dementia, who wanted to leave the ward, in a compassionate way. They made them comfortable and offered them a drink.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Feedback from patients and those who were close to them was continually positive. People we spoke with felt staff were attentive to their individual needs and the care provided by staff regularly exceeded their expectations.

Friends and Family test performance

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

The Friends and Family Test (FFT) response rate for the medicine care group was 47% from April 2018 to March 2019. The trust did not submit any FFT data in December 2018. A breakdown of FFT performance by ward for medical wards over this time period is shown below.

The feedback from the family and friends test was positive for all wards.

The response rate was less than 40% on six wards: Endoscopy Unit, Tamar Short Stay Unit, Burrator Ward, Merrivale Ward, Hartor Ward, and Norfolk Ward.
# Friends and Family Test – Response rate between 01/04/2018 to 31/03/2019

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</tr>
</thead>
<tbody>
<tr>
<td>ENDOCRINE UNIT</td>
<td>2,665</td>
<td>36%</td>
<td>99%</td>
<td>94%</td>
<td>98%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
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<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>MAYFLOWER</td>
<td>1,187</td>
<td>89%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
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<td>96%</td>
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<td>98%</td>
</tr>
<tr>
<td>PLANNED INVESTIGATION UNIT</td>
<td>985</td>
<td>42%</td>
<td>95%</td>
<td>98%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
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<tr>
<td>BRENT WARD</td>
<td>972</td>
<td>67%</td>
<td>100%</td>
<td>98%</td>
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<td>98%</td>
<td>94%</td>
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<tr>
<td>BICKLEIGH WARD</td>
<td>909</td>
<td>55%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>95%</td>
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<tr>
<td>MELDON WARD</td>
<td>953</td>
<td>74%</td>
<td>96%</td>
<td>90%</td>
<td>98%</td>
<td>93%</td>
<td>96%</td>
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<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>TAMAR (SHORT STAY UNIT)</td>
<td>892</td>
<td>33%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>95%</td>
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<td>96%</td>
<td>93%</td>
<td>100%</td>
<td>98%</td>
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</tr>
<tr>
<td>MARLBOROUGH</td>
<td>610</td>
<td>47%</td>
<td>100%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
<td>79%</td>
<td>92%</td>
<td>100%</td>
<td>99%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>BURRACO WARD</td>
<td>540</td>
<td>35%</td>
<td>95%</td>
<td>93%</td>
<td>93%</td>
<td>100%</td>
<td>97%</td>
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<td>99%</td>
<td>99%</td>
<td>92%</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>MERRYWYARD WARD</td>
<td>491</td>
<td>35%</td>
<td>96%</td>
<td>100%</td>
<td>98%</td>
<td>95%</td>
<td>94%</td>
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<td>98%</td>
<td>98%</td>
<td>94%</td>
</tr>
<tr>
<td>BRAUNTON WARD</td>
<td>487</td>
<td>62%</td>
<td>100%</td>
<td>99%</td>
<td>90%</td>
<td>95%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
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<td>96%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>HONEYFORD</td>
<td>442</td>
<td>42%</td>
<td>100%</td>
<td>93%</td>
<td>90%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>HEXWORTHY</td>
<td>433</td>
<td>40%</td>
<td>97%</td>
<td>94%</td>
<td>97%</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
<td>99%</td>
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<td>100%</td>
<td>96%</td>
<td>89%</td>
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<td>90%</td>
</tr>
<tr>
<td>MONKS WELL</td>
<td>372</td>
<td>59%</td>
<td>97%</td>
<td>95%</td>
<td>88%</td>
<td>92%</td>
<td>100%</td>
<td>93%</td>
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</tr>
</tbody>
</table>

| Highest score to lowest score |

Key

- 100%
- 50%
- 0%

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), as well as wards where there were less than 100 responses in total over the 12 month period.

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

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. For example, we observed a nurse give reassurance and support to a patient’s wife who was upset, offering a hot drink and advising them to take some time out.

Staff told us they would reassure patients verbally and by allocating a member of staff to work with the patient who had a rapport with them and who could spend time with them. When asked about patients’ emotional needs, staff spoke about patients in a compassionate way. They also used resources such as music, games, puzzles and physical touch to reassure and distract patients.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There were specially designed rooms on some wards and specialist staff available to support when breaking bad news. On the endoscopy unit the ward manager had plans to train staff in breaking bad news.

We saw staff showing warmth, kindness, care and compassion when having end of life conversations with patients. Staff showed empathy and gave people the time they needed to...
discuss all options available and to provide reassurance and involve additional support when needed. We saw these conversations were recorded clearly in patient notes.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

We saw evidence of patients’ personal and religious needs recorded in their care records. We observed and saw from care records that staff took the time to explain to patients the care that was being provided for them.

We saw a chaplaincy volunteer visiting patients on the medical admissions unit. There were forty ward visitor volunteers across the trust who supported patients and staff were positive about their contribution. Staff explained they had received training to enable them to provide support with difficult conversations and to be ‘a listening ear’ for people.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. For example, we observed a discharge of a patient and saw staff had a detailed conversation about pain relief and managing at home. Staff considered people’s wider social circumstances while planning for discharge and had sensitive conversations with carers. Patients we spoke with told us they were able to ask questions about their care and were happy with the response.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. For example, during a ward round we saw doctors discussing treatment plans in an open and clear way that patients could engage with. Staff checked people understood what was being said to them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. People we spoke with told us they were supported to feedback about all aspects of their care.

Staff supported patients to make informed decisions about their care. Staff involved patients and those close to them in planning and making shared decisions about their care and treatment. Records we reviewed showed the views of patients and their relatives were included in decision-making.

People were encouraged and supported to maintain communications with their family, friends and community. For example, visiting times were 7:30am until 10:00pm on most wards, maximising time available for people to maintain their personal and social relationships.

Support for carers was available. Carer identification cards were used and carers we spoke with told us this enabled them to access free car parking. Staff directed carers to local carer support organisations.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. For example, the service was working to improve care for frail older people. The service planned to reduce admissions of patients over 75 by seven patients a day. This was in response to feedback from the ‘getting it right first time’ (GIRFT) review of the frailty pathway. A frailty service was based on the acute assessment unit. At the time of our inspection rapid access frailty clinics were run by a geriatrician, two days a week, with plans to extend to five days once two geriatricians started in September 2019. At the weekend, frailty specialist nurses worked in the emergency department to support the needs of older patients and prevent unnecessary hospital admissions. The trust had plans to provide a seven-day service from October 2019. The service was also considering creating a short-stay elderly care ward.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. For example, we spoke with a ward sister on Thrushel unit where a female patient was placed in a side room on a male ward. The ward sister understood that this was not ideal, but the patient’s privacy was maintained as they were in a single room. The ward layout on Burrator acute medicine ward was not ideal or most appropriate for protecting patient dignity as female patients had to walk past a bay of male patients to go to the toilet or shower. The service had reported no mixed sex breaches in the past year.

Facilities and premises were appropriate for the services being delivered. Monkswell ward had day rooms for patients and visitors to use. We observed a physiotherapy session on Merrivale ward and saw that the gym was well-equipped. Elderly care wards were adapted to be ‘dementia-friendly’ environments with clear signage.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. The mental health liaison team had plans to provide 24 hours a day 7 days a week by April 2021. The learning disabilities team worked during office hours and staff were positive about their support.

The service had systems to help care for patients in need of additional support or specialist intervention. Link practitioners for learning disabilities had been introduced on each ward but the trust wide learning disability nurse team said the link practitioners did not have dedicated time for this role and so had minimal involvement with patients.

The service relieved pressure on other departments when they could treat patients in a day. The service had ambulatory care (medical care provided on an outpatient basis) and day case units to prevent unnecessary use of overnight beds. The service provided ambulatory care Monday to Friday 8am10pm and some weekend clinics. The service had plans for the ambulatory care service to be a seven-day service by September 2019, as recommended by NHS England. Marlborough ward was delivering up to two elective day case procedures, such as liver biopsies.

The provider had care pathways to discharge and support patients to go home as soon as possible. Staff could refer patients to a ‘home first’ service during multidisciplinary meeting. The ‘home first’ service was provided by therapists employed by a community provider. The ‘home first’
service provided up to six weeks therapy and support at home. Therapy teams were working to improve safe discharge by completing visits to assess a patient’s home environment in advance.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had access to a learning disabilities service to support patients accessing hospital services. Learning disabilities staff used a reasonable adjustment tool to assess patients’ needs. The hospital had a flagging system for patients with a learning disability and patients and carers could also self-refer. An autism service was due to launch on 2 September 2019. The purpose of the service was to train and enable staff to support patients with autism.

Wards were designed to meet the needs of patients living with dementia. We saw examples of dementia-friendly environments on Monkswell and Hartor wards. For example, yellow toilet signs, bright bay entrances and blue toilet doors (bright colours and high-contrast can help orient patients with dementia and patients with sight loss). On Monkswell ward there was a lounge area and several seating areas for patients and their families to sit throughout the ward. The lounge area has sofas and is set up with a focus on the past with old-style clock.

Staff supported patients living with dementia and learning disabilities by using patient passports. The service had adapted ‘this is me’ booklets to create ‘getting to know you’ documentation to gather information from carers about patient’s life history, likes and dislikes. Hospital passports were in use and these included additional pages for mental health, epilepsy and autism. For example, on Marlborough ward staff had communication aids such as cards with pictures and words on them that patients could point to.

The service had a dementia accreditation scheme for wards to encourage wards to improve dementia care. This accreditation included training for receptionists on person-centred communication. Dementia champions on wards had extra training in supporting patients living with dementia. Hartor ward had a mental health nurse recruited to the ward to support patients living with dementia and to build links with community providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss most of the time. Some wards had access to communication aids however most staff told us that they did not feel confident to use them.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access a list of staff who spoke different languages and also had access to a telephone interpreting service. Staff could access the learning disabilities team for support with using communication aids. Staff described examples of how this team had supported them to get patients who had experienced stroke or were living with dementia to communicate their views, wishes and feelings more effectively.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The menu included a range of option, including vegetarian, vegan and halal, for example, and we saw that patients were able to choose their preferred meals.
The service was responsive to the needs of patients with cancer and their carers. If a cancer patient was discharged and lived alone or a distance away they could stay at ‘the lodge’ in bed and breakfast accommodation paid for by the hospital.

**Access and flow**

Demand was outstripping capacity for beds and management of medical patients in non-medical beds needed to improve. However, for most specialities people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards for most specialities although performance for gastroenterology and cardiology needed to improve.

Our previous inspection identified the trust should act to reduce delayed transfers of care. This had improved. Delayed transfers of care as a percentage of bed base between March and July 2019 ranged between 2% and 4.6% this compared similarly to better than the South West average. The trust submitted weekly data on delayed transfers of care to commissioners.

The service monitored the average time between patients being medically fit and being discharged in days. The average time in days was consistently less than one day between February and July 2019.

Demand, especially for elderly care beds, frequently outweighed capacity in the hospital, and escalation areas (beds used at times when the hospital was at full capacity) were used frequently. The service had begun to plan for the forthcoming winter. Plans included: improving use of the discharge lounge and reviewing the number of beds available for medicine.

The service had not finalised a winter plan in September 2019. Medicine care group leads calculated a need for 120 additional medicine beds over winter. The service planned to mitigate the risk by focusing on admission avoidance of frail elderly patients, reducing length of stay and increasing ambulatory care hot clinics. Bed modelling to ensure availability of medicine beds over winter was in its third phase, to be completed by the end of September 2019.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff reviewed patients’ expected discharge dates regularly from admission. We observed the daily multidisciplinary meeting on Burrator acute medicine ward and saw all patients had an estimated discharge date. Staff reviewed discharge dates and patients were coded red, amber, or green depending on whether they were medically fit for discharge.

Staff worked to discharge patients as early as possible. The service monitored time of discharge and had key performance indicators for discharge by 10am and 12 noon. The following metrics relating to safe and efficient discharge were audited monthly on service line performance dashboards: % discharged (not in bed) before noon, % of weekday discharges occurring on a weekend, % of discharge summaries complete within 24hrs. Performance for elderly care wards in July 2019 was: 33% discharged (not in bed) before noon (meeting the trust target of 33%), 10% weekday discharges occurring on a weekend (against a target of 80%) and 100% discharge summaries complete within 24hrs. Monkswell ward was an exemplar ward for improving early discharge. Nurses were working to improve communication with discharge case managers – reducing delays to take away medicines and transport.

Therapy teams supported patient discharges to support flow through the hospital. A rapid response team of occupational therapists and physiotherapists was based on Thrushel ward. The team worked to reduce hospital admissions and support patients to rehabilitate in their own
homes. The stroke ward had access to an early supported discharge service provided by a local community trust to support stroke patients to rehabilitate in their own homes or usual place of care.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. The integrated discharge team helped supported complex discharges. They were responsible for coordinating available beds in the community or packages of care for patients to be discharged safely. Discharge case managers attended multidisciplinary meetings to address barriers to discharge and support with plans for discharge of patients with more complex conditions or social circumstances. We reviewed discharge plans for a patient with complex mental health needs on Marlborough ward and found clear plans were made by a multidisciplinary team.

Managers monitored the number of delayed discharges, knew which wards had the highest number and acted to prevent them. The main reason for delays to discharge was waiting for medicines. We saw that patients were delayed waiting for medicines during our inspection. Site management had access to real-time data on management of medicines for discharge.

Delays to arranging packages of care also delayed discharges. Consultants we spoke with were frustrated with delays to discharge caused by waiting for community services. Delayed transfers of care were monitored at board level.

Patients had direct access to the oncology unit in the event of deterioration. Patients with neutropenic sepsis could be admitted directly to Brent ward rather than being admitted through the emergency department. Managers audited this process to see if this improves patient outcomes.

Arrangements for ensuring regular consultant review of medical patients on non-medical wards needed to improve. There was no seven-day working available to cover medical patients outlying on surgical wards. When outlying medical patients on surgical wards needed medical review were seen by the medical outlier team. This was not a seven-day service and meant that not all patients on surgical wards were seen every day and staff expressed some difficulty accessing medical staff out of hours. The outlier team stopped working each Friday at 5pm and did not recommence until 8am the following Monday morning. This meant that should a medical patient be admitted to a surgical ward at 5:30 pm on a Friday, they would not be seen again until the following Monday unless their review was urgent.

We visited Wolf surgical ward to review the care of medical patients. A rostered outlier team were responsible for review of these patients. The outlier team started their ward rounds between 8-9am weekdays, and depending on numbers of patients allocated this dictated the time they would get to each ward. Some staff told us when consultants visited patients in the afternoon this delayed discharges. There were no consultant rounds at the weekends. The on-call registrar reviewed patients on the ‘problem list’, those whose observations showed that they were deteriorating, or those listed as identified for discharge. Medical patients seen on a Friday afternoon may have no formal review until Monday afternoon. Staff on Stonehouse surgical ward reported delays to being able to contact doctors in order to urgently review a medical patient. These delays contributed to increased length of stay.

Managers worked to minimise the number of medical patients on non-medical wards and the organisation of escalation beds had changed since our last inspection. At the time of inspection Postbridge surgical ward had not been used for medical patients since June 2019. We reviewed the standard operating procedure for use of Postbridge ward which stated in OPEL 3 (severe pressure) 10 beds could be opened in the day surgery unit. There was no escalation ward. Additional capacity was created by putting extra beds in existing medical wards, including: four
escalation beds on Meldon, two on Hembury, two on Hartor, two on Marlborough, one on Shipley and five beds Bracken ward. The use of the two escalation beds on Marlborough was under review at the time of our inspection.

The medical operations manager had oversight of all medical patients on non-medical wards. A meeting was held once a week to review all medical patients on non-medical wards. The matron for operational support told us it was a challenge to get patients to the correct medical speciality beds.

During our inspection we observed delays in allocating and moving patients to the most appropriate speciality ward.

At the time of our inspection, the discharge lounge was closed due to staffing shortage. This impacted negatively on patient flow through the hospital as patients who were medically fit for discharge and waiting for transport or medicines had to be cared for on the wards. The discharge lounge was based on Tamar short stay unit.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Length of stay was reviewed on service line performance dashboards. For example, the trust had set a target length of stay of 12 days for unplanned inpatients for healthcare of the elderly. This target was met for April to July 2019.

**Average length of stay**

Managers and staff worked to make sure patients did not stay longer than they needed to.

From March 2018 to February 2019 the average length of stay for elective medical patients at the trust was 4.3 days, which is lower than the England average of 5.9 days.

For non-elective medical patients, the average length of stay was 6.8 days, which is similar to the England average of 6.1 days.

**Elective Average Length of Stay**

- Average length of stay for elective patients in cardiology was similar to the England average.
- Average length of stay for elective patients in clinical oncology was similar to the England average.
- Average length of stay for elective patients in clinical haematology was lower than the England average.

![Average Length of Stay Graph]

*Note: Top three specialities for specific trust based on count of activity.*
Non-Elective Average Length of Stay

- Average length of stay for non-elective patients in general medicine was higher than the England average.
- Average length of stay for non-elective patients in neurology was similar to the England average.
- Average length of stay for non-elective patients in cardiology was higher than the England average.

Derriford Hospital

From March 2018 to February 2019 the average length of stay for medical elective patients at Derriford Hospital was 4.4 days, which is lower than England average of 5.9 days. For medical non-elective patients, the average length of stay was 6.8 days, which is similar to the England average of 6.1 days.

Elective Average Length of Stay

- Average length of stay for elective patients in cardiology is similar to the England average.
- Average length of stay for elective patients in clinical oncology is similar to the England average.
- Average length of stay for elective patients in clinical haematology is lower than the England average.

Non-Elective Average Length of Stay

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in neurology is similar to the England average.
- Average length of stay for non-elective patients in cardiology is higher than the England average.
Referral to treatment (percentage within 18 weeks) - admitted performance
From May 2018 to April 2019 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was consistently lower than the England average.

Referral to treatment (percentage within 18 weeks) – by specialty
From May 2018 to April 2019, five specialties were above the England average for admitted 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>100.0%</td>
<td>96.6%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>99.6%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>98.5%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>96.8%</td>
<td>94.3%</td>
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<tr>
<td>Neurology</td>
<td>94.0%</td>
<td>89.4%</td>
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Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

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<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>79.5%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>77.1%</td>
<td>81.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>58.7%</td>
<td>81.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

We reviewed referral to treatment time improvement plans for gastroenterology and cardiology. Referral to treatment times were challenged in gastroenterology and cardiology due to medical staffing shortage and an increase in demand. The service was recruiting consultants to address this.

At the time of our inspection, the trust reported RTT times for dermatology as 96.6%. Referral to treatment time performance had reduced due to a reduction in activity in July 2019. At this time the
service was piloting poly skin cancer clinics, a quality improvement project to ensure all suspected skin cancer patients were offered a full skin check, examination and photography.

**Patient moving wards per admission**

The service aimed to move patients only when there was a clear medical reason or in their best interest. Patient moves were recorded on the electronic patient information. If a patient had been moved three times during their admission this was flagged on the system.

**Patient moving wards at night**

From May 2018 to April 2019, there were 7,316 patients moving wards at night within medicine. The highest ward moves were Tavy – Medical Assessment Unit with 2,964 (40.5%) and Thrushel Medical Assessment Unit with 2,758 (37.7%). The medical assessment units had a high turnover of patients which contributed to the higher number of patient moves at night.

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

Staff worked to minimise patient moves between wards at night. Patient moves were tracked through an electronic system. On Monkswell ward, doctors told us discharges were happening late at night and this was not appropriate.

Managers worked to keep the number of cancelled treatments to a minimum. Staff used patient tracking lists to review referral to treatment times and cancellations. Cancelled appointments were monitored through service line performance dashboards.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients had access to information leaflets on how to make a complaint on the wards. There was also information on making a formal complaint on the trust website.

Staff understood the policy on complaints and knew how to handle them. On Mayflower unit we spoke with a patient who was positive about the way their complaint was managed and the response they received.

Managers investigated complaints and identified themes. For example, on Thrushel medical admission unit, following an increase in complaints relating to end of life care, money was raised to decorate a small break out room for patients and families.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed the last three complaint responses and found responses included an apology, a detailed investigation and information on what to do if not satisfied with the response.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared with staff during safety briefings and team meetings.

From June 2018 to May 2019 the trust received 153 complaints about medicine (21.6% of total complaints received by the trust). The trust took an average of 30.3 days to investigate and close
complaints. This is in line with their complaints policy which states that complaints should be dealt with within 40 working days.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>114</td>
<td>74.5%</td>
</tr>
<tr>
<td>Appointments</td>
<td>8</td>
<td>5.2%</td>
</tr>
<tr>
<td>Communications</td>
<td>8</td>
<td>5.2%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>8</td>
<td>5.2%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>6</td>
<td>3.9%</td>
</tr>
<tr>
<td>Facilities</td>
<td>5</td>
<td>3.3%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>3</td>
<td>2.0%</td>
</tr>
<tr>
<td>Admin/policies/procedures (inc patient record)</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>153</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From January to December 2018 there were 59 compliments about medicine at the trust.

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

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed. They supported staff to develop their skills and take on more senior roles. However, staff were not always positive about the visibility of the leadership team.

The medicine care group had a senior leadership team with the appropriate range of skills, knowledge and experience.

The leadership team of the medicine care group included a care group medical director, general manager and head of nursing. As our inspection was unannounced, not all staff were available to meet with us. We spoke with the medicine care group head of nursing, the cluster manager for healthcare of the elderly, renal, respiratory and neurology and the head of quality and governance to assess the leadership of the service.

The medicine care group leadership team was clear about current priorities and challenges and took action to address them and were very focused on operational challenges, such as staffing and flow. At the time of our inspection nurse staffing was the main challenge. Overseas recruitment was underway, with nurses planned to start work in September 2019. The service was also focusing on retention of nursing staff by introducing a ‘transfer window’ so nurses could move between different specialities and ward areas more easily. As the service had struggled to recruit into some specialist nurse roles they were working to develop staff into these roles with competency-based training and rotational posts.

Most staff told us they were well supported by their direct line managers, ward managers and matrons. However, staff were less positive about the visibility and support from care group leaders. Staff on some wards didn’t feel listened to.
The executive team had a programme of visits to ward areas. These were displayed publicly outside the chief executive’s office. However, staff on wards told us they did not see the executive team.

The leadership team felt they received support from the board.

Matrons were positive about the impact of the chief nurse, who had joined in April 2019 (four months before the inspection). There was work in progress to improve governance structures.

Leadership and development pathways were also available for staff to allow for progression within the trust.

**Vision and strategy**

The service had a vision for what it wanted to achieve and had recently developed a strategy to turn it into action, developed with staff. The strategy was aligned to local plans within the health economy.

The medicine care group was finalising a strategy at the time of our inspection. The strategy was aligned to trust strategic aims quality, people, sustainability, partnerships.

We spoke with care group leads about their vision for the service. They told us the strategy included: reducing inpatient length of stays, improving access and reducing waiting times for outpatient services. The service was using ‘people first’ and ‘lean’ quality improvement principles to guide the strategy. ‘People first’ core principles were: respect for staff, value the person we care for and enable teams to drive performance.

The medical care group engaged with staff in developing the strategy. Medical care group leaders organised an away day in July 2019 and 38 staff attended from a range of medical specialities to discuss service line priorities, with prompts to think about “what we need to do, what we need from others and barriers to progress.” Care group leads also told us about a ‘frailty think tank’ workshop to discuss plans about the frailty pathway with staff.

Staff we spoke with were aware of some elements of the strategy, for example, plans to recruit nursing staff from overseas.

Service lines had contributed their priorities to the strategy. For example, the medical assessment units planned to review demand and capacity, create three additional acute medicine consultant posts for weekend cover and review the process for managing the medical take.

Cardiology presented their strategic direction for 2019/20 at the July 2019 medicine care group board. Priorities included: funding two cardiology consultant posts to cover the move to speciality take on the medical assessment unit and developing virtual follow up appointments.

**Culture**

Staff felt respected and supported. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, not all staff felt valued by the trust.

Staff felt respected, supported and valued by direct colleagues and patients. Most staff we spoke with felt positive and proud to work for the hospital.
The trust recognised staff success through a recognition scheme. Shipley ward won ‘pride of Plymouth’ award for their work improving best practice – electronic prescribing and trialling a foam dressing with silicone adhesive.

However, most staff we spoke with told us they did not feel recognised and valued by the trust and got recognition from their direct team and patients and families they cared for.

Staff we spoke with at all were levels were confident to raise concerns. Staff knew about Freedom to Speak Up Guardians and their role. We spoke with a junior doctor freedom to speak up guardian on Monkswell ward. They told us about the trust’s plans to introduce equality and diversity champions to work alongside the guardians.

Senior nurses were working to create a ‘no blame’ culture around incidents and falls. Staff had access to Schwartz rounds, a forum to reflect on the emotional impact of their work. However, it was difficult for ward staff to access these when wards were busy.

Matrons encouraged staff to take care of their own wellbeing. For example, the matron for the medical admissions unit encouraged staff to take breaks, stay hydrated and access resilience training. Staff we spoke with on Torcross ward told us they were encouraged to take breaks.

**Governance**

**Leaders did not operate effective governance processes throughout the service. However, staff were clear about their roles and accountabilities and met regularly to discuss performance.**

Governance structures, systems and processes to support the delivery of quality care and treatment were not effective. We reviewed a sample of minutes from the last three months medicine care group governance meetings and saw actions were not always recorded and followed up at subsequent meetings. There was no evidence of learning identified following incident investigations or complaints. Improving governance structures was part of the medicine care group’s strategy. At trust level governance processes were being reviewed at the time of inspection.

There was a meeting structure and the following meetings reported to the medicine care group board, chaired by the care group manager:

- Monthly service line reviews (where care group leads reviewed performance dashboards with matrons)
- Monthly risk and assurance meetings (chaired by the care group manager)
- Quarterly clinical governance leads meeting (chaired by the care group director)
- Quarterly service line clinical governance and morbidity & mortality meetings chaired by the service line director or clinical governance lead.

However, it was not clear from meeting minutes how these meetings linked to each other to ensure ward to board assurance.

In addition to medicine care group governance meetings, there was a trust-wide harm free care meeting chaired by the chief nurse. The harm-free care matron presented reports on incidents and hotspots. The harm-free care matron acknowledged they were not confident learning from this meeting was communicated to wards and the governance arrangements for this meeting under review.
We reviewed the medicine care group board meeting minutes for May, June and July 2019. The meeting did not have a standard agenda, but most meetings included: exception reporting for junior doctors, review of standard operating procedures, finance update. Incidents, mortality reviews, risk and complaints, were not always reviewed at this meeting. The May 2019 meeting included an update following a ‘deep dive’ review of mortality and moderate incidents at service line level in April 2019. The aim of this work was to standardise and improve governance structures. The report identified issues with timeliness of reviews closing of investigations without going through situation, background, assessment, recommendation process.

Medicine directors, managers and matrons met every month. We reviewed meeting minutes for April and July 2019 and found there was no standard agenda. The meeting on 10 April 2019 included a summary report of incidents but there was a lack of evidence of action and follow up on managing open serious incident investigations. Trust policy stated that incidents should be reviewed and finally approved within 48 hours of incidents being reported on the electronic reporting system. The April 2019 report stated 588 incidents are awaiting final approval in the medicine care group, of which, 86% of medicine care group incidents were overdue review and final approval on the electronic reporting system.

Service line performance reviews happened with medicine care group leaders every month. Care group directors reviewed performance dashboards at this meeting. We reviewed the performance dashboard on Thrushel MAU performance board included: infection control, safe care, and mandatory training data.

Service line performance dashboards were organised into the CQC key questions – safe, effective, caring, responsive and well-led.

Governance of mortality and morbidity (M&M) reviews had not improved since our last inspection. Mortality and morbidity reviews were completed at specialty level and reported to divisions. Staff we spoke with told us summary hospital-level mortality indicator reports (SHMI) and hospital standardised mortality ratio (HSMR) mortality and morbidity data was included in performance dashboards and reviewed at monthly performance reviews, with crude mortality reviewed by ward and speciality.

The service did not follow trust policy to ensure all deaths were screened within 20 working days. We reviewed five M&M forms from the June 2019 meeting and found the form included the following headings: diagnosis, progress, other major illness, date of death, cause of death, any learning. Mortality screening tool or structured judgement review tool was not used. There was no learning documented in all of the five we reviewed. The trust mortality review policy stated all deaths must be reviewed within 20 working days. All five deaths were reviewed were outside this time frame with one outside the time frame by over five months. The trust also submitted two examples of an electronic mortality screening tool which included a grading of the care delivered from one (very poor) to five (excellent).

The service did not consistently use the structured judgement review process in line with the trust policy. We reviewed the meeting minutes for the May 2019 neurology M&M meeting – two cases were discussed. One death graded three, adequate care, on the mortality screening tool had a second review at the M&M meeting but the structured judgement review methodology was not used. The initial mortality screening of this case happened 30 working days following the death, outside the trust timescale of 20 working days.

The service had plans to improve governance of M&M meetings by learning from a local acute trust to standardise the outputs of M&M meetings.
Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. For example, the sister on endoscopy unit was clear about their role and was involved in three monthly medicine governance meetings. These governance meetings were open to all staff and they encourage band five nurses to attend.

Management of risk, issues and performance

Risk management processes were not effective. Leaders and teams had systems to identify risks, but they were not always reviewed and mitigated effectively.

Systems for identifying and acting on learning from incidents, complaints and safeguarding alerts needed to improve. Governance meetings did not have standard agendas so incidents, risk management, complaints were not always discussed. Detailed discussions of risk management and mitigation were not recorded.

The service had systems for identifying and recording risks. However, processes for reviewing and managing risks needed to improve. Risks were identified through the incident management system. We reviewed meeting minutes for the monthly risk assurance meeting for April, May and June 2019. The meeting did not follow a standardised agenda and so actions were not followed up consistently. For example, serious risks were reviewed at the May meeting but there was no recorded discussion of individual serious risk at the April or June meetings. CQC actions reviewed in April 2019, only in relation to Mental Capacity Act training and storage of COSSH were not followed up at the May or June meetings.

A selection of service line annual assurance reports was reviewed at this meeting. We reviewed a sample of these reports and found staffing, training compliance, audits and performance were discussed at these meetings. Where performance was below expected standards, actions were not always identified. For example, there were no actions recorded against the performance review for acute medicine, where five serious incident investigations were open, MRSA screening compliance was rated red for compliance, assessment of pressure ulcers on admission needed to improve.

Recorded risks were aligned with what staff said were on their ‘worry list’. We reviewed the care group risk register and saw risks matched concerns. The risk register was reviewed at the risk assurance meeting. Leaders on the wards and within specialties understood their risks and how to manage them. Top risks included nurse staffing, the high acuity of patients and managing patients with mental health needs. The trust had acknowledged care for patients with mental health conditions needed to improve and was about to carry out a review of service provision across the medical admissions units and the emergency department.

To manage the joint risk of staffing and supporting patients with mental health conditions, who often needed one to one care, the service was developing a clinically trained enhanced care team. This was following a review of the bed watch service. There were seven healthcare assistants in the team, with plans to grow the team. The team had experience in mental health and could support anxious patients.

We requested the standard operating procedure for requesting the enhanced care team and this had not yet been developed. There was an enhanced observation risk assessment plan for confused patients, to decide whether they need 1:1 observation from the enhanced observation team.

Staff could record the level of observation a patient needed in the electronic observation system. While there were clear criteria for accessing bed watch or the enhanced care team, staff told us
they could not always access bed watch or the enhanced care team and sometimes their requests for support were declined, and they didn’t know why.

The medical admissions unit had also developed a pool of registered mental health nurses and mental health care assistants to look at a patients’ triggers and ways to settle them. Mental health nurses would complete hourly risk assessments and feed back to staff. Staff we spoke with were positive about this resource.

Staffing shortage was being mitigated by international recruitment, local recruitment, and improving retention of students.

Nursing leaders managed any risks or issues which may impact the care group. For example, the sister of the endoscopy unit was aware of the risk that endoscopy was located on a different floor to the gastroenterology ward, that there was no 24-hour bleed nurse service and it was becoming difficult for the size of the unit to meet demand.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. Up-to-date electronic information was available to support the management of patient flow through the hospital. However, as some wards were slower to input information into the system, the site team had to visit or telephone wards to establish the true number of empty beds.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Performance dashboards were used to monitor each service line every month. Performance dashboards were organised in line with CQC key questions and included comprehensive data.

**Engagement**

Leaders engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. Working relationships with community providers had improved.

Wards held team meetings to engage with their staff, although the regularity of these was variable and there were difficulties to hold and get good attendance. The staff communication board on Thrushel MAU included ‘hot topics’ for learning, incidents, what went well and how to improve.

An action plan in response to staff survey results was presented at the May 2019 medicine care group board meeting. The service was working to improve staff satisfaction in relation to bullying and harassment at work. Managers discussed staff survey results at ward level and specific action plans were made. Managers on endoscopy and Thrushel acute assessment units were positive about improvements following the staff survey.

Medicine care group leaders acknowledged that public engagement needed a more formalised approach. There was some evidence of public engagement. For example, the dementia care steering group included external partners and volunteers and the dementia lead nurse attended the Plymouth Dementia Action Alliance.
Working relationships with community providers had improved since our last inspection. For example, the hospital and community providers were sharing information more effectively to review delayed transfers of care by using the same version on the hospital electronic patient information system. Therapy staff we spoke with were positive about improved relationships with the community provider and more integrated ways of working to support patient discharges.

**Learning, continuous improvement and innovation**

Leaders had a good understanding of quality improvement methods and the skills to use them.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. We saw some examples of quality improvement projects during the inspection. For example, improvement huddles on the acute assessment unit and Monkswell ward, where all had the opportunity to suggest improvements.

The service had started using the ‘people first’ improvement methodology. In July 2019 in the medicine care group nine practice coaches had been trained and eight staff had completed quality improvement training.

The medical admissions units had introduced simulation training, incorporating human factors (how behaviour and team relationships impact on patient safety) to improve staff’s ability to respond to incidents and challenging situations. Staff we spoke with were positive about the practice educator and access to simulation training.

Monkswell and Hartor wards were improving care for patients living with dementia. On Monkswell ward a play therapist was starting in September 2019 to support patients living with dementia with meaningful activity and distraction. On Hartor ward there were plans for improving the environment to create an alcohol-free ‘pub environment’ and a bus stop.
Facts and data about this service

University Hospitals Plymouth NHS Trust provides emergency and planned (often referred to as ‘elective’) surgery across a range of specialities including general surgery, plastic, cardiac, vascular, urology, and trauma and orthopaedics. These surgical treatments are mainly provided at the trust’s core site at Derriford Hospital, which has 290 beds located over 10 surgical wards. The hospital’s theatre complex currently comprises of 36 operating theatres as well as two interventional radiology rooms.

The trust had an agreement with a local private health company for planned orthopaedic operations to be carried at a location (referred to in this report as ‘a local NHS treatment centre’) operated by the private health company.

The trust is a designated cancer and major trauma centre.

The surgery core service is mainly managed by the trust’s surgery care group, which is one of the trust’s four care groups (or clinical divisions). Within each care group are a number of specialities (called service lines by the trust). The specialities in the surgical care group include anaesthesia, urology and neurosurgery.

The surgery care group management team consists of a care group general manager, quality manager, clinical director and head of nursing. The management of the specialities beneath the surgery care group follow a similar structure with a service line manager, director, matron and governance lead.

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

The trust had 40,113 surgical admissions from March 2018 to February 2019. Of these, 13,572 (33.8%) were emergency admissions. Day case admissions accounted for 19,514 (48.6%) and the remaining 7,027 (17.5%) were admissions for planned procedures.

(Source: Hospital Episode Statistics)

During our inspection, we inspected Derriford Hospital. We did not visit any of the trust’s community locations such as community hospitals.

At Derriford Hospital, we visited the following wards/areas (speciality/focus):

- Erme (pre-assessment unit)
- Hound (surgical assessment unit)
- Fal (day of surgery admission)
- Postbridge (day case recovery unit)
- Lynher (urology, maxillofacial, breast, ophthalmology, plastics, and ear, nose and throat)
- Crownhill (thoracic and upper gastrointestinal)
- Norfolk (orthopaedic)
- Stonehouse (colorectal, hepato-pancreato-biliary, upper gastrointestinal, general)
- Clearbrook (cardiothoracic and vascular)
- Moorgate (neurosurgery)
During our inspection, we spoke with over 70 members of staff, including members of the surgical care group management team, speciality managers, matrons, porters, medical and nursing staff, health care assistants, allied health professionals, pharmacy staff and administrators. We also spoke with six patients and three relatives, and we observed the treatment and care provided to patients. We attended safety briefings and bed meetings. We reviewed documentation, including 10 patient records, minutes of meetings, reports, and policies and procedures.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. However, there were some mandatory training courses where staff did not meet trust targets for updating these key skills.

Not all nursing and medical staff kept up-to-date with their mandatory training.

At our previous inspection, we identified staff did not meet trust targets for updating key skills through completion of some mandatory training courses. At this inspection, we found this was still the case.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 for nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</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>Trust update</td>
<td>380</td>
<td>412</td>
<td>92.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>358</td>
<td>412</td>
<td>86.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling</td>
<td>358</td>
<td>412</td>
<td>86.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>


In surgery, the 95% target was not met for the mandatory training modules listed above for which nursing staff were eligible. However, compliance was high for all the modules, ranging from 86.9% for manual handling to 92.2% for the trust update module.
A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling</td>
<td></td>
<td>302</td>
<td>367</td>
<td>82.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust update</td>
<td></td>
<td>269</td>
<td>367</td>
<td>73.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td></td>
<td>260</td>
<td>366</td>
<td>71.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was not met for the mandatory training modules listed above for which medical staff were eligible. Compliance was below the trust target, especially for the trust update and basic life support modules.

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

The trust's board papers for July 2019 noted the care group’s mandatory training performance continued to be challenging, and stated this reflected operational pressures.

Staff told us they had completed mandatory training, however some staff told us this was difficult due to staffing constraints and training was sometimes not a priority. In an attempt to support staff to access training, blocks of training had been set up with ward staff being covered to release staff to complete all mandatory training in that week.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us the quality of the training was suitable for their needs and supported them in their role. This included training on sepsis recognition and management.

Recovery staff were trained in immediate life support (ILS). This training took place on an annual basis.

Clinical staff mostly completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, staff on the surgical assessment unit had not received specific mental health training. This training was important as these staff were the first transfer ward from the emergency department and some patients needed specific mental health support in addition to their surgical needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was monitored by clinical educators or other senior staff on ward or departments who prompted staff to update their key skills when needed.

**Safeguarding**

The ‘trust update’ training module included ‘safeguarding adults (including Mental Capacity Act)’ and ‘safeguarding children’. It also included ‘prevent’ training which sought to support staff to identify people at risk from radicalisation and take appropriate action.

The trust set a target of 95% for completion of safeguarding training.

Nursing and medical staff received training specific for their role on how to recognise and report abuse.
A breakdown of compliance for safeguarding training courses from 16 May 2018 to 15 May 2019 for nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</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>Safeguarding – level 2</td>
<td>397</td>
<td>412</td>
<td>96.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust update</td>
<td>380</td>
<td>412</td>
<td>92.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for one of the two safeguarding training modules for which nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from 16 May 2018 to 15 May 2019 for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</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>Child protection – level 3</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding – level 2</td>
<td>285</td>
<td>360</td>
<td>79.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust update</td>
<td>269</td>
<td>367</td>
<td>73.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for one of the safeguarding training modules for which medical staff were eligible.

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

Staff could give examples of how to protect patients from harassment and discrimination. There were procedures for staff to follow for extra observation, supervision and restraint. Staff told us they had received some training but would call the trust security staff for further help.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with all demonstrated a clear understanding of their roles and responsibility to speak up about any safeguarding concerns. They explained the escalation and reporting process. However, they told us they rarely had any feedback of the outcomes, unless there was learning.

Staff had training in relation to female genital mutilation though staff we spoke with told us they had not encountered this issue.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Wards and theatre areas were clean and had suitable furnishings which were clean and well-maintained. Cleanliness, infection control and hygiene were observed to be well managed throughout the surgical wards and theatre departments. Cleaning staff were accessible 24-hours a day and cleaning schedules were used in some areas to ensure all areas had a daily clean. Cleaning staff were allocated to specific wards and were considered in most cases to be part of
the ward team. They told us they were advised of any infection control risks and had received infection control training.

Within the theatre departments cleaning staff used a daily checklist as an audit trail of cleaning completed. A senior person then checked all cleaning had been completed. Between operations, theatre staff cleaned the theatres, ready for the next patient. There was also a suitable air flow system in theatres. The effective operation of ventilation systems and air exchange in theatres are essential to ensure effective infection control by minimising airborne bacteria and viruses.

Staff used records to identify how well the service prevented infections. Hand hygiene audits were completed monthly to assess compliance with National Institute of Health and Care Excellence (NICE) quality statement 61 (statement 3). This states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. The trust’s target for hand hygiene was 95%, which was consistently exceeded by most areas. Audit results were displayed at each ward entrance as part of the safety information.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff took precautions to protect people from healthcare-associated infections. Staff followed the hospital policy and were bare below the elbow. Being bare below the elbows is important in preventing the spread of infection as bacteria can inhabit items such as jewellery. We saw staff washing hands between patient contact to minimise the risk of cross-infection.

Hand sanitiser gel was mostly available in the clinical areas we visited, but some of the dispensers were noted to be empty.

Staff cleaned equipment after patient contact and labelled some equipment to show when it was last cleaned. Ward and theatre areas were cleaned by domestic staff and equipment was cleaned by staff with labels identifying when the equipment was cleaned and ready for use. However, not all equipment had labels identifying when they had been cleaned. This meant staff could not always assure themselves that equipment was clean.

In July 2019, the trust reported that Derriford Hospital's national specification for cleanliness score was 97.4% for the month of April 2019. This was above the target for the trust which stood at 96.3%. Therefore, the trust was compliant with the national specification for cleanliness.

We reviewed patient-led assessment of the care environment (PLACE) results for surgery. PLACE is a review of non-clinical aspects of care undertaken by an external group of people. All surgical areas included scored highly for cleanliness, maintenance and appearance.

Staff worked effectively to prevent, identify and treat surgical site infections. We observed staff following guidance on the prevention of surgical site infections through the preoperative, intraoperative and postoperative phases. This included staff preparing an operative site for surgery.

Surgical site infections were monitored. The trust participated in the surgical site infection surveillance service scheme, which assessed speciality-specific surgical site infections. In its May 2019 board report, the trust reported surgical site infection rates broadly in line with comparable organisations nationally in the period from July 2013 to June 2018. The service took action to improve clinical practice where surgical infection rates were noted to be increasing or based on current outbreaks nationally.

Managers had made changes to address theatre delays caused by the process of cleaning and sterilising equipment. Staff explained previously theatre cleaning and sterilisation of equipment impacted on theatre utilisation. The theatre department now had an instrument manager looking at
theatre equipment sets, their management and waste. Staff had identified tears in equipment set wrapping had delayed theatre use, and so sets were also vacuum packed to ensure their use. The instrument manager also looked at any equipment issues and recall of equipment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All clinical areas in theatres were secure for the protection of patients and staff, with swipe card access. However, this was not always the case for all the wards we visited as the entrance doors to the wards were sometimes propped open for extended periods.

At our previous inspection, we told the trust they should ensure products deemed as hazardous to health were locked away and not accessible to patients. A review of storage had taken place, and new secure storage had been implemented in all ward areas. However, on Moorgate ward, we found a product potentially deemed as hazardous to health in an unlocked storage room which patients and visitors could have accessed. We informed staff on the ward of this and they removed the product.

Patients could reach call bells and staff responded quickly when called. We found patients mostly had access to a call bell and when sounded staff responded in a timely way.

The design of the environment followed national guidance. The wards had four to six bedded bays and side rooms. Patients identified as potentially being an infection risk were cared for, when possible, in a side room. There was signage to alert staff to use the stated extra precautions to prevent the spread of infection.

At our last inspection, we noted the day case post-surgical ward, Postbridge, was used during periods of operational pressure to accommodate overnight patients. We also noted the unit was not suitable for this purpose. On this inspection, the ward was not being used overnight. This was because the capacity within the wider hospital was being managed, and the extra space was not necessary.

Staff usually carried out daily and weekly safety checks of specialist equipment, although we did identify gaps. Theatre department and equipment checks were completed daily before the start of surgical lists. Checks were signed as completed and audits of those records maintained. We observed anaesthetic equipment checks being completed and checks of all surgical packs for the day's list. An asset register was maintained of all surgical equipment to ensure annual servicing was completed to manufacturer’s guidelines.

Resuscitation trolleys were mostly checked daily and weekly with some wards having gaps in the recording that checks had been completed. For example, on Moorgate ward, documentation of daily and weekly checks of the resuscitation trolley and emergency suction equipment had not always taken place. These included single days when this hadn’t happened as well as a series of consecutive days where it had not happened. Suitable arrangements were followed for storing oxygen.

The service had suitable facilities to meet the needs of patients’ families. Waiting areas for patients’ families were available outside all wards. Theatre departments had some external seating in the pre-admission unit and the Freedom Day Care Unit.

The service mostly had enough suitable equipment to help them to safely care for patients, but the environment did not always ensure the safety of patients. Safe spaces for patients with identified
mental illness risks were not always well-considered and known to staff. Staff in the surgical assessment unit confirmed assessments of ligature risks and unobserved parts of the ward had been completed, though the contents of these assessments were not always known to staff. Therapists told us resources could be a challenge. For patients with complex needs, specialist equipment such as specialist seating could be challenging to access.

Staff disposed of clinical waste safely. Clinical waste was managed safely. Sluices were clean, tidy and well-organised. Items were marked when they had been cleaned and were ready for use. Waste was managed safely. Sharp instruments, such as needles, were disposed of in sharps bins. These bins were signed and dated to ensure they were disposed of in a timely way.

We reviewed patient-led assessment of the care environment (PLACE) results for surgery. PLACE is a review of non-clinical aspects of care undertaken by an external group of people. All surgical areas included scored highly for cleanliness, maintenance and appearance. Sharp and Crownhill wards also scored well for meal provision. However, Sharp ward scored below (worse than) the trust average for patient privacy and dignity, and dementia and disability arrangements.

Assessing and responding to patient risk

Staff completed and updated most risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, risk assessments for venous thromboembolism were not always carried out.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Since our last inspection, the service had implemented the latest version of the national early warning score (NEWS2) to improve the early recognition of, and response to patients with sepsis. Fast recognition and starting specific treatment within the hour is essential for all patients with suspected sepsis.

Patients with suspected sepsis were identified and staff followed the sepsis six protocol, which was a bundle of medical therapies designed to reduce mortality in patients with sepsis. Staff completed ongoing observations to ensure patients’ safety. We looked at 10 patient records and all had observations completed and documented in line with their risk management.

We reviewed results of monthly internal audits of staff compliance with the trust’s sepsis pathway. The trust’s audit looked at areas of the trust deemed to be high-risk areas for sepsis, including the surgical assessment unit and surgical ward Stonehouse. We reviewed audit data for the period of January to July of 2019. We found data had not been collected for some months because of staffing and other issues. For those months where data was available, the audit showed patients identified with severe sepsis were being screened and treated with antibiotics within 60 minutes in most cases.

Staff completed most risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools.

Staff completed and acted on risk assessments for each patient. This included risk assessments for sepsis, nutrition, falls and pressure areas. We saw these were appropriately used in care records to assess patient risks and create management plans. However, our review of 10 records found four venous thromboembolism (VTE) assessments had not been completed. In one case, anticoagulant medicine had been prescribed and given. Two members of staff explained consultants in theatres would sometimes prescribe anticoagulant without undertaking a risk assessment, and so staff would administer as prescribed.
The trust was implementing an e-prescribing system which aimed to make risk assessments a necessity for all patients, therefore assessing individual VTE risks.

Staff knew about and dealt with any specific risk issues. Patients admitted with a fractured neck of femur (broken hip) received input from an orthogeriatrician. The service had a pathway for patients presenting with a fractured neck of femur, including frailty scoring and targeted echocardiogram before surgery.

A pilot was underway to develop one bay on some wards as higher dependency bays to accommodate high acuity/risk patients.

The service was mostly achieving its target for completion of the surgical safety checklist. However, some specialities were performing better than others. At our previous inspection, we told the trust it should improve compliance with the World Health Organisation’s (WHO) surgical safety checklist in the specialities where the trust's 95% compliance target was not being achieved. The WHO checklist was developed with the aim of reducing errors and adverse events and increasing teamwork and communication in surgery. In 2010, the National Patient Safety Agency (NPSA) introduced the Five Steps to Safer Surgery. The Five Steps to Safer Surgery was based on the WHO checklist and involves briefing, sign-in, timeout, sign-out and debriefing, and is now advocated by the NPSA for all patients in England and Wales undergoing surgical procedures. The trust's data showed overall compliance with the surgical safety checklist (i.e. whether a checklist had been completed) was just above the trust's target (95%) for 10 of the 12 months between August 2018 and July 2019, dipping to 94.4% at its lowest point. However, some specialities were performing worse than others. This included cardiology, vascular surgery and neurosurgery, all of which were red (RAG) rated (<92%) for six or more months between August 2018 and July 2019. For cardiology, completion rates varied from 77.3% to 95%. Please note the cardiology service line, and its compliance with the surgical safety checklist, sat with the trust’s medical care group.

The trust also carried out observational audits of the surgical safety checklist being completed. In July 2019, the trust achieved a 99% score across all areas (e.g. Theatre 1) and stages (e.g. sign in) of the safer surgery steps.

On this inspection, we observed the surgical safety checklists were performed as expected.

Staff undertook reviews of non-compliance with the checklist in regular reporting to the theatres clinical governance committee.

The service had three patient safety incidents (‘never events’) since June 2018 where failures in the surgical safety checklist were identified. This included failure to mark the site where the procedure was to be performed. We reviewed investigation reports into these never events which contained action plans to reduce or remove the risk of these incidents reoccurring.

Staff were aware of who they could contact if needed for support in theatres. In hours, a consultant was rostered to be doubled up with a senior trainee capable of continuing the list, so the consultant was available to provide immediate help to others. There was also a duty flow anaesthetist available to help. The duty floor anaesthetist was a consultant anaesthetist without any specific operating list responsibility, having a role in all aspects of ‘on the day’ organisation of theatre work instead. The on-call consultant provided support out of hours, and their contact details were also available to staff. Staff we spoke with said this system worked well.

Staff usually had access to mental health liaison and specialist mental health support when needed, including access to 24-hour psychiatric liaison services. However, staff spoke of delays in accessing the service.
Staff told us the psychiatric liaison service visited patients once the physical condition with which they were presenting at the hospital had been stabilised. Staff we spoke with in the surgical assessment unit found this challenging because when patients presenting with a physical illness or injury also had a mental health condition, their mental health condition could impact on how their physical needs could or would be delivered.

Staff across most of the service completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. However, staff in the surgical assessment unit told us risk assessments for patients with challenging behaviour or risk of self-harm or suicide were not completed, and staff were often not well informed of patients' mental health needs and how to meet them. However, staff told us they were able to seek specialist support if required from a local mental health facility.

Staff shared key information to keep patients safe when handing over their care to others. All departments used paper records. In most cases records followed patients from various teams and departments in the hospital in a timely manner.

Postbridge was a nurse-led ward with no designated medical staff. Staff on the ward had experienced difficulties in accessing surgical medical staff when they had concerns. A recent incident occurred when a patient's health was a concern and staff could not get access to the patient's consultant. As a result, lessons had been learned, and a line of communication through the site managers' office had been implemented.

Doctors completed discharge documentation prior to patients being discharged from the wards. However, on some wards, patients experienced delays to their discharge because of delays in the completion of discharge forms.

Shift changes and handovers included all necessary key information to keep patients safe. We observed two staff handovers. These were structured, comprehensive and included information staff needed to keep patients safe. The initial briefing included infection risks and any specific health needs. The nursing staff then took the individual handovers for the patients they would be looking after. These handovers included discussions about medicines, pressure areas, observations, the patient’s presenting complaints, any blood results as well as mental health issues. The handover also included any specific cultural, religious and social needs.

**Nurse and other staffing**

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, however, the staffing tool used to determine staffing levels was not appropriate for all patients. Managers gave bank and agency staff a full induction.

At our previous inspection, we told the trust they should continue to improve staffing levels and ensure they match the acuity of patients on all wards. Some improvements had been made, but staffing levels were not sufficient in all areas at all times. Staff including leaders across the service identified staffing as the biggest challenge or risk facing the service.

There were staffing issues within theatre with an ongoing need to use bank staff to meet safe staffing levels. Following the corporate staffing review in March 2019, there had been some staffing increases in obstetrics and gynaecology, and neurosurgery with the addition of health care assistants. Band seven nurses met weekly to review staffing levels for the week.
Recovery theatre staffing impacted on some patient pathways. There were three recovery trained staff out of hours in the department. One of those staff was always included in the maternity theatre recovery numbers and could be called there, leaving two recovery staff. There were occasions when a further member of staff was required to go to the intensive care unit. Staff told us of an example where a patient who had given birth and her baby having to be brought to theatre recovery because the staff were needed there. While this was a risk-based decision, it was a poor patient pathway.

The ward manager could adjust staffing levels daily according to the needs of patients. However, the staffing levels did not always match the demand on the wards. Staff shortages were identified as part of safe staffing reviews each day, and staff could be moved from ward to ward to support areas with shortages. Agency and bank staff were used to supplement shortages. Some of the wards had consistent staff shortages, and we were told about wards which were either short-staffed or when fully staff, the ward staff were moved to support wards elsewhere in the hospital. Staff explained the impact on patients were delays to treatment, such as patients not being repositioned on time. For example, staff we spoke with on Moorgate ward told us staffing levels meant there were sometimes delays in care and treatment being delivered to patients. We reviewed electronic incident reports filed by staff who were concerned about instances of what they perceived to be potentially unsafe levels of staffing on the ward. One of these incident reports alleged the staffing levels and mix of skills on the ward on a particular night in August 2019 was not adequate to cover the level of dependency of the patients on the ward. We saw senior staff had responded in a supportive manner in response to this case.

On Sharp ward, staff also spoke to us about staffing levels impact on delays to care. Specifically, staff told us about how shortages of staff created risks to patients who required regular reposition to maintain skin integrity.

The number of nurses and healthcare assistants on shifts on each ward did not always match the planned numbers. However, even where the number of nurses and healthcare assistants did match the planned numbers, the skill mix of staff did not always match the need on the wards. For example, on Stonehouse ward, a higher care bay was staffed by one nurse and one healthcare assistant to five patients. The rest of the ward had one nurse and one healthcare assistant to nine patients. On the day of our visit, one healthcare assistant was moved to the higher care bay to care for a patient who needed closer observation, thereby reducing the staffing level on the remainder of the ward until more staff could be found. Similarly, on Crownhill ward, there were four nurses on shift on the day we visited when the plan was for there to be five nurses. Of the four, two were newly qualified nurses, and one was an agency nurse.

The staffing tool used to determine staffing levels was not appropriate for all patients. Senior staff agreed the safer staffing tool used was not accurate for the higher physical needs of patients on Sharp ward. This meant the planned staffing numbers were not an accurate reflection of patients' higher physical demands. The care group management team told us they were in discussions to trial a new staffing tool on Sharp ward to better reflect the patients accommodated there.

The six-monthly assurance report of staffing levels to the board (March 2019) stated nursing vacancies remained a challenge and recruitment continued to be a priority. The report indicated there were occasions when, although the wards were suitably established, due to the number of vacancies across the trust and the high bed occupancy rate the wards are not necessarily staffed to the required demand. When wards were in escalation or above 85% bed occupancy, patient safety and staff well-being were at times at risk of being compromised.

Adult inpatient wards used the red flag system to escalate any patient safety events that were felt
to be difficult to manage within existing staffing establishments and highlight and record any clinical event that remains unresolved. A shortfall in registered nursing time was the top reason (60%) for raising a red flag in the SafeCare system in June 2019. The top 4 areas reporting red flags, for this reason, included the surgical ward Crownhill Ward. The trust’s red flag initiative was in line with guidance from the National Institute for Health and Care Excellence designed to help ensure safe and efficient nurse staffing levels on hospital wards that provide overnight care for adult patients in England.

Senior staff acknowledged staffing difficulties. However, they explained action was being taken to improve the situation. Senior staff told us as part of the staffing review there had been an increase in the recruitment of health care assistants. Furthermore, senior staff spoke about the expected arrival of 74 preceptees throughout September and October 2019 as well as 60 overseas nurses by the end of 2019. Senior staff explained these were planned to be spread across surgery as well as medicine.

The trust had appointed a lead nurse for recruitment including international recruitment to support efforts to recruit overseas staff.

Therapists had designated teams for specialities except for the speech and language team. This meant, for areas without funding for speech and language therapists, the care was provided by stretching the resources they had.

The table below shows a summary of the nursing staffing metrics in surgery compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1612.7</td>
<td>12.3%</td>
<td>7.4%</td>
<td>4.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse staffing</td>
<td>498.5</td>
<td>16.7%</td>
<td>11.2%</td>
<td>4.9%</td>
<td>60,979 (6%)</td>
<td>30,892 (3%)</td>
<td>164,911 (16%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Planned vs Actual

The care group had a fill rate of 83.3% for nursing staff for the period of May 2018 to April 2019.

Vacancy rates

For the period of May 2018 to April 2019, the care group’s annual vacancy rate for nursing staff was 16.7%. This was higher (worse) than the annual vacancy rate for all staff (12.3%) in the care group during the same period. The trust did not have a target for the vacancy rate.

Exit interviews had been started to look at why staff were leaving, and a band six/seven development programme had started in April 2019 to support staff retention strategies.
Turnover rates
For the period of May 2018 to April 2019, the care group’s annual turnover rate for nursing staff was 11.2%. This was higher than the annual turnover rate for all staff (7.4%) in the care group during the same period. The trust did not have a target for the turnover rate.

Sickness rates
For the period of May 2018 to April 2019, the care group’s annual sickness rate for nursing staff was 4.9%. This was higher (worse) than the trust’s target of 3.5% and slightly higher than the annual sickness rate for all staff (4.2%) in the care group during the same period.

Bank and agency staff usage
Bank and agency nurses filled 9% of available hours between May 2018 to April 2019. Managers worked to minimise use of agency staff and requested bank staff familiar with the service where possible. They made sure bank and agency staff had a full induction and understood the service.

Medical staffing
The service mostly 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service always had a consultant on call during evenings and weekends. The surgical consultant rota included four surgical consultants with one consultant taking the ‘consultant of the week’ role. On-call medical staffing was divided into two teams: the surgical ‘take’ team who received all new patients and the surgical ‘post-take’ team. The ‘take’ team worked from 7 am to 7 am. If a patient was seen on admission by the take team and that team’s shift ended, then the patient would be seen by the on-call ‘post take’ team.

The post take team was made up of two junior staff with a senior house officer or registrar and a duty on-call consultant. The consultant was not in the hospital but could be called in when needed.

The care group management team explained the care group had seen a significant improvement in the reduction of vacancies for junior doctors. At the time of our inspection, there were two vacancies at foundation year 1. Staff also told us the service was managing vacancies in foundation year 1 and 2 staff by making greater use of other roles including advanced nurse practitioners.

Junior doctors told us they felt supported by senior medical staff.

The care group management team explained their biggest concern in terms of medical staffing was staffing at consultant level in urology. They explained the recruitment of consultants in this speciality had been an issue for the group. The care group were mitigating this issue by increasing the number of clinical nurse specialists and registrars.
The table below shows a summary of the medical staffing metrics in surgery compared to the trust’s targets, where applicable.

<table>
<thead>
<tr>
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</thead>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>All staff</td>
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<td>12.3%</td>
<td>7.4%</td>
<td>4.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>393.7</td>
<td>10.2%</td>
<td>3.3%</td>
<td>1.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Planned vs Actual

The care group had a fill rate of 90% for medical staff for the period of May 2018 to April 2019.

Vacancy rates

For the period of May 2018 to April 2019, the care group’s annual vacancy rate for medical staff was 10.2%. This was lower (better) than the annual vacancy rate for all staff (12.3%) in the care group during the same period. The trust did not have a target for the vacancy rate.

Turnover rates

For the period of May 2018 to April 2019, the care group’s annual turnover rate for medical staff was 3.3%. This was lower than the annual turnover rate for all staff (7.4%) in the care group during the same period. The trust did not have a target for the turnover rate.

Sickness rates

For the period of May 2018 to April 2019, the care group’s annual sickness rate for medical staff was 1.5%. This was lower (better) than the trust’s target of 3.5% and lower than the annual sickness rate for all staff (4.2%) in the care group during the same period.

Bank and locum staff usage

The trust did not supply medical staff locum usage data.
Staffing skill mix

In February 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at University Hospitals Plymouth NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>55%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>11%</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)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, records were not always stored securely.

Patient notes were comprehensive and all staff could access them easily. We reviewed a total of ten records and found all notes were legible, complete, signed and dated. All records included an audit trail of decisions made and treatment. They included risk assessments and management plans.

Not all records clearly identified the patients' decisions around resuscitation. Staff told us their understanding was all patients were for resuscitation unless the patient had requested not to be resuscitated.

Fal, the pre-assessment ward, received patients' notes the evening before admission. The notes were prepared, and investigative test results included. On the day of operation, the notes went with the patient to surgery and on to the inpatient ward. If the patient was for day surgery, the notes went to the coding department and on to storage.

When patients transferred to a new team, there were no delays in staff accessing their records. All departments used paper records. Patients' records contained information about their care and plans of care from other healthcare organisations. This was in line with the National Institute for Health and Care Excellence (NICE) quality statement 15 (statement 12): Patients’ care was coordinated by a clear and accurate information handover between different wards and departments.
Records were not always stored securely. Lockable cupboards were used on the wards to confidentially store patients’ medical records. Observation records were stored by patient beds. The security for confidential patient records and information was not always adequate. We found three sets of patient medical records left unattended in a corridor on Moorgate ward. Similarly, on Clearbrook ward, we found an unlocked and unattended cabinet storing patient records. A set of patient records was also out on top of one of these cabinets. Although these cabinets were in front of the reception area, the reception was not being staffed at the time. As a result, the security of these patient records could not be assured. We brought this to the attention of staff on the ward who took immediate action to secure these records.

We observed computer screens being locked when not in use, and access was password protected to prevent unauthorised access.

From March to April 2019, an audit of the quality of operative notes against the Royal College of Surgeons (RCS) guidelines was undertaken. The audit showed some significant deficits against the RCS standards, and recommendation were made to address the shortfalls. There was a planned re-audit to establish if the improvements had been embedded.

Records audits had been completed between March to April 2019 and April for vascular, dermatology, neuro and dental surgery. The audit looked at what was included and if the records were clear, signed and dated. Results were varied, vascular surgery had the lowest compliance at 71%, and dermatology had the highest compliance with 100%.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when prescribing, administering, recording and storing medicines. Medicines were stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely and managed appropriately. Regular balance checks were performed in line with trust policy. We saw that in theatres medicines were only prepared when the patient was present, and these were all appropriately labelled.

Medicine audits were completed to cover a range of criteria, and we looked at data from September 2018 to August 2019. This included if drug allergies had been recorded in the right place, for which there were high scores. Appropriate documentation of antibiotic allergies varied but showed an improvement in August 2019. Other areas included missed doses of medicines and how they were recorded.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw nursing staff introduce themselves to patients before offering them medicines and they explained what they were giving. A pharmacist visited daily to review prescriptions and advise medical staff when doses needed to be revised. The pharmacist also told us that they would try and visit in the morning to carry out the screening for to take away medicines for patients identified as medically fit for discharge. We saw that for the four patients reviewed an initial venous thromboembolism (VTE) assessment had been completed but for three of these patients there was no record that the 72 hour VTE review had been completed. All 4 patients were seen to be prescribed appropriate anti-coagulants in accordance with policy.
Staff stored and managed medicines and prescribing documents in line with the trust’s policy. Records showed daily checks of medicines stock on the resuscitation trolleys had been performed to ensure they were fit for use in accordance with trust policy. Medicines fridge records showed temperatures were maintained within the recommended range.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff supported patients to make informed decisions about their care and treatment. We did not see any patients prescribed medicines to control their behaviour.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. All staff we spoke with were aware of their responsibility to report incidents. Incidents could be reported on an electronic system, which staff explained was simple to use. Staff described the incidents they reported, and these included, staffing shortages, accidents, falls, drug incidents and equipment failures.

**Never Events**

The service had three 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 April 2018 to March 2019, the trust reported three never events for surgery at Derriford Hospital. All three involved surgical/invasive procedure incidents – namely, wrong site surgery. We reviewed investigation reports prepared following these incidents. The investigations into these incidents identified a range of contributory factors. In two of the investigation reports, a failure to adhere to the trust's surgical safety checklist policy was identified as the root cause of the incident. Work pressures were also identified as contributory factors in these two incidents. The investigation reports documented that the patients involved were offered an explanation and an apology and learning from the investigations was disseminated to colleagues.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust. Managers shared learning with their staff about never events that happened elsewhere. Staff told us when never events happened, the learning was shared promptly as part of the daily safety brief. In theatres, email alerts were sent to colleagues, informing them of incidents to raise awareness and learning.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from April 2018 to March 2019.
A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls</td>
<td>4</td>
<td>22.2%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>4</td>
<td>22.2%</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>3</td>
<td>16.7%</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>Medical equipment/ devices/disposables incident</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>Medication incident</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff described the duty of candour and their role in ensuring open and transparent reporting, apologising and being transparent with patients and relatives about errors or mistakes made.

Staff received feedback from investigation of incidents. At our last inspection, staff told us they did not always receive feedback after reporting incidents. Staff we spoke with on this inspection told us this had improved and when requested they were given feedback.

There was evidence changes had been made as a result of feedback. For example, following previous incidents past patients were now given wristbands with barcodes on them to improve patient safety by reducing the risk of patient misidentification.

Managers investigated incidents thoroughly. Incidents were investigated by senior ward or theatre staff. Serious incidents were also escalated to the executive team.

Managers debriefed and supported staff after any serious incident. There were procedures for ongoing support to be provided to staff in the event of sudden or unexpected patient deaths or catastrophic events. This included team debriefs.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see.

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. It has been designed to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for venous thromboembolism. 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. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

We saw each ward had displayed the falls occurred in the previous three months, audits of hand hygiene and cleanliness, as well as planned and actual levels of staffing.

The safety thermometer data showed the services achieved over 95% harm free care for the last
12 months. Data from the patient safety thermometer showed the trust reported 39 new pressure ulcers, 10 falls with harm and 10 new catheter urinary tract infections as part of the once a month snapshot of harm data collected from May 2018 to May 2019 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at University Hospitals Plymouth NHS Trust**

1. Total Pressure ulcers (39)

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 Catheter acquired urinary tract infection level 3 only)

(Source: NHS Digital)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care, treatment and support were delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE).

The trust had a policy to ensure the uptake of national clinical guidance recommendations. This included guidance issued by the Royal Colleges and the National Institute for Health and NICE.

The trust’s clinical audit and effectiveness group reported to the care group management team on the performance of the care group with regards to the effective review and implementation of national guidance. This gave assurance to the management team about their compliance in this
regard. At the surgical care group governance meeting on 7 August 2019, the care group's performance was noted to be satisfactory.

Accreditation had been awarded for general surgery and neurosurgery in 2016 through the Anaesthesia Clinical Services Accreditation scheme. As part of the accreditation programme, the service was benchmarked against standards and local, regional and national performances. The assessment covered all aspects of general anaesthetic care. At the time of our inspection, the trust was applying for reaccreditation.

The service also participated in the National Anaesthetic Audits Projects which sought to study anaesthesia-related complications of low incidence that are potentially serious for patients and important to patients and anaesthetists.

A range of clinical care pathways were used in accordance with national guidelines. These included, among others, fractured neck of femur (broken hip) and sepsis. We found these were being used effectively to manage patients’ care and treatment.

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. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We observed nurses, healthcare assistants and members of the housekeeping team, providing meals and drinks snacks for patients. Before offering any food to patients, staff checked with the nurse or doctor, or patients’ records to check the patient was able to eat and drink. We saw staff knew which patients needed assistance to eat and drink. Staff provided adequate support to these patients.

Our review of patient-led assessment of the care environment (PLACE) results for surgery showed the care group performed well in terms of meal provision.

Staff told us about incidents in the past where patients, such as those with swallowing difficulties, were given food of a texture that was not appropriate for them. In response to these incidents, staff explained the service had recently adopted the International Dysphagia Diet Standardisation Initiative framework. Staff told us this framework sought to eliminate the use of the imprecise term ‘soft diet’ and, instead, introduce standard terminology to describe texture modification for food and drink. Staff told us the framework had been implemented effectively, with awareness being raised among staff.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. For patients with an identified need, staff recorded the food and drink they consumed and checked this against the recommended levels in their care plan. Staff shared information about patients who needed more or less fluids during staff handovers. Staff assessed the need for intravenous fluids and administered, monitored and recorded these accordingly.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff reviewed the tool regularly to identify any change in the needs of the patient.

An audit had been carried out of malnutrition universal screening tool records between February 2019 and July 2019. Of the 603 documents reviewed, 94% had an assessment completed.
Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it.

**Pain relief**

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

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain levels were assessed using a scoring system. Staff considered patients who were unable to verbally communicate about pain and ensured any visual signs were monitored and appropriate pain relief provided.

Patients received pain relief soon after requesting it. Patient records we reviewed showed those patients had a pain score recorded, and there had been a timely administration of pain relief where required. We observed staff asking patients if they had any pain and their level of discomfort. Patients told us staff regularly asked about levels of pain and provided pain relief when needed. We saw staff return to patients to check the pain relief had been effective.

There was a pain service at the hospital covering the management of acute, chronic and cancer pain. Acute pain management and advice were available through this service.

Staff prescribed, administered and recorded pain relief accurately. Medicine administration records showed pain relief was accurately recorded when given.

The service carried out pain audits. In 2017, the service completed an audit of referrals made for consultant inpatient pain reviews. Incidents relating to opioids were reported within the trust and a spreadsheet was now completed regarding incidents that have been recorded. Of the 90 incidents reported in the last six months, 44 had been stock/pharmacy related incidents. Training was regularly provided to nursing and medical staff to reduce errors in pain relief prescription.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. However, there was a deterioration in performance in many of the audits in which the service took part. The service was performing worse than comparable trusts and/or failing to meet national standards against many of the measures in these audits. The service had been accredited under relevant clinical accreditation schemes.

**Relative risk of readmission**

**Trust level**

**Elective Admissions**

The service had a higher than expected risk of readmission for elective care than the England average. This was an indicator of the outcome for these patients following their initial admission being suboptimal.

From February 2018 to January 2019, patients at the trust had a higher than (worse) expected risk of readmission for elective admissions when compared to the England average. Of the top three specialties by number of admission (urology, ear, nose and throat, and colorectal surgery) all had a higher than (worse) expected risk of readmission than the England average.
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 trust based on count of activity

Non-Elective Admissions

The service had a lower than expected risk of readmission for non-elective care than the England average.

Patients at the trust had lower than expected risk of readmission for non-elective admissions when compared to the England average. Of the top three specialties by number of admission (colorectal surgery, upper gastrointestinal surgery, and hepatobiliary and pancreatic surgery) all had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

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 trust based on count of activity

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

Derriford Hospital

Elective Admissions

From February 2018 to January 2019, all patients at Derriford Hospital had a higher than (worse) expected risk of readmission for elective admissions when compared to the England average.

Of the top three specialties by number of admission (colorectal surgery, urology, and ear, nose and throat (ENT)) all had a higher than (worse) expected risk of readmission for non-elective admissions when compared to the England average.
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

Non-Elective Admissions

Patients at Derriford Hospital had a lower than (better) expected risk of readmission for non-elective admissions when compared to the England average. Of the top three specialties by number of admission (colorectal surgery, upper gastrointestinal surgery and hepatobiliary & pancreatic surgery) all had a lower than (better) expected risk of readmission for non-elective admissions when compared to the England average.

The service participated in all relevant national clinical audits. The service performed variably in national clinical outcome audits. Managers used some of these results to improve services further.

National Hip Fracture Database (2018)

The table below summarises Derriford Hospital’s performance in the national hip fracture database.

For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means the trust’s performance fell within the middle 50% of results nationally.

The hospital performed similarly or better compared to other trusts in four of the five indicators in the audit. However, the hospital performed worse compared to other trusts in one of the indicators: crude proportion of patients having surgery on the day or day after admission.

Compared to the previous year, the hospital had improved its performance against most of the indicators in 2018. However, the hospital’s performance deteriorated in 2018 compared to 2017 against one of the indicators: crude peri-operative medical assessment rate.
We asked leaders about the trust’s performance in this audit. Leaders explained that following a clinical governance meeting in April 2018 regarding pressure sores, a wide-ranging action plan was implemented. This involved, among other things, highlighting of vulnerable patients at risk of developing or evolving pressure sores in daily safety briefings, as well as ongoing pre-optimisation of patients with intravenous fluids to avoid volume depletion and tissue perfusion. Leaders explained these steps had resulted in a noticeable improvement in the trust’s performance in the metric measuring patients documented as not having developed pressure ulcers.

Leaders said the trust’s performance regarding the proportion of patients having surgery on the day or after admission had remained variable and “intermittently been poor”. They explained this has been raised with the trust board, and the relevant surgical speciality was developing an action plan to improve performance.

(Source: National Hip Fracture Database)
The table below summarises the trust’s performance in the national bowel cancer audit.

The trust’s case ascertainment (or the proportion of eligible cases included in the audit) was ‘poor’ compared to other trusts. The trust had submitted less than half of its eligible cases to the audit. A lower proportion of cases submitted may mean the results based on those cases are a less accurate reflection of the care provided. Leaders told us of action taken to improve case ascertainment in this audit going forward.

Compared to the previous year, the trust had improved its performance against four of the measures in the 2018 national bowel cancer audit. However, the trust was a negative outlier for the measure: 18-month temporary stoma rate in rectal cancer patients undergoing major resection. An outlier is a result further from the overall average value than would usually occur by chance alone.

The trust performed within the expected ranges compared to other trusts for the other measures.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>45.6%</td>
<td>Poor</td>
<td>Good is over 80%</td>
</tr>
<tr>
<td>Risk-adjusted post-operative length of stay &gt; 5 days after major resection (A prolonged length of stay can pose risks to patients)</td>
<td>64.6% (68% in 2017)</td>
<td>Worse than national aggregate</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 90-day post-operative mortality rate (Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</td>
<td>3.6% (8% in 2017)</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 2-year post-operative mortality rate (Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</td>
<td>18.0% (23% in 2017)</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 30-day unplanned readmission rate (A potential risk for early/inappropriate discharge is the need for unplanned readmission)</td>
<td>12.5% (7.7% in 2017)</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection (After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)</td>
<td>67.4% (65.5% in 2017)</td>
<td>Negative outlier</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit)
Following an alert regarding its status as a negative outlier, the trust reviewed its performance with regards to the reversal of stomas in bowel cancer patients. The trust’s review identified poor compliance with submission to the audit, as well as a need to standardise the policy for the use of planned Hartmann’s procedures in rectal cancer surgery.

As part of our inspection, leaders told us their review found the trust was not an outlier in relation to this metric and their current data for patients undergoing a major resection compared favourably with the national average. They explained that the result in the audit was due to incomplete data submitted for the trust. Leaders explained their action plan following this review was due to be completed in March 2020 and part of this action plan was a drive to improve data capture for the National Bowel Cancer Audit. Leaders said there was no further action plan with regards to this audit.

**National Vascular Registry (2018)**

The table below summarises the trust’s performance in the national vascular registry. The trust saw a year-on-year deterioration in its performance in the 2018 national vascular registry. This included a deterioration in the average amount of time patients wait to have surgery after the onset of their symptoms, which had gone up from 11 days in 2017 to 18 days in 2018. The trust performed ‘worse’ in this measure when compared to other trusts and failed to meet the 14-day national standard. The trust performed ‘within the expected range’ in comparison to other trusts with regards to other measures in the audit: risk-adjusted post-operative in-hospital mortality rate and risk adjusted 30-day mortality and stroke rate.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal Aortic Aneurysm Surgery</strong> <em>(Surgical procedure performed on an enlarged major blood vessel in the abdomen)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment <em>(Proportion of eligible cases included in the audit)</em></td>
<td>107.0%</td>
<td>Better</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk-adjusted post-operative in-hospital mortality rate <em>(Proportion of patients who die in hospital after having had an operation)</em></td>
<td>4.4% (3.3% in 2017)</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Carotid endarterectomy</strong> <em>(Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment <em>(Proportion of eligible cases included in the audit)</em></td>
<td>92.0%</td>
<td>Better</td>
<td>Yes</td>
</tr>
<tr>
<td>Crude median time from symptom to surgery <em>(Average amount of time patients wait to have surgery after the onset of their symptoms)</em></td>
<td>18 days (11 days in 2017)</td>
<td>Worse</td>
<td>No</td>
</tr>
<tr>
<td>Risk-adjusted 30 day mortality and stroke rate <em>(Proportion of patients who die or have a stroke within 30 days of their operation)</em></td>
<td>1.4% (0% in 2017)</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Vascular Registry)

Leaders told us there was no action plan to improve the trust’s performance in relation to this audit.
The table below summarises the trust's performance in the national oesophago-gastric cancer audit, which is an audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust-level metrics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case ascertainment</strong></td>
<td>81 to 90%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age and sex adjusted proportion of patients diagnosed after an emergency admission</strong></td>
<td>20.8%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends overall rates over 15% could warrant investigation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk adjusted 90-day post-operative mortality rate</strong></td>
<td>4.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of patients who die within 90 days of their operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer Alliance level metrics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude proportion of patients treated with curative intent in the Cancer Alliance</strong></td>
<td>33.3%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Proportion of patients receiving treatment intended to cure their cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
National Emergency Laparotomy Audit (2018)

The table below summarises Derriford Hospital’s performance in the national emergency laparotomy audit (for the period December 2016 to November 2017).

The audit reports on the extent to which key performance measures were met and grades performance as red (less than 55% of patients achieving the standard), amber (between 55% and 85% of patients achieving the standard) and green (more than 85% of patients achieved the standard).

The trust’s performance against most of the measures in the audit was rated ‘amber’, and it failed to meet the national standard with all of these measures except the proportion of eligible cases included in the audit (case ascertainment). The trust met the national standard and was ‘within expected range’ for the metric for risk-adjusted 30-day mortality rate.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>85%</td>
<td>Amber</td>
<td>Yes</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death (Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td>60% (61%, 2017)</td>
<td>Amber</td>
<td>No</td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time frames (Proportion of patients who were operated on within recommended times)</td>
<td>77% (73%, 2017)</td>
<td>Amber</td>
<td>No</td>
</tr>
<tr>
<td>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</td>
<td>70% (65%, 2017)</td>
<td>Amber</td>
<td>No</td>
</tr>
<tr>
<td>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</td>
<td>80% (88%, 2017)</td>
<td>Amber</td>
<td>No</td>
</tr>
<tr>
<td>Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</td>
<td>7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Emergency Laparotomy Audit)

Leaders told us there had been concerns regarding the trust’s reported proportion of eligible cases included in the audit (case ascertainment). They explained they expect the data capture and quality will improve going forward.

Leaders explained there was no action plan regarding the trust’s performance in this audit.

The table below summarises the trust’s performance in the national ophthalmology database audit, which is an audit of patients undergoing cataract surgery.

The trust was a positive outlier for one of the metrics and ‘within expected range’ for the other metric in this audit.

| Metrics  
(Audit measures) | Trust performance | Comparison to other Trusts | Meets national standard? |
|---------------------|-------------------|-----------------------------|--------------------------|
| **Trust-level metrics** 
(Measures of hospital performance in the treatment of cataracts) | | | |
| Case ascertainment  
(Proportion of eligible cases included in the audit) | 99.2% | N/A | No current standard |
| Risk-adjusted posterior capsule rupture rate  
(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.) | 0.6% | Positive outlier | No current standard |
| Risk adjusted visual acuity loss  
(The most important outcome following cataract surgery is the clarity of vision) | 0.7% | Within expected range | No current standard |

(Source: National Ophthalmology Database Audit)

National Joint Registry (2018)

The table below summarises Derriford Hospital’s performance in the national joint registry, which is an audit of hip, knee, ankle, elbow and shoulder joint replacements.

The trust performance in relation to case ascertainment did not meet the national standard and was worse than other hospitals. The trust performance in relation to the proportion of patients who consented to have their personal details included on the register of implanted prosthetics was similar to other trusts and did not meet the national standard. Performance in the other measures was ‘within expected range’ in comparison to other hospitals and met the national standards. Trust leaders explained the trust’s performance with regards to the case ascertainment metric in this audit had been affected by the trust’s arrangement with a local private health provider for some surgical procedures to be carried out away from the hospital at a local NHS treatment centre. Leaders explained the trust’s performance in the case ascertainment metric was due to initial challenges in setting up this arrangement.

| Metrics  
(Audit measures) | Hospital performance | Comparison to other hospitals | Meets national standard? |
|---------------------|----------------------|-----------------------------|--------------------------|
| **Trust-level**  
| | | | |
| Case ascertainment (hips, knees, ankles and elbows)  
(Proportion of eligible cases within the trust submitted to the audit) | 74.0% | Worse | No |
| Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)  
(Patient details help ‘track and trace’) | 88.3% | Similar | No |
implanted prosthetics. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register.

<table>
<thead>
<tr>
<th>Hospital level: Hips</th>
<th>Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who need their hip replacement ‘re-doing’)</th>
<th>0.7</th>
<th>Within expected range</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospital level: Knees</td>
<td>Risk-adjusted 5 year revision ratio (for knees excluding tumours) (Proportion of patients who need their knee replacement ‘re-doing’)</td>
<td>0.6</td>
<td>Within expected range</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: National Joint Registry)

National Prostate Cancer Audit (2018)
The table below summarises the trust's performance in the national prostate cancer audit.

The trust performed ‘within expected range’ in comparison to other trusts in relation to relevant metrics in this audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men with complete information to determine disease status</td>
<td>97.1%</td>
<td>N/A</td>
<td>No</td>
</tr>
<tr>
<td>(This is a classification describing how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy (A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect patients experienced a complication related to the surgery after discharge from hospital)</td>
<td>11.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy</td>
<td>4.3%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
Complications following surgery may reflect the quality of surgical care

| Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy (External beam radiotherapy uses high-energy beams to destroy cancer cells) | 2.6% | Within expected range | No current standard |

(Source: National Prostate Cancer Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph below, whereas proportions of patients reporting they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues namely mobility, self-care, usual activities, pain or discomfort, anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living; a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.

In 2016/17, performance on groin hernias (EQ VAS) was better than the England average.

For varicose veins, hip replacements, and knee replacements performance was about the same as the England average.
The service had received full anaesthesia clinical services accreditation (ACSA) in 2016. ACSA consisted of a set of standards based on recommendations from the Royal College of Anaesthetists’ Guidelines for the Provision of Anaesthetic Services. At the time of our inspection, the trust was in process of applying for re-accreditation.

All NHS funded organisations were required to respond to a National Patient Safety alert issued by NHS England in September 2015. This required organisations to identify areas where invasive procedures were undertaken and to develop Local Safety Standards for Invasive Procedures, incorporating the required elements of the National Safety Standards for Invasive Procedures (NatSSIPs). As of June 2019, audits had identified shortfalls, and an improvement plan had been started. Staff did not have a clear understanding of the rationale for NatSSIPs as well as ways of working and human factors. Currently, the trust was working to improve this by using the theatre education team.

**Competent staff**

The service sought to ensure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development. However, the trust’s appraisal target rate was not met by all staffing groups in the service.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service was rolling out training on the foundations of perioperative practice to ensure staff had the skills to competently carry out their role.

Some theatre staff had access to further training to progress to assistant practitioner roles, and the trust was supporting operation department practitioner training. There was also discussion about the value of education mapping, looking at developing links to psychologist and the intensive care unit.

Managers gave all new staff a full induction tailored to their role before they started work. Anaesthetic staff were required to conduct a self-assessment of competency against anaesthetic equipment.
Appraisal rates
Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals were completed in a tier system with each member of staff being appraised by the next higher band.

At our previous inspection, we told the trust they should improve appraisal rates to meet the trust’s target.

From April 2018 to March 2019, 88% of required staff in surgery received an appraisal compared to the trust target of 95%. With the exception of estates and ancillary, no staff groups met the trust target of 95%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing</td>
<td>304</td>
<td>339</td>
<td>89.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>79</td>
<td>98</td>
<td>80.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>236</td>
<td>255</td>
<td>92.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>176</td>
<td>205</td>
<td>85.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medical</td>
<td>235</td>
<td>270</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>8</td>
<td>12</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>1,043</td>
<td>1,185</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Appraisals were identified as an area of improvement following the results of the care group's NHS staff survey (2018) results. The results showed the care group performed below the trust average with regards to whether staff had received an appraisal with the last year, as well as scoring below the trust average for the quality of appraisals. There was an action plan to improve on the care group’s performance by delivering training sessions on providing appraisals as well as seeking feedback from those who have had appraisals.

Staff we asked on this inspection told us they had received an appraisal within the last year. They told us their appraisals were tailored to them to meet their particular development needs.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. We spoke with four staff who were newly qualified and were undertaking preceptee supervision. They told us they had felt supported as part of this ongoing training and in several cases had been supernumerary to enable them to be free to observe and develop their skills.

There were enough clinical educators to support staff learning and development. Staff in most areas were supported by clinical nurse educators. The educator provided training and supported
staff with learning while on the wards or in the theatre department. The feedback from staff was positive about this role.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, at the time of our inspection, preoperative assessment nurses were being trained on the interpretation of ECGs and bloods. This was to upskill nurses and improve the efficiency of the service.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff had access to further training. External and internal courses were available, including human factors training.

Managers identified poor staff performance promptly and supported staff to improve. Managers monitored poor performance through the appraisal process and through support from the human resources team.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients. We observed all staff across all grades, functions and departments working well together to support patients’ needs. Staff attended handovers to ensure an understanding of patients’ potential and actual needs.

All teams worked well together to meet the needs of patients. For example, porters were used to transport patients to wards and theatres. The surgical departments had a link to portering services, and we were told porters, when requested, arrived promptly. They were seen to be polite and helpful.

Information was shared with patients’ GPs on discharge and discharge letters sent when patients were discharged from the service. If patients were asked to attend a follow-up clinic, letters advising of this were sent to patients’ GPs.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Psychiatry liaison services attended wards and worked with staff to ensure patients’ best interests were being met.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Nurses and medical staff provided on-site or on-call cover 24-hours a day, seven-days a week.

Junior and middle-grade doctors told us consultants were always accessible, gave them good support and would attend as required when they were on call.

The anaesthetic team provided a seven-day service with on-call general surgery, neurosurgery and paediatric anaesthetists.

Staff could call for support from doctors and other disciplines, including mental health services
and diagnostic tests, 24 hours a day, seven-days a week. Pharmacy services were available either in the department, accessible by telephone or on call. Staff told us should they need specific medicines not stocked in the department, they could access these medicines from stock cupboards elsewhere or through the on-call pharmacist.

Diagnostic imaging services, which included X-ray and scans, were available 24 hours a day, seven-days-a-week. Staff told us this service worked well and provided timely reporting and discussion.

Therapy was not a seven-day service. Therapists told us they provided a week day service with on-call access for emergency therapy only.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Information in leaflet and poster form was evident in most ward areas. We observed nursing and medical staff talking to patients and relatives about how their health conditions could be managed and improved and providing literature to support them.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. All patients had full risk assessments undertaken as part of their admission. This information was available for nursing and medical staff to advise as appropriate on changes to lifestyle, including smoking cessation and weight loss. We saw, when identified, patients preferences were communicated.

The care group were trialling a prehabilitation programme with a local university. This involved patients undergoing an initial cardiopulmonary exercise testing (CPET) at the hospital. Patients were then referred to a fitness suite at a local university where they worked with a fitness instructor to prepare for surgery. The patient would then return to the hospital for a follow-up CPET to measure the impact the exercise has had. Leaders explained these programmes sought to not only make patients fitter before their surgery but to also embed healthier lifestyle choices among patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff requesting consent prior to care and treatment. As part of the consent to surgery, we saw staff explaining procedures and ensuring patients were clear about what to expect. We observed consent being requested, and where consent was refused, this was documented, along with confirmation the patient had capacity to make the decision.

Staff told us if in an emergency a patient refused treatment that was needed and in their best interests, the consultant would make a best interest decision about what to do in the least restrictive way.
When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff followed the trust policy and procedure when a patient could not give consent.

Each consent for surgery form had space to include the details of any translation service used.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients’ records.

Treatment escalation plans were audited in March 2019 which included decisions around resuscitation. The audit noted areas of success and areas of concerns. An action plan was completed to meet the shortfalls, and all areas were recorded as completed with feedback to all areas noted as ongoing.

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

Nursing and medical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Training on the Mental Capacity Act and deprivation of liberty safeguards were covered in the modules for safeguarding adults’ levels two and three. All staff we spoke with confirmed they had completed training and understood the scope of their role in ensuring patient safety. Staff explained should a patient's capacity be variable, a multi-step test would be completed to identify if the patient had capacity.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood deprivation of liberty safeguards and gaining valid consent as and when required. All staff we spoke with demonstrated a clear understanding of their responsibilities to patients who may lack the capacity to make their own decisions. We saw when a deprivation of liberty safeguard was used, staff understood the scope of its use.

Staff implemented deprivation of liberty safeguards in line with approved documentation. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff were able to explain the process used to apply for the implementation of a deprivation of liberty safeguard. They were clear about their role and that the medical staff would sign final requests. The trust also had a safeguarding team who were notified of all deprivation of liberty safeguards applications and would monitor their timescale and use.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff explained the care an elderly and confused patient was receiving. Extra staff had been provided to walk with the patient and ensure their safety. The staff member spoke quietly and calmly to the patient, listening to their answers and trying to find a solution to help the patient to be settled and comfortable.
Patients said staff treated them well and with kindness. Patients told us they had been treated with dignity and respect by staff. We observed staff treating patients with empathy and kindness. Patients’ comments to us included the following:

- “The nurses are all very nice, both days and nights, I have no complaints.”
- “Staff come when you call... They are so busy [but] they are always quick with [providing] pain relief”.
- “Staff are absolutely brilliant.”
- “Nurses are run off their feet, they really need more staff. Call bells are answered, but there are delays.”
- “Lynher is a really nice ward to be on [with] lovely... very friendly [staff].”

Patients’ privacy and dignity was respected in all areas we visited. Staff pulled curtains – and doors were shut – when delivering care. Patients in theatres were covered at all times with consideration given to their dignity. Staff introduced themselves and their roles to help patients feel more comfortable.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We listened to two staff briefings and handovers. We observed patients’ preferences and views were included and respected. We saw one patient had a dog visit them to provide comfort. Staff told us pets could be brought to the ward if agreed beforehand according to the trust’s policy.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress.**

They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff listening, supporting and providing explanations to patients and relatives. All patients and relatives we spoke with were aware of the next stages of their treatment. We observed staff ensuring patients understood information and could ask questions.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff supported patients to have their curtains closed if they preferred. Some patients were supported, when possible, in a side room, especially those patients at the end of their lives. This offered patients and visitors privacy at a challenging time.

Staff in the interventional radiology department told us about how they supported the family of a patient who passed away in the department. Their description of the event demonstrated their compassion towards the family, as well as how they supported each other as a team.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Not all wards had space available for staff and patients to have privacy to discuss potentially distressing news. However, staff tried to ensure patients had privacy when needed.

Staff understood the emotional and social impact a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff explained open visiting often alleviated patients
anxiety and distress. They explained when patients had a full-time carer at home, the carers could stay at the hospital to maintain continuity for the patient.

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

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff involved patients and those close to them in decisions about their care and treatment. We observed staff explain each step they were taking and why.

Matrons across the service held regular 'Tea with Matron' sessions, which were opportunities for patients and their families and carers to meet matrons and chat about any aspect of care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. All patients and relatives we spoke with confirmed they understood what was happening with their care and the next stages of their care pathway. For example, four patients were delayed being discharged and were aware they were waiting for doctors to complete their discharge records. One patient explained they had been in the hospital for an extended period and required therapy support before they could leave.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were able to provide feedback through the Friends and Family Test, and feedback was collated and provided to staff. We also saw many thank you cards throughout areas of the care group from patients and their families expressing their gratitude for the care received.

**Friends and Family test performance**

The Friends and Family Test (FTT) asks people if they would recommend the services they have used. The FTT response rate for surgery at the trust was 37%, which was better than the England average of 27%, from April 2018 to March 2019. The trust did not submit any data in December 2018.

A high proportion of patients gave positive feedback about the service in the FFT survey. The FFT feedback was positive for all areas, varying from 92% recommendation on Moorgate ward to 99% recommendation on Freedom Day.

FTT results were displayed across the service for staff and patients (and their relatives and carers) to view. Some areas displayed qualitative feedback from patients about their experiences, as well as feedback ('you said, we did') on what the service was doing in response to patient feedback.
A breakdown of FFT performance by area for surgery at trust level from April 2018 to March 2019.

4. 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), as well as wards where there were less than 100 responses in total over the 12 month period.

5. Sorted by total response.

6. 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)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Staff explained some theatres ran later in the day to meet patient demand and to accommodate patients who worked during the day. This meant the last patient could be treated at 8 pm with the unit closing at 10 pm.

We reviewed data provided by the trust on mixed-sex breaches between October 2018 and May 2019. The care group had 24 mixed-sex breaches. These breaches were over 39 days, which meant some breaches lasted longer than a day. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were mostly appropriate for the services being delivered. Ward areas and theatre suites were organised to accommodate patients and their relatives or carers. Waiting areas were suitable for their purpose, and we did not see any overcrowding. Signage was adequate to direct patients to the appropriate area. Information was displayed to patients and included what to expect in each area or department.

The set up for nurse-led assessments in the pre-assessment unit based on Erme ward did not always ensure patient dignity and confidentiality. Patients had their nurse-led assessments in one of eight pods all located in one of the rooms in the unit. These pods were not soundproofed. It was possible for patients - and relatives or carers accompanying them - to hear conversations taking place in other pods. Staff in the unit told us where possible they tried to accommodate patients who asked for their assessment to take place in a private room.
The trust had approved a business plan for alterations to the environment in interventional radiography. Staff working in the department felt their voice had been heard as they had suggested there should be an interventional treatment room in the day case unit, which had been added to improvement and business plans. The work was due to be carried out over the next couple of years and to be completed by 2021.

Staff could access emergency mental health support 24-hours a day 7-days a week for patients with mental health problems, learning disabilities and dementia. There was a psychiatric liaison service available by referral if needed once a patient's physical condition had stabilised.

A learning disability outreach team was available to support patients in the department if needed. An alert could be placed on the computer system by staff, and this automatically notified the learning disability team. Staff told us patient passports were used to provide details of patients' specific care preferences and needs.

Meeting people’s individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients living with dementia were identified in the pre-assessment unit to help them prepare for their operation. Carers were encouraged to complete 'this is me' documents with the personal preferences of the patient, so this was ready for the patient’s stay in hospital. Staff on wards support patients living with dementia by using 'this is me' to find out about patients' preferences.

Wards were designed to meet the needs of patients. Corridors and entrances were wide enough for wheelchair access and wards had separate male and female toilets and showers, with disabled facilities available. Signage was clear and supported patients with cognitive impairment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed two handovers where we saw this was standard practice.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Patients with hearing impairment could access an electronic tablet for interpretation services, or the trust would book an interpreter for them.

The service had information leaflets available in languages spoken by patients and the local community. Information leaflets were available, and these included leaflets in large print. Leaflets in other languages were available on request. Staff showed us reference cards with pictures and signals to aid communication. Health-related advice leaflets were available on a range of subjects.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to access interpreters for patients whose first language was not English. This could be arranged through an external company over the phone. Staff we spoke with said this worked well.

Patients were given a choice of food and drink to meet their cultural and religious preferences. If patients ate a particular diet because of their religion or culture, they were encouraged to inform staff of this so the service could cater to their needs.
Staff had access to communication aids to help patients become partners in their care and treatment.

**Access and flow**

People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly above (worse than) national standards.

Managers monitored waiting times. However, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets.

Performance for referral to treatment times (RTT) for incomplete pathways had deteriorated since our last inspection and was worse compared to national averages across all specialities for which data was available. The trust’s cancer waiting times for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was above (worse than) the national standard. The percentage of cancelled operations at the trust has been consistently above (worse than) the England average. Similarly, the percentage of patients whose operation was cancelled and were not treated within 28 days was consistently above (worse than) the England average. However, the service’s performance for RTT for admitted pathways was generally in line with the national average, though performance varied among specialities.

**Planned surgery**

Patients undergoing planned surgical procedures were referred for surgery from their outpatient appointment. Based on the advice of the referring consultant and the availability of sessions, the majority of patients (except orthopaedics) were then seen at the pre-assessment unit on Erme ward. At the pre-assessment unit, patients underwent necessary tests as well as a nurse-led assessment to ensure they were prepared for their operation.

Fal ward offered an admissions area for patients being admitted on the day of their planned surgery. Following their procedure, patients would be moved to Postbridge as a second stage recovery area. These two units supported a day case pathway for patients undergoing planned surgery. The pathway for patients requiring overnight stay was for them to be moved to a surgical ward following their operation.

Surgical treatments were mainly provided at the trust’s core site at Derriford Hospital. However, treatments were also provided at other locations operated by the trust such as Tavistock Hospital.

**A local NHS treatment centre**

In November 2018, the trust began an 18-month pilot with a privately-run local NHS treatment centre. The pilot was to have elective orthopaedic treatments being undertaken by a joint team of surgeons and anaesthetists from both organisations at Derriford Hospital and this local NHS treatment centre. The purpose of the partnership was to increase capacity and, thereby, reducing waiting times for planned operations. Leaders told us efforts were ongoing to maximise the benefits of this arrangement in terms of creating additional capacity for the trust.

**Emergency surgery**

There was capacity for emergency surgery. This was provided throughout the week, out of hours and at weekends. An emergency team was available for this cover out of hours and at weekends.
Referral to treatment (percentage within 18 weeks) – incomplete pathways

Following our previous inspection, we told the trust it must ensure referral to treatment times (RTT) for incomplete pathways were improved. We also told the trust it must improve the cancer waiting times for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment.

A breakdown by speciality of referral to treatment rates for surgery in July 2019 (the most recently published data) can be found below:

<table>
<thead>
<tr>
<th>Speciality grouping</th>
<th>Result</th>
<th>England averages</th>
<th>Last inspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>71.1%</td>
<td>84.5%</td>
<td>73%</td>
</tr>
<tr>
<td>Urology</td>
<td>71.8%</td>
<td>82.9%</td>
<td>82.8%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>66.1%</td>
<td>83.6%</td>
<td>66.1%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>78.9%</td>
<td>82.6%</td>
<td>79.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>88.6%</td>
<td>85.4%</td>
<td>94%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>No data available</td>
<td>80.7%</td>
<td>No data available</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>46.7%</td>
<td>79.8%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>79.9%</td>
<td>82.7%</td>
<td>80.2%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>65.3%</td>
<td>83.6%</td>
<td>90.4%</td>
</tr>
</tbody>
</table>

The results for RTT for incomplete pathways had deteriorated for all specialities for which data was available except trauma and orthopaedics compared to figures we reported at our last inspection. The RTT rates for incomplete pathways was also worse compared to national averages for all specialities for which data was available.

The cancer waiting list was not always meeting the required targets. Between August 2018 to July 2019, the trust failed to achieve the 85% target of 62 days cancer target, with performance fluctuating between 68.3% to 78.5%.

These figures indicated people did not always have timely access to initial assessment, diagnosis and urgent treatment. Access to timely treatment is important to prevent patients deteriorating and their condition worsening.

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

From May 2018 to April 2019, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Three specialities were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>91.8%</td>
<td>79.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>69.6%</td>
<td>63.9%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>61.5%</td>
<td>60.2%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>72.2%</td>
<td>75.5%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>63.9%</td>
<td>78.5%</td>
</tr>
<tr>
<td>General surgery</td>
<td>53.8%</td>
<td>71.9%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>52.4%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>51.4%</td>
<td>58.6%</td>
</tr>
</tbody>
</table>

The care group management team told us the service was facing above expected demand, the impact of which was compounded by nationwide challenges in staffing. In urology, for instance, leaders explained they had seen a 19% increase in demand so far during the current financial year at the time of our inspection. Leaders said this impacted on, among other things, the trust’s performance with regards to the 62 days cancer target. The trust had an action plan to improve its performance for RTT pathways as well as its cancer targets which included a recruitment plan as well as working with local stakeholders to increase capacity within the service.

Theatre scheduling and performance utilisation

At our last inspection, we told the trust it should continue to improve theatre utilisation. The trust had made changes to improve their theatre utilisation, however they were still restricted by the bed capacity in the hospital and the impact this had.

The care group had adopted the 6-4-2 theatre management process, allowing reviews of the theatre programme every week and looking six weeks ahead. Through the 6-4-2 method, the care group checked surgeons were available, and operating lists were scheduled appropriately and on time. Weekly 6-4-2 theatre meetings were held with all specialities expected to attend to go through the theatre programme.

Weekly list previews were also taking place between senior theatre staff and senior managers in each speciality. These meetings were an opportunity to look at performance over the previous week to see if there was any learning, as well as looking at the following week to see how lists could be improved to maximise efficiencies.

The care group held meetings at 2 pm every day by which time all lists were expected to be finalised. Leaders acknowledged they were often not achieving this, and this was an area they were working to improve. The care group was adopting a policy of not staffing lists that were yet to be finalised by 2 pm the day before as a way to encourage specialities to complete lists on time.

The care group did not have an electronic theatre management system. Staff spoke about the challenges in theatre utilisation with the multiple layers of communication causing delays. Staff were looking towards an electronic management system which would clarify planning and reduce the delays. Leaders explained this was with procurement and out to tender at the time of our inspection, and they were expecting to have a theatre management system by the end of the
calendar year. However, to improve the accuracy of their scheduling and, thereby, improve their theatre utilisation, the care group had calculated the mean operating times for all surgeons and anaesthetists. These mean operating times were used when apportioning time for procedures.

The care group was working towards a national theatre utilisation target of 85%. Leaders explained they launched a programme to enhance theatre utilisation in January 2018 at which point the hospital's theatre utilisation rate stood at 75%. Since then, leaders told us theatre utilisation at the hospital had risen to 81.5%, and they were aiming to reach the national target of 85% in October 2019.

Staff consistently told us the main obstacle to theatre utilisation as well as access and flow through the hospital was bed capacity. We reviewed a breakdown of non-clinical operation cancellations from August 2018 to July 2019. Bed capacity was the most common reason for cancellations in every month except one (July 2019). There was a steady decline during this period in the percentage of cases where bed capacity was the reason for cancellation.

In response to concerns about bed capacity and the impact this was having on theatre utilisation, the care group launched an 'automatic send' policy. This policy stated all theatre lists automatically start with their first patient unless that patient required a critical care bed. The policy was to have no more than 10 inpatients going ahead first on the list during OPEL 1-3 and no more than five inpatients going ahead when the hospital was in OPEL 4. Operations pressure escalation levels (OPEL) is a method used by the NHS to measure the stress, demand and pressure a hospital is under, with 'OPEL 4' status denoting the highest level of operational pressures. Staff we spoke with were broadly positive about this 'automatic send' policy but some staff thought the policy merely moved the problem along the day, with the issue of not having patient beds available still an ongoing issue.

Staff told us one of the biggest challenges was flow into theatre from multiple directions. This meant an increased capacity issue within both inpatient and day-case theatre and a bottleneck in recovery, causing delays in getting patients out of theatre. A recovery flow coordinator had been introduced to oversee all patient activity through recovery to prioritise risk and manage successful flow through recovery.

Leaders told us they had commenced work on theatre modelling against demand. This involved looking at demand and waiting list backlogs to assign the appropriate amount of theatre sessions to specialities more accurately.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

At our last inspection, we told the trust it should reduce the number of cancelled operations. From April 2017 to March 2019 the percentage of cancelled operations at the trust has been consistently above (worse than) the England average (see chart below). However, the percentage of cancelled operations had reduced over the course of this 12-month period. The most common reason for non-clinical cancellation of operations on the day of surgery or admission was due to operational pressures in the hospital restricting the availability of bed space post-surgery.
Over the two years, the percentage of cancelled operations at the trust was higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - University Hospitals Plymouth NHS Trust**

(Source: NHS England)

Managers worked to keep the number of cancelled operations to a minimum. Surgery for cancer was only cancelled when necessary and with sign off from care group management or an executive. Leaders told us all options would be explored before deciding to cancel. This would involve discussions with consultants, and a decision to cancel would not be made without input from the consultant. Staff told us it was very unlikely cancer patients would be cancelled, and there was a culture to protect these lists.

**Patient flow**

Bed capacity was identified as the biggest obstacle to access and flow through the service, though the care group was undertaking short and long-term work to make improvements. We attended a bed management meeting as part of the inspection. We saw the challenges of managing the flow of patients through the surgical wards. At lunchtime of the second day of our inspection, 33 patients needed surgical beds, and the bed management and surgical staff were working collaboratively to manage the shortfall.
Bed capacity was an issue across the service. Staff we spoke with identified Lynher ward as a particular concern. Lynher accommodated multiple specialities including urology, all of which used Freedom theatres for surgery. This meant that when the ward was busy, this caused gridlock in Freedom theatres. Leaders explained growing demand on the specialities on the ward meant the capacity there no longer sufficient. For example, the ward had eight beds for urology patients, but leaders said what was now required was 13-15 beds. At the time of our inspection, the care group was working on bed modelling to move urology out of Lynher to a bigger bed base.

Critical care staffing was also identified as an issue impacting on theatre utilisation. This staffing issue meant some beds were closed, potentially resulting in cancellations for patients requiring critical care beds. At the time of our inspection, the care group had finalised a business case for a new staffing model in critical care to improve capacity there and, thereby, improve theatre utilisation.

Managers worked to minimise the number of surgical patients on non-surgical wards. Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Surgical patients were not all able to be accommodated on the right speciality ward, often due to capacity. In this case, patients became ‘outliers’ on other surgical and medical wards. We saw that those patients were recorded as outliers on the correct speciality ward. This was to keep track of the patients' consultants and prompt medical staff to review them each day. We saw records which demonstrated those patients were seen when needed and staff on those wards knew how to access the consultant team covering the patient's care.

In some cases, the hospital's capacity to admit medical patients to medical wards could not be met. In this instance, medical patients were admitted to surgical wards. Staff were clear about the care the patients needed and the medical teams covering the care for those patients.

**Enhanced recovery**

The care group were carrying out a range of initiatives to encourage enhanced recovery. This included health promotion during the pre-assessment sessions where patients were encouraged to adopt healthy behaviours, including exercise and smoking cessation.

The care group were trialling a prehabilitation programme with a local university. In addition, the care group were launching an intravenous (IV) iron service for which they had shortlisted a candidate at the time of our inspection. Leaders said by giving anaemic patients IV iron at an early stage, coupled with the prehabilitation programme, patients would be able to get fitter before their surgery. Through these initiatives, the care group sought to reduce cancellations and lengths of stay at the hospital post-surgery, thereby improving theatre utilisation and access and flow.

**Average length of stay**

Managers and staff worked to make sure patients did not stay longer than they needed to. At trust level, the average length of stay for patients having planned (or ‘elective’) surgery was higher (worse) than the England average. For non-elective surgery, the length of stay was lower (better) than the England average. The average length of stay for patients undergoing elective and non-elective surgery at Derriford Hospital was similar to the overall trust levels. This is unsurprising bearing in mind most of the surgical treatments provided by the trust took place at the trust's core site at Derriford Hospital. The length of stay for patients undergoing surgery at the trust's other locations was lower (better) than the England average.
**Trust Level**

From March 2018 to February 2019, the average length of stay for patients having elective surgery at the trust was 4.2 days. This was higher (worse) than the average for England, which was 3.8 days.

Of the top three specialties by number admission, the average length of stay for:

- Trauma and orthopaedics surgery at the trust was 3.5 days. This was lower (better) than the average for England, which was 3.7 days.
- Cardiac surgery at the trust was 6.2 days. This was lower (better) than the average for England, which was 8.7 days.
- Neurosurgery at the trust was 3.1 days. This was lower (better) than the average for England, which was 4.8 days.

**Elective Average Length of Stay**

![Graph showing elective average length of stay](image)

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

**Non-elective patients**

From March 2018 to February 2019, the average length of stay for patients having non-elective surgery at the trust was 4 days. This was lower (better) than the average for England, which was 4.7 days.

Of the top three specialties by number admission, the average length of stay for:

- Colorectal surgery at the trust was 3.2 days. This was lower (better) than the average for England, which was 4.2 days.
- Gastrointestinal surgery at the trust was 2.8 days. This was lower (better) than the average for England, which was 3.9 days.
- Hepatobiliary and pancreatic surgery at the trust was 2.8 days. This was better than the average for England, which was 5 days.

![Graph showing non-elective average length of stay](image)

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

**Elective Average Length of Stay**

From March 2018 to February 2019, the average length of stay for patients having elective surgery at Derriford Hospital was 4.4 days. This was higher (worse) than the average for England, which was 3.8 days.

Of the top three specialties by number of admissions, the average length of stay for:

- Cardiac surgery at Derriford Hospital was 6.2 days. This was lower (better) than the average for England, which was 8.7 days.
- Neurosurgery at Derriford Hospital was 3.1 days. This was lower (better) than the average for England, which was 4.8 days.
- Trauma and orthopaedics surgery at Derriford Hospital was 4.3 days. This was higher (worse) than the average for England, which was 3.7 days. Trust leaders explained their performance was affected by the trust’s arrangement with a private health provider for some planned orthopaedic operations to be carried at a local NHS treatment centre. They explained less complex procedures were channelled to the local NHS treatment centre, which meant the complexity of the procedures carried out at Derriford Hospital was increased. This increased the trust’s length of stay for planned trauma and orthopaedics surgery.

![Bar chart showing average length of stay by specialty at Derriford Hospital and England.](image)

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

**Non-Elective Average Length of Stay**

From March 2018 to February 2019, the average length of stay for patients having non-elective surgery at Derriford Hospital was 4 days. This was lower (better) than the average for England, which was 4.7 days.

Of the top three specialties by number of admissions, the average length of stay for:

- Colorectal surgery at Derriford Hospital was 3.2 days. This was lower (better) than the average for England, which was 4.2 days.
- Upper gastrointestinal surgery at Derriford Hospital was 2.8 days. This was lower (better) than the average for England, which was 3.9 days.
- Hepatobiliary and pancreatic surgery at Derriford Hospital was 2.8 days. The average for England was 5.0 days.
Discharge

Managers and staff worked to make sure they started discharge planning as early as possible. Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff supported patients when they were referred or transferred between services.

Once a patient was seen and admitted, they would be seen after 24-hours by the ‘post take’ team. Staff told us delays on the surgical assessment unit were caused by patients waiting to be seen by the post take team. This was because this team would be in theatres operating and so were not available on the wards to see and potentially discharge patients. There was an escalation process with staff going to theatre to see if any medical staff could be released to attend the ward and review patients.

We visited the surgical assessment unit after lunch and saw four patients waiting to be discharged. All had been told they would be going home that day and were waiting for their discharge paperwork to be completed. Two were waiting for the post take team to review and discharge them.

Patient moving wards per admission / at night

Managers monitored patient moves between wards/services were kept to a minimum.

From May 2018 to April 2019, there were 5,083 patient ward moves at night within surgery. The Surgical Assessment Unit (SAU) accounted for 1,552 (30.5%) ward moves and Fal Ward accounted for 1,190 ward moves (23.4%). The highest number of ward moves at night occurred in October 2018 with 550 (10.8%).

Staff told us one of the considerations for them when deciding to a move a patient to facilitate access and flow was whether that patient had already been moved throughout their current admission. Staff said they worked to minimise the number of times patients moved between wards/services.

(Source: Routine Provider Information Request (RPIR) – Ward and Moves at night tabs)
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Trust level

Patients, relatives and carers knew how to complain or raise concerns. Information about how to raise a complaint was available in leaflet form and was displayed in the entrance to each ward.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Senior ward or theatre staff investigated formal complaints, and the responses to complainants were collated and sent by the trust's complaints team.

From June 2018 to May 2019, the trust received 229 complaints in relation to surgery at the trust (32.2% of total complaints received by the trust). The trust took an average of 29.7 days to investigate and close complaints. This is in line with their complaints policy which states complaints should be closed within 40 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>143</td>
<td>62.5%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>34</td>
<td>14.9%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>20</td>
<td>8.7%</td>
</tr>
<tr>
<td>Appointments</td>
<td>11</td>
<td>4.8%</td>
</tr>
<tr>
<td>Communications</td>
<td>8</td>
<td>3.5%</td>
</tr>
<tr>
<td>Facilities</td>
<td>4</td>
<td>1.8%</td>
</tr>
<tr>
<td>Admin/policies/procedures (inc patient record)</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Restraint</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>229</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was discussed at governance meetings, team meetings and team briefings. Staff were able to tell us about the outcomes and learning from complaints had resulted in improvements in the service.

Number of compliments made to the trust

From January to December 2018 there were 63 compliments received for surgery at the trust (26.7% of all received trust wide).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge, experience and integrity to perform their role. The surgery core service was managed by the trust’s surgery care group which consisted of a number of specialities including anaesthesia, urology and neurosurgery.

The surgery care group management team consisted of a care group general manager, quality manager, clinical director and head of nursing. The management of the specialities beneath the surgery care group followed a similar structure with a service line manager, director, matron and governance lead.

There was stable leadership at the care group and service line (or speciality) levels.

At the time of our inspection, two members of the care group management team had been in their role for a year. The other two members of the team had been in post for multiple years. The care group management team worked well together and brought an effective mix of skills, knowledge and experience to the team.

The care group maintained the quality of leaders throughout the service by effectively reviewing performance against objectives. Service line managers regularly reported and presented to the care group management team about the performance of their respective service lines.

Leaders understood the challenges to quality and sustainability, and identified the actions needed to address them. Leaders were open and transparent about their challenges, and the challenges they identified largely matched the issues raised with us by staff.

Leaders throughout the surgical care group identified staffing as the biggest challenge facing the service. Waiting lists particularly for certain specialities and bed capacity were also identified as challenges facing the service by senior leaders.

Leaders were mostly able to identify the actions needed to address the challenges to quality and sustainability. Leaders were working together, and with staff in the care group more generally, to address these challenges.

Leaders were visible and accessible. The care group management team were carrying out quarterly walkarounds throughout the service as part of the #surgerywecare programme. As part of these walkarounds, the care group management team sought feedback from staff on what was working well and what may be improved. Staff we spoke with about this confirmed this was happening and spoke positively about efforts to engage with staff in the service.

Leaders throughout the service, including matrons, spoke passionately about wanting to work closely with their teams. The care group management team members we spoke with described staff across the care group as the ‘eyes and ears’ of the service. By being visible and accessible to staff, they were able to lead the service more effectively.

Staff we spoke with knew who their managers and leaders were, and were able to access them when needed. They found them to be supportive and approachable.
Leaders also made themselves visible and accessible to staff through regular meetings, including governance and performance meetings discussed later in the report.

Vision and strategy
The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and a set of values, with quality and sustainability as priorities. There was a strategy for achieving the priorities and delivering good quality sustainable care. The care group's vision was to deliver excellent care and treatment to patients. The care group had a one-year strategy towards achieving this vision. The strategy consisted of three workstreams: people, estates and performance. Within each of these workstreams, there were a series of projects designed to achieve the care group’s vision. Sustainability and quality were at the forefront of this strategy, with a focus on winter planning and sustainable staffing.

Leaders knew and understand what the vision, values and strategy were, and their role in achieving them. Staff we asked were able to tell us the trust's values of putting patients first, taking ownership, respecting others, being positive and listening, learning, improving.

The strategy aligned to local plans in the wider health and social care economy, and services were planned to meet the needs of the relevant population. Leaders told us the care group was in the process of beginning a project to improve sustainability. This included beginning work on mapping out future demand on the hospital by looking at demographics and health indicators. Leaders referred to predicted rises in colorectal and urology cancers, and the importance of the trust having the infrastructure to meet this demand.

Culture
Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could speak up without fear. However, operational pressures adversely affected staff well-being and development.

Staff mostly felt supported, respected and valued. It was evident from our conversations with staff they highly valued and respected their colleagues. Leaders spoke passionately about the quality of work and commitment of all staff.

There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. We saw staff proactively support each other and communicate in a respectful way. A staff member told us “We pull together as a team. We work really closely together. It’s almost like an extended family.”

Staff were also recognised through excellence reporting. Staff were encouraged to submit reports about colleagues who had demonstrated good practice under the 'Learning from Excellence' initiative.

Senior staff were aware that staffing issues were having an impact on staff morale. They explained the overseas lead nurse for recruitment had been visiting all areas of the care group to reassure
staff about the work being undertaken to recruit staff. Senior staff told us the overseas lead nurse for recruitment would also be providing a pastoral service to new staff from overseas to support them and help them settle.

The culture centred on the needs and experience of people who use services. All staff spoke positively about patient focus and that they wanted to provide over and above care every day. They were proud of the team working and felt supported and reassured by the feedback from patients.

Staff mostly felt positive and proud to work in the surgical care group. Although staff were aware of the challenges facing the service, especially staffing shortages, all staff we spoke with were passionate about their jobs. Staff told us they liked working at the trust. A member of staff told us, “The best thing about the ward is the team and the people, we dig in and help out when it's tough. The staff make the job easier.” Staff expressed motivation and enthusiasm for the future of the service.

Action was taken to address behaviour and performance inconsistent with the care group’s vision and values, regardless of seniority. We witnessed examples of staff challenge each other for conduct falling below what was expected. For example, we observed a nurse challenge a consultant for not following the trust's policy on being bare below the elbow. Staff we observed responded positively to being challenged.

The culture in the surgical care group sought to encourage openness and honesty at all levels, including with people who use services, in response to incidents. Safety performance information such as the latest number of falls and pressure ulcers were presented in the surgical wards we visited for the information of patients and their family and carers.

Staff received training on, and understood, the duty of candour. We saw examples of staff applying the duty of candour in response to incidents.

Leaders and staff understood the importance of staff being able to speak up about issues and to make suggestions for improvement without fear of retaliation. Leaders encouraged staff to speak up through a range of routes, including electronic incident reporting.

Staff we asked knew about the trust's freedom to speak up guardian, who provided independent and impartial support to workers to speak up. However, we did not see any forms of communication advertising freedom to speak up or the freedom to speak up guardian role during our inspection.

Senior staff in theatres told us “the authority gradient [in theatres] was addressed by human factors training, where staff knew they had a responsibility to raise issues”. Staff we spoke with confirmed they were aware of their responsibility to raise issues.

Staff we spoke with told us the speaking up culture had improved. A member of staff said that in the past they would have considered going outside the trust to raise a concern. However, they explained they no longer saw any need to do this as they would be listened to within the trust.

Appropriate learning and action was taken as a result of staff speaking up. Leaders and staff told us of actions taken in response to staff speaking up.

There was an emphasis on the safety and well-being of staff. However, this was sometimes affected by operational pressures. As part of the trust's Making Mealtimes Matter campaign, leaders visited areas across the care group to remind staff of the importance of them taking timely breaks and staying hydrated. Leaders also told us they sought to regularly keep staff updated, including on progress to improve the issue of staffing shortages, to seek to improve staff morale.
However, some of the staff we spoke with told us operational pressures affected staff wellbeing. Some staff told us the daily reallocation of staff across the hospital to promote safe levels of staffing in all areas sometimes negatively affected staff morale. This was because staff who were being reallocated were working away from their usual wards and were being assigned to areas where they were perhaps not as comfortable. In one of the wards we visited, we were told one of their health care assistants working there had not worked on that ward for six weeks because they had been moved to other areas to fill in gaps.

Staff also told us due to operational pressures, they did not always have the time to complete training. At the time of our inspection, preoperative assessment nurses were being trained on the interpretation of ECGs and bloods. This was to upskill nurses and improve the efficiency of the service. Staff told us operational pressures meant they often had to do their training in their own time.

Equality and diversity were promoted within the organisation. Staff felt they were treated equitably. Anti-bullying and harassment posters were displayed in parts of the service. These posters encouraged black and other ethnic minority staff to speak up if they experienced bullying and harassment. Staff we spoke who identified as having a protected characteristic under the Equality Act said they felt they were treated equitably.

**Governance**

Governance processes were not always operated effectively, and there were examples where staff were not complying with their roles and responsibilities to ensure the delivery of good quality care and performance. However, staff had regular opportunities to meet, discuss and learn from the performance of the service.

Service lines in the care group held regular governance meetings, as well mortality and morbidity reviews. Minutes and learning from clinical governance meetings were disseminated to staff through emails and bulletins titled Reducing Errors and achieving Change Together (REACT). These meetings fed into minuted fortnightly care group governance meetings. These care group governance meetings were an opportunity for the care group management team to discuss a range of issues, including moderate/serious risks and patient experience information. Service line management teams attended the care group governance meetings on a rotational basis to present their quality assurance report to the care group management team. Service lines of concerns could be asked to participate in these meetings more regularly for greater oversight and management by the care group.

The care group management team also held monthly performance meetings with service line management teams. Leaders of the care group told us the monthly performance reviews had been strengthened with greater accountability. Whereas only service line managers used to attend these meetings, it was now mandatory for the whole service line management team to attend.

The care group management team reported every month to the trust management team, covering a range of issues including risks, incidents and performance against targets. The trust management team, in turn, reported to the board assurance committees and the trust board.

The care group governance structure was in the process of being embedded and was regularly reviewed and improved.

The arrangements sought to ensure issues were not missed and there was effective assurance about the delivery of good patient care. However, governance and management did not always function effectively or interact with each other appropriately, and staff were not always clear about
their roles and responsibilities for good governance. As identified earlier in this report, on this inspection, we found VTE assessments and surgical safety checklists were not always being carried out or recorded appropriately. Minutes from mortality and morbidity meetings were not standardised, thereby potentially reducing their ability to support learning (though in our review of the care group governance leads meeting in July 2019, we saw instructions to all specialties to standardise the format of these meetings). Many of these issues were identified in the trust's previous inspection, and they remained outstanding on this inspection.

There was also a deterioration in performance in many of the audits in which the service took part. The service was performing worse than comparable trusts and/or failing to meet national standards against many of the measures in these audits. This included the trust's performance with regards to its case ascertainment. The service did not have comprehensive action plans to improve its performance in all of these audits.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The trust had entered into an agreement with a local private health company for planned orthopaedic operations to be carried at a location (referred to in this report as ‘a local NHS treatment centre’) operated by the private health company. A joint clinical board, including NHS consultants, was set up to oversee arrangements. Surgeons from the care group were attending governance meetings run by the private health company and the private health company’s surgeons were attending governance meetings run by the care group. Leaders explained this was to facilitate information sharing and a shared understanding of potential or actual risks and concerns, as well as to promote open and transparent partnership working. The care group also had oversight of incidents occurring at the private health company as part of the arrangements to effectively promote good patient care.

Management of risk, issues and performance

Leaders and teams used systems to manage performance was mostly effectively. They identified and escalated most risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams used systems to manage performance effectively. They identified and escalated most relevant risks and issues and identified actions to reduce their impact. The division's risk manager reviewed all incident reports which highlighted a moderate or severe risk of harm to patients. All moderate or serious risks, as well as new risks, were reviewed at care group governance meetings. A review of risks also took place at speciality level governance meetings.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’. The care group management team identified growing demand, particularly in specialities such as urology and staffing as challenges facing the service. We reviewed the divisional risk register and saw risks matched concerns.

Staff had access to the risk register either at a speciality or care group level and were able to escalate concerns as needed effectively. Leaders on the wards and within specialties also had a good understanding of their risks and how to manage them.
Where new systems or processes were being introduced, these were assessed for their expected impact on the quality of care being delivered. The governance arrangements and a focus on seeking feedback allowed for ongoing review of impacts on quality and sustainability.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity.

**Information management**

Staff were mostly able to find the data they needed, to understand performance, make decisions and improvements. However, the service did not always collect reliable data and analyse it. Data or notifications were not always consistently submitted to external organisations as required.

There was a holistic understanding of performance, which covered and integrated people’s views with information on quality, operations and finances. Leads used the performance dashboard and quality and assurance reports to access and assess the most recent data. This included all relevant metrics. The data was colour coded to identify areas of concern. This data fed into a board assurance framework.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Matrons and other senior leaders in the service had a clear, daily view of staffing. Matrons and relevant managers were informed of all patient safety incidents reported. Matrons could access up to date information regarding mandatory training compliance of individual staff members. Senior staff expressed confidence in the quality of the data.

However, arrangements to ensure the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant was not always effective. In our review of minutes of performance meetings, we found the care group management team challenged speciality leads to maintain the standard of information they provide in their quality and governance assurance schedules. However, there were ineffective arrangements to ensure data or notifications were submitted to external bodies as required. The care group’s case ascertainment in multiple audits was below (worse than) comparable trusts and failed to meet relevant standards. As stated earlier in this report, a lower proportion of cases submitted to audits may mean the results based on those cases are a less accurate/reliable reflection of the care provided. Leaders we spoke to said there were plans to improve the care group’s case ascertainment in audits; however, we were not provided with a formal action plan.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. There was collaboration with partner organisations to help improve services for patients.

People who use services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. Staff shared examples of how they have worked with patients to improve the service, including mapping patients’ journey through the service. This involved following a patient through the service when they arrive for consultation or procedure. Staff found the patient's journey not only to be inefficient but also to be a poor patient experience. Leaders showed us their action plan to improve the patient journey in the service.
Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. The care group identified three areas of improvement in response to the results of the NHS staff survey 2018. These areas of improvement included the need for better staff engagement for change and improvement in the service. The care group had an action plan to address these areas of improvement from the staff survey, including a #surgerywecare ‘extravaganza’ scheduled for August and September 2019. As part of this extravaganza, senior leaders were planning to visit all parts of the care group to listen to staff and share with them examples of changes already made on the back of feedback from staff.

Staff we spoke with told us there had been a culture change in the care group, with staff feeling encouraged to make suggestions for improvement. Staff were able to give examples of where they had made changes to the services. We saw leaders encouraging staff to take ownership and make suggestions for change.

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, and to deliver services to meet those needs. This included the care group’s partnership with a local private health company to deliver planned orthopaedic operations from a location run by the private health company. Care group leaders described this relationship as an attempt to improve waiting times for patients, particularly during operationally challenging times such as winter.

Learning, continuous improvement and innovation

Staff sought to learn and improve services, and leaders encouraged innovation and participation in research. However, there was not always effective participation in and learning from internal and external reviews.

Leaders and staff strove for continuous learning, improvement and innovation. This included participating in appropriate research projects and recognised accreditation schemes.

Leaders and staff responded to challenges facing the service by seeking to learn how things could be done better. This was evident in many areas, including the efforts to improve theatre utilisation. Leaders described how work to improve theatre utilisation was informed by learning from other trusts.

The care group was also involved in various research projects, including a trial prehabilitation programme to understand how patients’ outcomes could be improved through a fitness regime.

Service leaders were exploring how technology could be used to improve the service. For example, at the time of our inspection, the care group were in discussions to explore the possibility of offering certain patients the option of completing their pre-assessment questionnaires electronically from home rather than having to visit the hospital, thereby saving patients a potentially long journey as well as freeing up capacity at the hospital. Leaders also told us the care group had also received approval for an on-site lithotripters which care group managers said was expected to free up capacity in theatres.

All staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance. This led to improvements and innovation. The service was part of the trust-wide People 1st programme. As part of this programme, staff and patients came together to identify areas of improvement most important to them and to work as a team to make those improvements happen. Teams met regularly to track progress towards improvement and to advertise this to staff and patients more generally. Leaders told us this was a
three-year project aimed at changing the culture in the service to encourage and empower staff to actively learn and continuously improve the service.

However, there was not always effective participation in and learning from internal and external reviews. For example, many of the issues identified in this inspection were identified and raised following the trust's previous inspection and remained outstanding. These included continuing challenges with compliance with the surgical safety checklist, especially among certain specialties, as well as the issue around the lack of standardisation of minutes of mortality and morbidity reviews. Similarly, participation and learning from clinical audits were not always effective. The service had seen a deterioration in performance in many of the audits in which it took part. In particular, the care group's case ascertainment in multiple audits was below (worse than) comparable trusts and failed to meet relevant standards. A lower proportion of cases submitted to audits may mean the results based on those cases are a less accurate/reliable reflection of the care provided. There were no action plans to improve said performance in some of these audits.

As mentioned earlier in this report, the surgery care group reported three never events between April 2018 and March 2019. The investigation reports into never events we reviewed showed similar causes and contributory factors were behind some of these incidents, and that suggestions and for improvement/learning had not always been implemented. These evidenced there was not always effective participation and learning from internal and external reviews.
Maternity services are offered to women in Plymouth, South East Cornwall and South West Devon centrally by University Hospitals Plymouth NHS Trust at Derriford Hospital. We conducted an unannounced inspection of maternity services on 20, 21 and 22 August 2019.

The trust has 59 maternity beds at Derriford Hospital and maternity services are located across three floors of the hospital. The maternity services include antenatal clinics, ultrasound scanning and a day assessment unit, should additional tests or monitoring be required, intrapartum and postnatal provision. Midwifery led antenatal and postnatal care is provided by community teams.

During antenatal care a risk assessment of the care needs of women and their babies provides an indication of whether their care should be consultant or midwife led. For those who wish to have a home birth care is provided by midwives based in the community.

Inpatient care is provided on Argyll Ward and the triage observational ward is on the central delivery suite which includes a birthing pool and a bereavement suite. Women with babies who require additional care are supported on the transitional care ward. The transitional care ward led directly to the neonatal unit; women whose babies were being cared for on the neonatal unit could stay on the transitional care ward to ensure easy access to their babies. Currently, the maternity service does not have an alongside or stand-alone midwifery led unit, however midwife led care is provided to women on the central delivery suite.

Doctors and midwives, supported by maternity care assistants and nursery nursing assistants, provide care for the women and their babies. Women have access to other specialist support services within the trust as required.

From January 2018 to December 2018 there were 3,593 deliveries at the trust. A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

**Number of deliveries at University Hospitals Plymouth NHS Trust – Comparison with other trusts in England**

(Source: Hospital Episodes Statistics (HES))
A profile of all deliveries and gestation periods from date to date can be seen in the tables below.

### Profile of all deliveries (January 2018 to December 2018)

<table>
<thead>
<tr>
<th></th>
<th>Plymouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3,544</td>
<td>98.6%</td>
</tr>
<tr>
<td>Multiple</td>
<td>49</td>
<td>1.4%</td>
</tr>
<tr>
<td>Mother’s age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>144</td>
<td>4.0%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,833</td>
<td>78.8%</td>
</tr>
<tr>
<td>35-39</td>
<td>497</td>
<td>13.8%</td>
</tr>
<tr>
<td>40+</td>
<td>119</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td>3,593</td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

### Gestation periods (January 2018 to December 2018)

<table>
<thead>
<tr>
<th></th>
<th>Plymouth Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Gestation period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>3,289</td>
<td>92.3%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total number of deliveries with a valid gestation period recorded</td>
<td>3,564</td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’. Gestation periods were unrecorded for 0.8% of deliveries at this trust compared to 18.7% nationally.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with ‘*’ (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

We observed care provided by staff and spoke with 12 women about their care and treatment. We spoke with 77 staff, including a range of medical, nursing, administrative and domestic staff.

During our inspection we reviewed 16 sets of clinical records of women who had received maternity services and reviewed 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 made sure everyone completed it.

Midwifery and nursing staff received and kept up-to-date with their mandatory training. The trust has stated that the annual ‘Trust update’ module encompasses the following:

- Equality, Diversity & Human Rights
- Health, Safety & Welfare (including Medical Gases, Medical Devices)
- NHS Conflict
- Fire safety
- Infection, Prevention & Control
- Moving & Handling
- Safeguarding Adults (including Mental Capacity Act)
- Sepsis
- Preventing Radicalisation
- Safeguarding Children
- Resuscitation
- Information Governance

During our last inspection maternity services did not always achieve the trust targets for medical, nursing or midwifery staff mandatory training. During this inspection we saw mandatory training was comprehensive, met trust targets, and met the needs of women and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received monthly reports from the workforce team demonstrating; training compliance, midwives booked on training courses and midwives not attending courses booked.

Mandatory training weeks were held once a month and staff were automatically allocated to session.

Trust level

During our last inspection the overall completion rate by midwifery staff in maternity was 78.1% and midwifery staff only met the trust target of 95% for seven of the 21 courses.

A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 at trust level for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 3</td>
<td>19</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>155</td>
</tr>
<tr>
<td>Trust Update</td>
<td>151</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>150</td>
</tr>
<tr>
<td>Child Protection Level 3</td>
<td>128</td>
</tr>
</tbody>
</table>

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

We observed data, during our inspection, which demonstrated compliance, across all modules,
of between 93.2-96.6%. Although all modules did not achieve the trust target of 95% this was a significant improvement on previous training levels and there was a team effort to improve results from the last inspection.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism though staff felt they were not equipped to fully support women's needs. Mental Health Act and Mental Capacity Act were included in e-learning, but the content was described as minimal. The training was designed to signpost midwives rather than to provide any in-depth learning. Staff told us the training did not equip them for supporting women with mental health, learning disabilities, autism and mental capacity difficulties.

Medical staff did not meet trust targets for mandatory training. Medical staff for obstetrics and gynaecology are mapped to Services for Children and Young People. We requested updated data which demonstrated the following compliance (including paediatricians); 80% with Trust Update training, 67% with resuscitation training, 67% with manual handling training and 87% with child protection (level 2) training. Compliance had improved since the last inspection, however for moving and handling and resuscitation training this was only by 1%.

**Safeguarding**

Staff understood how to protect women 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.

Midwifery and nursing staff received training specific for their role on how to recognise and report abuse. Staff had a good awareness of the signs of safeguarding and the actions they should take to keep people safe.

Staff knew how to identify adults and children at risk of, or suffering significant harm, and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could confidently talk us through the identification of safeguarding concerns and how to report these; they had support from the trust safeguarding leads. There was a safeguarding champion within maternity services.

Safeguarding needs were identified during the antenatal booking process to identify at risk women and the Local Authority would be notified where necessary. Within the community there were five safeguarding link midwives to provide support and resources to colleagues and the women they cared for. The safeguarding link midwives connected with the trust-wide safeguarding team to assess the risks of women and disseminate any key messages to colleagues. Where midwives identified concerns, they were able to refer to the safeguarding midwives for advice and support.

The lead midwife for safeguarding for maternity attended regular internal and external multi-agency risk assessment conferences.

Where child protection concerns were identified the lead midwife for safeguarding would liaise with the relevant Local Authority. There were procedures to protect children who were to be placed in the care of the Local Authority and observed these procedures during our inspection.

Learning from safeguarding serious case reviews was disseminated to staff through newsletters, mandatory training and projects resulting from learning. As a result of a serious case review, there was a plan to introduce the ‘ICON: Babies Cry, You Can Cope!’ programme in September 2019. This programme provides key messages and resources to parents, and particularly fathers, that infant crying is normal, along with methods on how to cope with infant crying. Learning, from the ‘ICON: Babies Cry, You Can Cope!’ case review was shared through the August 2019 maternity newsletter.
There were processes to recognise female genital mutilation (FGM) and staff could find appropriate support from the safeguarding team. Female genital mutilation (FGM) training occurred at the same time as safeguarding training. Staff had access to the safeguarding policy which included reference to FGM.

Staff were aware of the baby abduction policy. The abduction policy and procedures, including action cards, detailing exact actions to be taken at the time of an abduction. The policy was within date, having been finalised in April 2018. however, they did not undertake baby abduction drills to test its effectiveness.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training. All staff within the maternity services were required to complete Level 3 safeguarding training in accordance with Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2014). Staff are provided with two days of safeguarding training during induction and a yearly update consisting of one day’s training.

**Trust level**

In maternity the 95% target was met for the safeguarding training module for which registered midwives and midwives were eligible.

Data received demonstrated 75% compliance with Level 2 safeguarding training for medics, whereby two out of 14 staff training had recently expired and was due for update. However, the trust did not submit compliance with Level 3 training.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. The service had an infection control midwife.**

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were arrangements for deep cleaning and staff we spoke with demonstrated knowledge of different cleaning techniques.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed all staff were bare below the elbow in clinical areas and protective equipment was used appropriately. All clinical areas had a good supply of gloves and aprons.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. ‘I am clean’ stickers were seen on equipment when cleaned to indicate it was ready to be used again.

Hand hygiene audits were undertaken monthly. Results were displayed on each ward, so staff, women and visitors could see their performance. We observed results demonstrating 100% compliance.

National guidelines were followed for the screening of women admitted to the maternity services. High risk women would be screened for MRSA in line with relevant criteria. All hospital acquired infections for example, MRSA, were investigated to look for key themes. We reviewed data which demonstrated two cases of MRSA between April and July 2019.
Staff followed aseptic non-touch techniques in theatre, to prevent contamination of key parts.

There was a good supply of clean linen and linen was frequently replaced. Dirty linen was discarded in designated trolleys to ensure laundry services were aware of any specific risks.

Ward areas were clean and mostly had suitable furnishings which were clean and well maintained. We observed cleaning during the inspection and staff and women told us they regularly saw cleaning staff.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The design of the environment did not always ensure midwives had a clear line of sight of women and their babies from the midwives' station. Staff used a temporary midwives' station to ensure sight of the whole ward was achieved. During our inspection we observed this temporary midwife's station was not always used and so a consistent view was not always maintained.

Babies were not tagged and were generally kept with their mums at the bedside. If a woman wanted to leave the ward, they would inform a staff member. On the ward, should mum need to leave the area, babies could be left in the nursery where there was a member of staff present at all times.

Security arrangements on wards and the central delivery suite was by means of security intercoms; staff would identify the visitor using CCTV and grant them access. We observed visitors showing identification at the transitional care ward and heard staff asking appropriate questions to visitors. However, on a number of occasions members of the public were able to follow other visitors on to the ward unchallenged. We raised this with the service at the time of inspection and it was agreed that a notice would be put on doors exiting the wards to remind visitors not to let anyone in before staff had identified them. Members of staff gained entry through a card swipe system.

There was appropriate room for women to be cared for safely, and fire exits were clearly marked with no blocked exits.

There were clean and well-equipped obstetric theatres, on the same floor and attached to the central delivery suite. There were two dedicated obstetric theatres. One of the theatres was smaller, meaning there was a restriction on the number of people and equipment the theatre could accommodate. Each delivery was assessed to determine the most appropriate theatre. Staff recognised the restriction of the smaller theatre and this was on the maternity risk register.

Women could reach call bells and staff would respond quickly when called. Staff ensured women who had limited mobility, particularly immediately following birth, had call bells to hand.

The service had enough theatre and ward equipment to help them to safely care for women. There was neonatal resuscitation equipment, including a separate emergency trolley. Each room on the central delivery suite was equipped to care for women and their babies and included; resuscitaires, oxygen and cardiotocograph monitors. All equipment observed had been serviced to confirm safety for use.

All areas of the maternity service had access to specialist emergency equipment and staff carried out daily safety checks of the equipment. During our last inspection we found daily checks were not always completed on emergency resuscitation trollies. During this inspection we observed
consistently completed daily and weekly checks on emergency trollies to ensuring all the equipment would be available in an emergency.

Clinical waste was managed well across the maternity services. Different types of waste was segregated and managed according to the risk of infection. Sharps boxes were labelled appropriately, not overfilled, closed and tagged to prevent access to discarded sharp items.

Ward staff had the equipment they needed to do their job. Women told us they had all they needed to care for their babies.

Staff in the community told us they had very good equipment. They had their own antenatal kit with everything they needed. The community midwives were responsible for ensuring the maintenance of their equipment took place as required. They told us there was a procedure for faulty equipment. Community midwives had access to large blood pressure cuffs for women with raised body mass index.

During our last inspection we found home birth boxes containing items that had already been opened. Also, at the time, we could not find evidence of when the boxes were checked or establish clear processes for checking and restocking. In the August 2019 maternity newsletter, we saw prompting to check the home birth kits so that equipment would not go missing. During this inspection we saw appropriate kit checks and the correct items present.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.**

Staff carried out comprehensive risk assessments for women at the time of their first antenatal appointment. These included regular risk assessments for raised BMI (body mass index) smoking, gestational diabetes and pre-eclampsia, mental health issues and pre-existing health problems or vulnerable circumstances. Risk assessments were continually evaluated throughout a woman's pregnancy and where women were identified as being at higher risk, or if their risk had increased during pregnancy, they were referred for consultant led care.

Women received a risk assessment for venous thromboembolism (VTE) and bleeding at booking, in labour and during post-natal care in line with national guidance.

There were processes to identify and respond to changing risk, deteriorating health and medical emergencies, however these were not always used. There were procedures to aid decision-making and staff could tell us of circumstances in which they had escalated concerns and the support they had received.

Modified early obstetric warning system (MOEWS) to monitor health and wellbeing and to identify deterioration, using physiological parameters, were used. Guidelines required staff to measure, and document, a full set of observations using the MOEWS on all women admitted to the maternity unit, on transfer to another ward and those visited in their postnatal period in the community. Every time a set of observations was performed they should be recorded on the MOEWS and recorded in the women's notes; records reviewed documented the scores.

Midwifery staff completed the modified early obstetric warning score to assess a woman's observations and there were protocols for staff to follow if the observations deviated from the norm. We observed the use of MOEWS on the labour ward and we were told concerns were escalated appropriately. However, we reviewed an audit of MOEWS charts undertaken between December 2018 and February 2019. A random sample of 16-20 inpatient notes, who had already
delivered, demonstrated the following compliance, December 2018 25% triggered, 50% escalated, 50% actioned; January 2019 47% triggered, 36% escalated, 36% actioned; February 2019 41% triggered, 57% escalated, 43% actioned. This meant there was a possibility of not escalating a deteriorating woman. Actions resulting from the audit included, monthly auditing to ensure compliance, modification of the MOEWS chart to generate an ‘amber’ reading for temperatures between 37.5°C and 37.9°C and raising the importance of compliance during a ‘Theme of the Week’ meeting.

Staff had received training to identify and manage suspected sepsis. There was a separate maternal sepsis screening tool to be used where an infection was suspected, or clinical observations were outside normal parameters.

There was a procedure for transferring babies from the central delivery suite to the neonatal intensive care unit (NICU) and staff followed a checklist.

**Theatre safety**

There were arrangements to ensure that checks were made before and after surgical procedures. During our inspection we observed safety briefings and a team briefing in obstetric theatres prior to a procedure. We observed the World Health Organisation checklist, used to identify risk factors, undertaken prior to a procedure. The use of the checklist is a requirement of the National Safety Standards for invasive procedures, introduced by NHS England in 2015 to improve patient outcomes.

We reviewed the World Health Organisation checklist audit for July 2019 demonstrated a compliance rate of 96.6%, taken from a sample of 120 women.

**Mental Health**

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). The service had access to the hospital psychiatric liaison service.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. The team mainly referred women to other services if there were concerns about their mental health. Staff completed a psychosocial risk assessment that consisted of tick boxes to denote women’ current and historical mental health difficulties. This was a standard assessment used nationally.

**Triage**

There were systems to assess (triage) women in the antenatal or postnatal period, who contacted the central delivery suite with concerns. Women in their antenatal or postnatal period could telephone the dedicated triage team, based on the central delivery suite, for advice if they had concerns, 24 hours a day. Between the hours of 08:00 – 18:00 calls were handled by the University Hospitals Plymouth triage midwives based at a local ambulance service. This improved flow through the central delivery suite, for women who were advised to attend the labour ward. Outside these hours the triage calls would be answered by midwives allocated to the triage team for the day.

Women were provided with information about conditions and symptoms, which should prompt them to seek advice, and the telephone number for the central delivery suite (in their hand-held notes) and could gain advice from a midwife.
We observed midwives respond to women’s calls for advice. We heard staff respond to women admitted to triage area. We heard the midwife take a history of symptoms and refer women to obstetric staff as necessary.

**Midwifery and nurse staffing**

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough nursing and midwifery staff of relevant grades to keep women safe. Managers accurately calculated and reviewed the number and grade of midwives, midwives, and maternity care assistants needed for each shift in accordance with national guidance.

The service could adjust staffing levels, daily, according to the needs of women. The number of midwives and maternity care assistants on all shifts on each ward matched the planned numbers. Managers accurately used the ‘Safer Nursing Care’ acuity tool to determine safe staffing. This acuity tool reviewed safety at existing staffing levels; it was updated in the morning and periodically through the day to determine safe staffing numbers.

During the inspection staff told us their workload was intense and they often felt they were short staffed. They told us they did not think staffing levels were unsafe but sometimes women had to wait longer than they should for staff attention. Staff also said that they were often unable to take their breaks, although coordinators worked hard to facilitate rest time.

At the time of the inspection there was no vacancies in the midwifery service, however, there were 17 midwives on maternity leave. There was escalation plans to ensure safe staffing at all times, especially at short notice; these included an on call rota for senior members, and managers, of the team. The escalation plans had been audited and demonstrated attendance by the escalation midwife as required.

We reviewed the midwifery staff rota for the four weeks prior to the inspection for the central delivery suite, and found staffing levels were in line with the Safer Nursing Care acuity tool. We observed staffing for night and day shifts met demands and there was an appropriate skill mix.

The table below shows a summary of the midwifery staffing metrics in maternity compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>None</td>
<td>None</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>241.7</td>
<td>7.0%</td>
<td>10.4%</td>
<td>4.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered midwives and midwives</td>
<td>165.9</td>
<td>7.7%</td>
<td>9.9%</td>
<td>4.1%</td>
<td>16,570 (5%)</td>
<td>1,169 (&lt;1%)</td>
<td>37,118 (12%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Midwife and nursing staffing rates within this core service were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for
vacancy, turnover or bank staff usage.

**Vacancy rates**
The service had low vacancy rates, however, there were high proportion of staff on maternity leave (17).

**Sickness rates**
The service had a number of long-term staff not working due to sickness, 1.2% above the trust target overall. This was managed in line with trust policy.

![Sickness rate - qualified nurses, health visitors and midwives](image)

Monthly 'sickness rates' over the last 12 months for qualified midwives shows a shift from November 2018 to April 2019.

**Agency hours**

![Agency hours - qualified nurses, health visitors and midwives](image)

Monthly 'agency hours' over the last 12 months for qualified midwives shows a shift from January 2019 to June 2019. The service had reduced agency hours through the introduction of incentives to bank staff working via NHSP. This incentive scheme was reported as successful for covering short notice sickness and in turn reduced the agency staffing numbers.

**Midwife to birth ratio**

From January to December 2018 the trust had a ratio of one midwife to every 27.4 births. This was similar to the England average of one midwife to every 24.6 births.

(Source: Electronic Staff Records – EST Data Warehouse)
Medical Staff

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

There was a consultant present on the central delivery suite between 08.00 - 18.00 and 19.30 – 08.30, Monday to Friday. At weekends a consultant, or registrar, was on-call. If the registrar was present, or on-call they had the support of a consultant. A duty anaesthetist was available at all times, 24/7.

Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We observed a ward round on the central delivery suite. This was attended by a mix of medical staffing including, consultant obstetrician, obstetric registrars, anaesthetist and senior house officer. We observed consultants reviewing women on the transitional care ward and Argyll ward.

The service had enough medical staff to keep women and babies safe. We reviewed the medical staff rota and observed levels were in line with acuity, including in the recovery areas.

Staffing numbers were displayed on boards outside the central delivery suite and all ward areas.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In March 2019, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average. Medical staff enjoyed working in the service.

The service always had a consultant on-call during evenings and weekends.

Staffing skill mix for the 33.9 whole time equivalent staff working in maternity at University Hospitals Plymouth NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>28%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>24%</td>
<td>6%</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)
Records

Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. We reviewed 18 sets of clinical records and found good record keeping.

When women transferred to a new team, there were no delays in staff accessing their records.

Paper and electronic records were used. During our last inspection records were not always held securely. During this inspection we observed records were stored securely in locked cabinets with pin codes to access the notes. Records were accessible to a range of healthcare professionals during pregnancy, labour and the postnatal period.

Staff told us it was a challenge to ensure all documents were filed in a timely way due to reduced administration support. Staff acknowledged this was problematic, trust-wide, and administration recruitment was a priority.

However, carbon monoxide monitoring was not recorded regularly. This meant they were not identifying women at risk of having a low birth rate baby. The National Institute for Health and Care Excellence recommend that the carbon monoxide level, of women identified as a smoker, be recorded in the woman’s hand-held record or use protocols to record this information.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines and the service had systems to ensure staff knew about safety alerts and incidents.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. During our last inspection we observed the safe storage of medicines, including storage within refrigerators, was not consistent. We also raised concerns regarding the management of the supply or administration of drugs under Patient Group Directions (PGDs). During this inspection we observed a procedure to review PGDs. PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines in the absence of a written prescription. We checked a PGD used by the nursing team and saw this was being used effectively to support women access to pain relief in a timely way.

Medicines were stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely and managed appropriately. Regular balance checks were performed in line with trust policy. We saw the storage of medicines for home births were now stored in the clinical room and the trust had introduced a register to show when they had been taken out of the department. This also included a record of when medicines were restocked, and expiry dates checked.

Medical gases were stored safely and there were also padded carriers and signage for when the cylinders are taken out for home births.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. During our last inspection we observed non-controlled medicines were not always locked away on the central delivery suite, Argyll ward and the day assessment unit, in line with the provider’s policy. During this inspection we observed medicines and prescribing documents managed in line with the policy.
Records showed that daily checks of medicines stock on the resuscitation trolleys had been performed to ensure that they were fit for use in accordance with trust policy. Medicines fridge records showed temperatures had been maintained within the recommended range.

Staff reviewed patient’s medicines regularly and provided specific advice to women and carers about their medicines. A pharmacist visited daily to review prescriptions and advise medical staff when doses needed to be revised.

Staff followed current national practice to check women had the correct medicines. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff knew how to report incidents or near misses via the trust’s electronic reporting system. Staff we spoke with felt confident in raising an incident should they need to. They gave us examples of what they would report as an incident and how they would respond to the person involved.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women’ consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. For example, when there was a need to administer sedatives to reduce anxiety or agitation to facilitate a medical or diagnostic procedure.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They were able to describe the range of events which should be reported. This included, for example, medication errors, unintended outcomes such as significant blood loss in labour and ‘near misses’. Staff reported all incidents that they should report. They were familiar with the incident reporting procedure and told us it was easy to use, and they were encouraged to use it. Managers felt there was a good reporting culture; all midwives understood their responsibility to report concerns or mistakes.

**Never events**

The service had no never events on any wards. 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 April 2018 to March 2019, the trust reported no never events for maternity.

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

Staff reported serious incidents clearly and in line with trust policy. Serious incidents were discussed at weekly executive-led governance meetings, where there was appropriate scrutiny and challenge.

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from April 2018 to March 2019. During our inspection we reviewed a random sample of two Serious Incidents; the root cause analysis for both was completed with appropriate actions and learning.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>10</td>
<td>90.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Staff and managers were able to describe the circumstances in which the duty of candour would apply. Managers were prompted to consider duty of candour when they investigated incidents. We saw an example, where duty of candour was applied in response to a complaint. This had implications for another service user and we saw further examples where women had experienced complications in labour and/or there were unexpected outcomes. Women were invited to be involved in the investigation of the incident and to receive a copy of the final investigation report.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback from incidents which they had reported and those which had occurred in the maternity service. They were not able to describe any feedback or learning from incidents which had occurred outside of their service.

Staff met to discuss incidents and look at improvements to women's care. There was evidence that changes had been made as a result of incidents. This included staff debriefing and training. There was a weekly governance meeting, where senior staff conducted case review of incidents. Trends and themes were discussed at monthly clinical effectiveness committee meetings. The risk midwife told us a recent theme was identified which related to incorrect labelling of blood samples. The service had worked with the blood bank to find solutions and had issued advice to staff via the maternity newsletter.

Learning from incidents was cascaded to staff at staff meetings, safety briefings and via the maternity newsletter. There was a ‘theme of the week’, which often arose from learning following incidents. This was discussed at staff handover meetings for a week and emailed to staff. We saw risk reviews discussed in the maternity newsletters which included safety recommendations and policy updates; with relevant documents embedded within the newsletters.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations.
Managers debriefed and supported staff after any serious incident. Staff told us they were offered emotional and practical support when this was required. We reviewed two investigation reports which were thorough and appropriate and resulted in clear action plans to ensure learning arising from the incidents was put into practice.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors. The service used a maternity safety thermometer, which was reviewed monthly at the Clinical Effectiveness Committee. The service also maintained a maternity dashboard to monitor safety performance and benchmark this with other services in the region.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

During our last inspection we were not assured staff were following the latest evidence-based practice. During this inspection we were assured staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

We reviewed the following policies; management of breech presentation, epilepsy in pregnancy, anaemia in pregnancy, pain relief in labour, external cephalic version and Group B Streptococcal. All policies had clear pathways for treatment, referenced the Royal College of Obstetricians and Gynaecologists guidelines, along with MBRRACE for epilepsy in pregnancy, and were in date.

During our last inspection community midwives did not have access to a computer to review maternity guidelines. We found, during this inspection, this had not changed. However, community midwives were informed of important policy and guideline updates at meetings or by email. The trust was developing an electronic guidelines app, however, midwives currently needed to use their personal phone as work phones did not have Wi-Fi data to access the app.

The service conducted audits to assess compliance against local and national standards. The service had an annual audit schedule. The lead midwife oversaw the audit programme alongside the clinical governance lead for obstetrics. Audits were presented at the multidisciplinary Clinical Effectiveness Committee where agreed actions were monitored.

Consultants and specialist midwives regularly contributed to the maternity newsletter informing midwives of relevant guideline updates and how to view these updates. We saw examples of these contributions in the April 2019 maternity newsletter alerting staff to updated guidelines on viral rashes in pregnancy and pain and bleeding in pregnancy. We saw another example in the June 2019 newsletter of specialist midwives presenting guidelines on diagnosing gestational diabetes at 36+ weeks.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers, including all relevant history of mental health, in line with national guidelines.
Nutrition and hydration

Staff gave women 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 women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs and would access dieticians when requiring advice. Staff fully and accurately completed women's fluid and nutrition charts where needed. There was plenty of choice from the menu and food tasted good. Snacks and drinks could be purchased from vending machines outside of meal times.

Women were given a choice of food and drink to meet their cultural and religious preferences. Menus displayed vegetarian and vegan options and women could request additional choices dependant on their needs.

Women were supported to feed their babies. Staff were reassuring, supportive and knowledgeable, and maternity care assistants were available at all times to assist as well as nursery nursing assistants on the transitional care ward. Staff took time to discuss feeding options available, including breast and bottle feeding.

Written information was readily available for both methods of feeding. We saw information boards, on all wards, displaying illustrations/photos of breastfeeding positions and methods. We observed staff assisting women to feed their babies. Women who could not breastfeed were supported to express milk.

Staff provided guidance for women to express milk. We saw expressed milk stored in a secure milk fridge, correctly labelled and only containing breast milk.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Women received pain relief soon after requesting it. Pain relief was available to women during pre, peri and postnatal care. Staff responded quickly to requests for pain relief and were understanding of women's pain, including at the time of labour. We saw a woman requesting pain relief and a midwife responding to this request.

Staff prescribed, administered and recorded pain relief accurately. There were a range of pain relief methods available during labour. Women received both written and verbal information about pain relief options available to them in labour, during antenatal classes. Women who did not attend antenatal classes received the information during antenatal appointments. Women told us they had been given information about different options for pain relief in labour and received unbiased advice. Each delivery room was equipped with piped nitrous oxide gas and oxygen and this was also available for homebirths.

There was a birthing pool, supported by an up to date policy, which could be used for pain relief in one of the rooms on the labour ward. The birthing pool was not available when the room was in use by another woman.
Women who underwent a caesarean section were given advice about pain relief. They were encouraged to contact their midwife or GP if they needed more than ‘over the counter medicines’ once at home.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.**

Maternity services offered effective care to pregnant women. During the period between April and July 2019 there were on average 340 live births and seven home births per month (2%), which is in line with the national average.

The service monitored patient outcomes through a maternity dashboard which demonstrated clinical outcomes.

The maternity dashboard was reviewed by the service and shared within the trusts care groups. It demonstrated a number of performance metrics including; number of births (including home births), assisted births including caesarean section and ventouse and forceps deliveries, maternal and neonatal morbidities, complications including tears sustained during delivery and the number of inductions of labour. We reviewed the maternity dashboard and saw evidence of outcomes which were rated as below, in line and above the national average. The data demonstrated the number of caesarean sections, for July 2019, had increased and therefore was above the national average.

The service participated in national and local audit so it could benchmark performance and patient outcomes against other providers and identify areas for improvement.

There was a midwife led audit and guideline champion, who oversaw the local maternity audits. Medical leads oversaw the national maternity and obstetrics audit programme, which was a rolling programme, supported by the head of midwifery and the maternity risk manager. Audits were shared at the clinical governance meetings. Every six months the audit lead presented audit findings and plans to the trust Clinical Outcomes Committee.

Managers carried out a comprehensive audit programme and used information from the audits to improve care and treatment.

We reviewed the audit programme including results and actions arising from these audits. For example, we saw audit results for the implementation of the ‘Saving Babies Lives’ care bundles. We reviewed the actions resulting from this audit which included, emailing findings to midwives, repeated reminders to midwives of the importance of documentation standard of cardiotocography with hourly fresh eyes, and findings presented to the Clinical Effectiveness Committee. In June 2019 audit results demonstrated improved compliance since the audit in September 2018.

The service was implementing the Saving Babies Lives 2 bundle programme, which is an evidence-based programme leading on from Saving Babies Lives, to reduce stillbirths. The service planned to introduce and embed the updated programme early as there was an acknowledgement that there were improvement outcomes for staff and women.

Ongoing audits included:

**Third and fourth degree tears**

These are tears of the perineum, extending to the muscle that controls the anus (the anal sphincter) - otherwise known as Obstetric Anal Sphincter Injury (OASI). An audit demonstrated a
reducing rate of third-degree tears during the period of April to July 2019 and a low rate of fourth degree tears (1) in the same period.

**Induction of labour (IOL)**

Induction of labour is where labour is started artificially, usually because the baby is late or there are other known risk factors. We reviewed the maternity dashboard which rated induction of labour as outside of the national average rate. During April and June 2019 an audit highlighted the induction rate was 26.2% and 27.2% respectively; and this demonstrated rates outside the national average.

National audits included:

**National Neonatal Audit Programme**

The table below summarises Derriford Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? (Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)</td>
<td>89.2%</td>
<td>Within expected range</td>
<td>Yes</td>
</tr>
<tr>
<td>Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? (Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)</td>
<td>67.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)

**National Maternity and Perinatal Audit Programme**

The table below summarises Derriford Hospital’s performance in the 2017 National Maternity and Perinatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>104.3%</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Antenatal measures (before birth, during or relating to pregnancy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date (Babies who are small for their age at birth are at increased risk of problems before, during</td>
<td>52.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Intra-partum measures (during labour and birth)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)</td>
<td>18.6%</td>
<td>Lower than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted overall caesarean section rate for single, term babies (The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)</td>
<td>23.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7 (The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)</td>
<td>1.4%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)</td>
<td>3.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml (Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)</td>
<td>1.9%</td>
<td>Lower than expected</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

| Post-partum measures (following birth) | | |
| Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit (Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance) | 73.1% | Middle 50% | No current standard |

(Source: National Maternity and Perinatal Audit Programme)
Standardised Caesarean section rates and modes of delivery

From January to December 2018 the total caesarean section rate was in line with the national average. Standardised caesarean section rates for elective sections were similar to expected and rates for emergency caesarean sections were similar to expected.

### Standardised caesarean section rate (January 2018 to December 2018)

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>PLYMOUTH HOSPITALS NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.8%</td>
<td>357</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>16.5%</td>
<td>596</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>29.3%</td>
<td>953</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is ‘other’ or ‘unrecorded’.

In relation to other modes of delivery from January to December 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

### Proportions of deliveries by recorded delivery method (January 2018 to December 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>PLYMOUTH HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>953</td>
<td>26.5%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>433</td>
<td>12.1%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>2,207</td>
<td>61.4%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>3,593</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’. ¹Includes elective and emergency caesareans ²Includes forceps and ventouse (vacuum) deliveries ³Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES))

**Maternity active outlier alerts**

As of July 2019, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES))

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Category of comparison to other trusts with similar service provision</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilised and risk-adjusted perinatal mortality rate</td>
<td>6.60</td>
<td>Up to 10% higher than the average for the comparator group</td>
<td>No current standard</td>
</tr>
<tr>
<td><em>(The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK’s death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: MBRRACE-UK)

MBRRACE recommends four key areas to improve perinatal mortality:

1. Screening for gestational diabetes
2. Monitoring fetal growth
3. Managing reduced fetal movements
4. Improving local learning though high quality review of deaths.

The maternity dashboard showed there was five stillbirths during the period April to July 2019.

For stabilised and risk-adjusted perinatal mortality rates, the trust performance was higher than the average comparator group. We were told this was due to the neonatal intensive care unit being a level three unit, which meant they admitted extremely pre-term and sick babies, against the comparator group who had level two units and therefore did not admit very unwell babies.

**Infant feeding**

The service had an infant feeding lead to offer practical feeding advice to new mums and staff and raise awareness of the benefits of breastfeeding.

Although the service had not achieved full UNICEF Baby Friendly accreditation the service’s infant feeding policy worked within the standards expected and training complied with UNICEF Baby Friendly Initiative best practice standards. The service’s website had links to the Baby Friendly Initiative on UNICEF’s website.
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 development.

The service employed a practice development midwife to oversee the training for all midwifery nursing and support staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Midwives worked on a rotation basis which meant they had experience of working on the labour ward and in the community, including conducting home births. Staff felt this was beneficial to women as all staff had confidence to provide support both in the home and on the labour ward.

Managers gave all new staff a full induction tailored to their role before they started work. Staff felt supported with training and supervision. All newly qualified midwives undertook a 12-month preceptorship programme. This programme supported the newly qualified midwives support to build confidence and consolidate learning gained as a student.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff truly felt supported with training and development opportunities. Midwives were given opportunities to specialise in areas of interest and to broaden their skillset and obtain managerial experience. There were ‘off rotation experts’, who were band six midwives, specialising in a particular field and supported to obtain a ‘manager’s passport’, a structured way of building a portfolio of experience to equip the midwife to apply for promotion to a band seven position.

Supervision is undertaken by means of Advocating and Educating for Quality Improvement (A-EQUIP), rather than formal supervision. Staff completed an e-learning programme (developed in collaboration with NHS England and the Royal College of Midwives) to understand the changes to supervision. The A-EQUIP model was developed to support and empower midwives to provide safe, kind, high quality and compassionate care to women and their families. A team of professional midwifery advocates, who were experienced practising midwives, provided supervision and pastoral support. Staff could access this supervision through group meetings and one to one contact with the advocates.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had a dedicated practice development team who assessed the training needs of the staff and booked training when required.

Staff told us of opportunities to progress in their career and undertake projects they had interest in. One staff member told us of participating in the professional midwifery advocate training and was able to describe how this had given new direction to their role in supporting staff members.

Community maternity care assistants attended a study day at the Bristol Newborn Screening laboratory, so they could gain an understanding of requirements and procedure for bloodspot sampling.

Junior doctors had protected time for education and these sessions were consultant-led. Staff felt supported and enjoyed working with colleagues and the service; they attended Clinical Effectiveness Committee meetings to support their training.

The Head of Midwifery met with students at least once every six months. There was an open-door policy for any student needing advice or support.
Appraisal rates

Although managers supported staff to develop through yearly constructive appraisals of their work the service did not meet the trust target of 95% for appraisal compliance; this was due to the high number of midwives on maternity leave.

From 16 May 2018 to 15 May 2019, 86.8% of staff in maternity received an appraisal compared to the trust target of 95%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>16 May 2018 to 15 May 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Scientific, Therapeutic and Technical staff</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Registered midwifery and Nursing staff</td>
<td>131</td>
<td>149</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>42</td>
<td>51</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>190</td>
<td>219</td>
</tr>
</tbody>
</table>

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

From 16 May 2018 to 15 May 2019, 57.1% medical staff received an appraisal compared to the trust target of 95%. We reviewed updated data and for the period of June 2018 to May 2019 and 92.4% of medical staff, excluding emergency medicine, received an appraisal.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. We observed effective multidisciplinary working during the Women and Children’s Care Group meeting which discussed; staff, governance, reducing harm events, optimising services and finance. This meeting was attended by service leads, senior HR staff, director of midwifery, matrons, care group managers, finance advisors, director of governance, administration manager, service line cluster manager and associate director of nursing.

Staff worked in an open and honest way and challenges were welcomed. Challenges were acknowledged and actions agreed. There was a sense a collaboration between all services and a commitment to improving the service for women. Discussions acknowledged tensions in provision of care and looked at innovative ways to reduce these tensions.

Doctors and midwives reported good working relationships with each other and there was mutual respect for each other's professions. Midwives told us if they needed a medical opinion, they were able to get this without delay. There was a multidisciplinary handover on the labour ward at the start of the day, where all women were discussed, and prioritised and management plans agreed for high risk women.
Staff worked across health care disciplines and with other agencies when required to care for women. Women who met the criteria for the perinatal mental health service had their mental health difficulties highlighted for the community midwife service to follow up with the woman. We heard that an example of a woman being treated in accordance with advice the team had sought from a specialist at another hospital.

Staff referred women for mental health assessments when they showed signs of mental ill health or depression. These mental health assessments were provided by the psychiatric liaison service for women within the hospital. Women that were returning to the community were followed up by the community midwife and mental health service.

**Seven-day services**

**Key services were available seven days a week to support timely care.**

Consultants led daily ward rounds on all wards, including at weekends and out of hours. Women were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Obstetricians were available at all times as well as scanning and diagnostic services.

Community midwives were available at clinics Monday to Friday and saw women at home. There was an on-call system for bank holidays and weekends.

The triage service provided advice, both through an advice line and from the unit, for all women 24 hours a day, seven days a week.

**Health promotion**

**Staff gave women practical support and advice to lead healthier lives.** Throughout the service health promotion information was widely displayed on notice boards including leaflets regarding; diet, immunisation, breastfeeding, diabetes and bereavement.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Staff assessed each woman’s health when admitted and provided support for any individual needs to live a healthier lifestyle. The ‘Great Expectations’ four-week antenatal programme, providing parents to be with information and practical skills to help them feel more comfortable about birthing choices. This was promoted through word of mouth and the maternity services internet pages.

The service promoted healthy life style choices to women during their pregnancy. Women were encouraged to maintain a healthy diet and there was written information and practical support to help them with this. The maternity section of the trust’s website included eating well in pregnancy and foods to avoid during pregnancy. The website contained advice on healthy eating in pregnancy and while breastfeeding. Advice was provided for women with a body mass index of 30 or above.

The service promoted emotional well-being and provided signposting to counselling services and domestic abuse support.

We saw women in antenatal clinics with Mama Academy pouches which held antenatal notes and included key health messages printed on the pouch to help women have safer pregnancies. The content printed on the pouches formed part of the Department of Health and Stillbirth and
Neonatal Death charity agreed set of messages surrounding safer pregnancy and reducing stillbirth.

Specialist advice was available to women who smoked. Midwives supported women in a non-judgmental way and gave them achievable goals to work towards. In accordance with NICE guidance *Smoking: stopping in pregnancy and after childbirth*, women were offered carbon monoxide tests and could be referred to a specialist midwife. Midwives were encouraged to engage with partners and other family members, who were smokers, to support them also. Women and their families were offered support either at home or individual clinic appointments locally. This service was also available to postnatal women.

The wellbeing team shared guidance on the importance of reporting raised carbon monoxide and health benefits to stop smoking as well as recent media reports and research on smoking and reminded staff to share ‘Test your Breath’ leaflets with women who smoke during pregnancy.

One woman told us she had received support to stop smoking.

There was specialist advice available to women who were alcohol or substance dependant. Women were encouraged to contact their GP, or the midwife, for advice and support and could be referred to other organisations for specialist support.

There was screening and monitoring of women with diabetes or those at risk of developing gestational diabetes. A multidisciplinary diabetes clinic was held weekly to support these women. We observed the multidisciplinary diabetes clinic and heard advice on what to do next.

We spoke with one woman, who told us she had been well supported to manage her diabetes, using technology to report readings during clinics.

Women were encouraged and supported to breastfeed their babies. Women were given written and practical advice by midwives, and breastfeeding support workers, and had access to information posters and leaflets. Women were supported to harvest (collect and store) colostrum (first breast milk after birth) if they were likely to have difficulties feeding their baby in the first few days after birth.

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

**Staff supported women to make informed decisions about their care and treatment. However, staff had limited and variable understanding of the relevant consent and decision-making requirements.**

We spoke with 20 staff members, including medics, regarding consent, capacity, deprivation of liberties, Gillick competence and Fraser Guidelines. Staff had limited and variable understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff lacked confidence in assessing vulnerable patients, however, they knew who to contact for assistance.

Care records showed that there was a process for women to consent to their nursing assessment in the hospital although these were not always completed accurately. This meant staff could not be assured that consent was appropriately obtained.

One doctor we spoke to said they would call psychiatric liaison for advice and that they would not feel confident enough to make an assessment. For mental health difficulties, staff were aware of and knew how to approach the perinatal mental health specialist midwife for advice and support.
Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. One member of staff we spoke to did not know their responsibilities regarding Gillick competence and Fraser guidelines. However, they said ward doctors and the general manager of the hospital could offer advice.

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

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The Mental Capacity Act and Deprivation of Liberty Safeguards were only briefly covered in the trust mandatory training.

Although staff had completed training on the Mental Capacity Act, achieving the trust’s target, staff told us they were not trained in Deprivation of Liberty Safeguards. They told us doctors had been trained in Deprivation of Liberty Safeguards and therefore they would seek advice when needed.

Staff knew how to access the appropriate policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. These were available on the trust intranet.

There was no monitoring of how well the service followed the Mental Capacity Act and so the trust had no assurance they were following the act correctly.

Staff were not confident in protecting the rights of women subject to the Mental Health Act and followed the Code of Practice. For example, the central delivery ward had cared for a woman who was under section 17 of the Mental Health Act and one member of staff told us they did not know what the section meant. This meant that the staff were unaware of the scope of the section and may not have followed it.

**Is the service caring?**

**Compassionate care**

All staff, without exception, treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Women were truly respected and valued as individuals and were partners in their care, practically and emotionally.

Staff were committed to supporting women during pregnancy, labour and postnatally to ensure women, and their families, had a positive experience. Staff demonstrated empathy towards women who experienced loss before, during or after birth.

Feedback from women, their partners and family, at the time of our inspection was without exception excellent. We listened to numerous examples of staff excellence, including staff staying behind after their shift had finished and supporting women who had had previous bereavements during labour and childbirth.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Women said staff treated them well, with kindness, dignity and respect. We observed staff introduce themselves by name to women and their partners. Staff described their role and discussed their care and what would happen next. We saw staff ask women and their partners if they understood everything and asked if they had any questions.

Recent feedback from women included:
“We were blown away by the level of care, thank you.”

“An incredible midwife…truly amazing at her job. She worked with me and we worked as a team to ensure a beautiful delivery of my twin girls. She kept me calm and focused and gave me her undivided support. I honestly believe it could not have been a better experience”.

“I felt my birthing experience was tranquil. She took her leads from me and she made me feel calm and relaxed…she’s a midwife who definitely goes above and beyond”.

“…she was so professional and put our minds at ease through quite a stressful time and then was really kind and thoughtful afterwards…taking care of the 3 of us”.

“…she was helpful and kind and really made us smile. Having a baby is such a precious thing but it can be hard as well…but having a friendly, smiley, chatty staff member can make all the difference in those early days when you are feeling unwell and anxious…she was brilliant”.

“Thank you so much for staying with me until she came into the world. You made me feel like I was very special”.

“The midwives were amazing. Thank you for being so funny and wonderful!”.

“Thank you. Incredible care”.

“At no time did we have any doubts she was in safe hands”.

“…She went above and beyond her role…and even came to greet me afterwards, while I was in hospital…she showed complete commitment and care through a difficult time”.

Women we talked with told us:

“Words are not enough to tell you how brilliant the midwives are”

“They are truly wonderful, and we are so grateful to them…”

“The level of care and compassion here is second to none. We have just been transferred from another hospital and the difference is evident.”

“From the time we came in we have been treated amazingly and the care is fantastic”.

The service worked hard to promote continuity of care and we saw feedback from women who had appreciated the familiarity and the bond they had formed with their midwife, many referring to them as friends.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgemental attitude when caring for or discussing women with mental health needs. Women we spoke with felt heard by and understood by staff. They felt like genuine partners in their care. We saw staff explaining treatment options to women and making decisions together. Staff followed policy to keep women’s care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. One woman told us they had been offered a female staff member at all times during their care and labour. Another woman told us their preference for same sex staff members was recorded.
The service used the friends and family test to capture women’s feedback. Feedback was consistently excellent.

Results from the friends and family test were approximately three months old. Senior staff acknowledged that this was frustrating but understood the amount of data needed to be analysed.

**Friends and Family test performance**

**Friends and family test performance (antenatal), University Hospitals Plymouth NHS Trust**

From May 2018 to April 2019 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

![Graph](image1)

**Friends and family test performance (birth), University Hospitals Plymouth NHS Trust**

From May 2018 to April 2019 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally was generally similar to the England average.

![Graph](image2)

**Friends and family test performance (postnatal ward), University Hospitals Plymouth NHS Trust**

From May 2018 to April 2019 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

![Graph](image3)
Friends and family test performance (postnatal community), University Hospitals Plymouth NHS Trust

From May 2018 to April 2019 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: Friends and Family Test – NHS England)

CQC Survey of women’s experiences of maternity services 2018

The trust performed about the same as other maternity services in in the CQC maternity survey 2018. They were worse than other trusts for one question and better than other trusts for one out of 19 questions

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>7.4</td>
<td>Worse</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.9</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>7.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>5.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>Thinking about response time, if attention was needed after</td>
<td>7.4</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>the birth, did a member of staff help within a reasonable amount of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the</td>
<td>7.8</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>birth of your baby, were you given the information or explanations you</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the</td>
<td>8.6</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>birth of your baby, were you treated with kindness and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>understanding?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who</td>
<td>5.5</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>was involved in your care able to stay with you as much as you</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>wanted?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the</td>
<td>8.9</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>hospital room or ward you were in?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

**Emotional support**

**Staff provided emotional support to women, families and carers to minimise their distress. They understood women’s personal needs.**

Staff gave women and those close to them help, emotional support and advice when they needed it. We were told “…sonographers made me feel special, even though it must be every day and normal for them. They took time to explain everything to me and put me at ease”.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We saw an example of staff assisting a woman to prepare the labour room for delivery. The woman was anxious and had been in hospital for some time. During this time expectations were discussed, and emotional support given to overcome anxieties and make the room feel less clinical.

Staff supported women and families who experienced the loss of a baby and there was a bereavement lead. Staff supported high risk women through their pregnancies; this included pregnant women who had previously experienced the loss of a baby. They supported women in labour and following a loss, worked with families to ensure the precious time they spent with their babies was as they wanted. This included supporting them, for example, to bathe and dress their baby, and making baby’s handprints and footprints.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. There were examples of staff supporting women who previously had a loss of a baby. Staff welcomed women back to the central labour suite to help with anxieties. Staff were able to explain how they would do this by including staff the woman was familiar with to support them when they were distressed.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. When asked about women’s emotional needs, staff spoke about women in a compassionate way. We observed care given to a woman by midwives and medical staff, and involvement of those close to the woman, to ensure she was emotionally supported.
Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. Women told us they felt well informed throughout their pregnancy and during the birth of their baby. Fathers told us they felt welcomed and included in their partner’s pregnancy and the birth of their child. We were told of a couple who arrived, unannounced, at the service because they were anxious about the birthing environment. We saw feedback after that visit “…showing us around and telling us what we need to do….she hadn’t needed to do this and yet she completely put our minds at ease with her kindness….she introduced us to staff”.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. All women we talked to told of positive experiences. Staff supported women to make informed decisions about their care. They told us they were encouraged to ask questions and seek support when they needed it. Women were encouraged to make advanced decisions about their care. Women told us they felt their decisions were respected and, where possible, followed.

During our inspection a woman, who was attending the diabetes clinic, told us that she had been well supported to make informed decisions about her pregnancy. She told us she had been given information about healthy diet and had been encouraged to manage her treatment plan at home with the support of the staff. Her partner felt respected and involved in decisions.

Women regularly had a doula (someone without formal obstetric training to provide guidance and support during labour) present and were encouraged to individualise care plans for the birth of their baby. Staff would discuss anxieties to ensure the best possible experience for women.

A high proportion of women gave positive feedback about the service in the Friends and Family Test survey. The feedback from the Friends and Family Test was positive for all wards.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. They worked with commissioners and engaged with the local community to ensure that maternity services reflected the diverse needs of the population.

They service worked with partners across the Devon health system, including the Local Maternity System (LMS) (the clinical director co-chaired the meeting of this forum), to plan and deliver maternity care for the local population. Local maternity systems were set up to deliver the national vision for maternity care, set out in NHS England’s Better Births (2016).

The service monitored the rate of homebirths which, whilst in line with the national average was below the target set by NHS England. We reviewed the maternity dashboard which demonstrated in the period April to July 2019, 2.1% of births were achieved in the home. No planned homebirths
were cancelled for non-clinical reasons during that time. Women who had chosen home births but delivered in the hospital had done so due to clinical reasons.

The service hoped to achieve a yearly average of 4-5% of women achieving home births. This figure had been set by NHS England and working with the LMS, the partners were looking at strategies to achieve this target.

The service had a newly appointed perinatal mental health specialist midwife to develop pathways for mental health. They were completing a training needs analysis for maternity staff and reviewing policies and guidelines. For example, Valproate warnings were not in the policy on perinatal mental health and these were being added. The perinatal mental health specialist midwife had begun to look at new referrals in order to organise early help for women, including meeting their safeguarding and mental health needs.

Premises and facilities were appropriate for the services that were delivered. The maternity unit was based in the women’s unit. This was well sign-posted from the main hospital and the hospital’s main car park. There was information about car parking and hospital maps available on the trust’s website.

Although the environment was bright, on the central delivery suite rooms appeared clinical, mostly storing hospital equipment. There was also a few ‘home from home’ items or areas for women to keep their belongings or walk during labour. The delivery suite rooms layout was the bed was in the centre of the room, however, there was no dimmable lighting to aid a more relaxing birth environment. There were facilities to play music and reclining chairs for partners.

There were plans to provide a better ambience in the delivery rooms, with candles (battery operated), walls murals chosen by the Devon Maternity Voices Partnership and affirmations on the walls. Delivery rooms had been measured for these changes and charitable funding had been sought.

The service had suitable facilities to meet the needs of women's families. There was a day care assessment unit providing support to women who needed extra monitoring during pregnancy.

On the labour ward, the aim was to offer women individual care in a relaxed environment. Women could bring two partners into the birthing room and were encouraged to bring anything that provided comfort, such as music, pillows, snacks. Expectations were discussed during antenatal visits. Partners could stay if their partner had been allocated a private room. There were chairs for partners in bay areas and we observed alternative arrangements for partners to stay overnight.

The design of the environment did not always enable privacy and dignity for women. The early pregnancy unit was sited next to the antenatal clinics with a shared reception. This meant women who had experienced a loss of pregnancy would be waiting to book-in with pregnant women. There were no available resources, currently, to make the changes required to separate the two services.

However, women whose babies were in the neonatal intensive care unit were placed in a ward close to the unit to provide reassurance that they were near their baby.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia. However, staff told us that the response from the psychiatric liaison service was slow out of hours.

Within the labour ward, but separate from other labour rooms, there was a bereavement suite. This doubled as a labour room for normal deliveries, however priority would always be given to women whose baby had died, to labour and/or receive specialist postnatal bereavement support. The room was sensitively named the Snowdrop Room and the local snowdrop charity (part of the
national Stillbirth and Neonatal Death charity (SANDS)) had helped to fund the decoration and furnishing of this room.

**Bed Occupancy**

From October 2017 to March 2019 the bed occupancy levels for maternity were generally lower than the England average, with the exception of 2018/10 quarter 2 (July to September 2018), where bed occupancy was higher, with the trust having 64.9% occupancy compared to the England average of 58.1%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

**Meeting people’s individual needs**

The service was inclusive and took account of women’s individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Services were planned and delivered to provide accessible care, flexibility, choice and continuity of care. There was a pan-Devon project to ensure women who accessed maternity services throughout Devon received the same care whichever trust they chose to attend. The service worked with the Devon Maternity Voices Partnership (MVP) to develop maternity services. The MVP is a collective of parents, and parents to be, providers of maternity services (including charities and Healthwatch), to review and contribute to the development of maternity services throughout Devon.

The service provided support to women, who had suffered a loss in a previous pregnancy. Midwives organised their caseloads, so these women saw the same midwife from booking to delivery.
Staff could access specialist support and ensured women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Women with mental health difficulties told us staff were understanding and supportive.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. Staff knew they could access interpretation services including registered signers for women with communication needs, however staff told us the interpretation service would cancel regularly, and at times at the last minute. The language line would be used if the interpretation service cancelled, but staff felt that this was not an ideal service. Staff regularly required interpreters, and this could be a challenge to ensuring women received the best service and experience.

Staff supported women whose first language was not English. Women were asked to specify their first (native) language when they booked, and to state whether an interpreter was required. Staff could arrange face-to-face interpreters to accompany women to clinic appointments and they could access telephone interpretation services.

**Access and flow**

*People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.*

The service monitored flow, staffing and efficiency to ensure women could be supported to give birth where they chose, unless complications prevented this. The midwifery team supported women, who were assessed as being low risk, to choose to have their babies at home. Options were discussed at the beginning and during pregnancy and care plans developed, which were tailored to women’s needs and preferences. Women who were assessed as being high risk had care plans to offer safe choices.

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. To increase the accessibility of the service antenatal services were delivered as locally to where pregnant women lived as possible. Community midwives ran antenatal clinics from local GP surgeries and community premises.

Women requiring specialist care, such as diabetes or raised BMI, were seen in clinics within the hospital. Women requiring ultrasound scans were also seen within the hospital. Women arriving at the antenatal clinics were directed to appropriate waiting areas. Waiting times were kept to a minimum although at times the clinics were very busy.

We observed a woman being admitted after discussion during a specialist clinic. There was a number of specialist medical staff present who discussed care and treatment with the woman. We heard the woman given reason for admission and time and place of admission. The woman told us, later that day, the admission process “*had been seamless and they knew why we were here when we arrived*”.

Managers and staff worked to make sure women did not stay longer than they needed to and staff worked to make sure that they started discharge planning as early as possible. Women were either discharged home from the central delivery suite or admitted to the wards for additional care. The Transitional Care Ward provided additional specialist care for babies when the woman was well. The neonatal unit was attached to the Transitional Care Ward and this allowed women to stay on the ward and be close to their baby on the neonatal unit.
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. Women and families, we spoke with were uncertain of the formal procedure to report complaints but told us they would feel comfortable raising concerns directly with staff. They felt confident their concerns would be taken seriously.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Formal complaints were centrally managed by the trust’s complaints team, who acknowledged concerns in writing and allocated them to the relevant service line managers. Complainants were fully engaged in and supported through the complaints process. In some cases, complainants were contacted by telephone by the investigating manager. This allowed them to introduce themselves, explain the process and timescales and to ‘triage’ the complaint to ensure the concerns and expectations of the complainant were fully understood.

Summary of complaints

From June 2018 to May 2019 the trust received 23 complaints in relation to maternity at the trust (3.2% of total complaints received by the trust). The trust took an average of 23.2 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed in 40 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>13</td>
<td>56.5%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>5</td>
<td>21.7%</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>8.7%</td>
</tr>
<tr>
<td>Staff numbers</td>
<td>1</td>
<td>4.4%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>4.4%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

Complaints were discussed at monthly clinical effectiveness committee meetings, where any emerging themes were identified. Staff involved in complaints received individual feedback from investigating managers and themes and learning were shared at team meetings and via maternity newsletters. There were no significant themes identified at the time of our inspection.

Number of compliments made to the trust

From January to December 2018 there were eight compliments received for maternity at the trust (3.4% of total trust wide).

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

There were many more compliments displayed in maternity services for staff and women to see. (see caring section above)
Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.

Managers were highly respected and well liked. The director of midwifery provided strategic leadership for midwifery and was based on the central delivery suite. Although not frequently visible to staff or women in all parts of the service, staff told us she was approachable and supportive. The director of midwifery reported to the trust’s chief nurse and had direct access to the board and presented bi-annual reports to them.

The director of midwifery was supported by two matrons, who provided operational day-to-day leadership. One was responsible for inpatient care and the other for outpatient, day case and community services. Matrons were frequently visible in all parts of the service and undertook walkabouts Monday to Friday to ensure they were accessible to staff and women. They participated in the on-call rota for support out of hours.

Midwives were supported professionally by a team of professional midwifery advocates, who were experienced practising midwives providing clinical supervision and pastoral support. There were also team leaders and specialist midwives who led in different areas, such as staff education and bereavement support.

Medical staff had service line leadership. There was a service line director for obstetrics and gynaecology, a consultant gynaecologist, who had protected time for managerial responsibilities and provided strategic leadership for the medical workforce. They were supported by a governance lead consultant for obstetrics. All junior doctors had a clinical supervisor and an educational supervisor.

Service lines (maternity and obstetrics) were supported by a service line manager. Although the three leaders did not meet formally as a triumvirate management team they all described a close working relationship with one another; they spoke daily, and all attended weekly governance and monthly clinical effectiveness committee meetings. The service line manager spoke with pride about how the management team had worked together to find joint solutions during a challenging year when the service faced significant staff shortages.

The management team told us of the challenges the service faced and describe their priorities for ensuring a sustainable, compassionate and inclusive and effective leadership. They spoke confidently about workstreams and improvement plans which had been developed and were ongoing to improve performance.

There was evident succession planning and aspirant leaders were supported to develop their managerial skills. One of the matrons was supported to complete the Aspiring Head of Midwifery programme and had support from an external mentor. Both matrons and other senior midwives were encouraged to represent or accompany the director of midwifery at executive level and external meetings.
Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff knew how to apply them and monitor progress.

The service was an active member of the county-wide Local Maternity System, which had developed a local vision and delivery plan. The trust’s vision and plans were aligned to the pan-Devon vision and plans, and national priorities outlined in Better births: Five year Forward View for Maternity Services (NHS England 2016) and a ‘Strategy on a page’ had been produced to communicate trust priorities to staff. The director of midwifery told us this had been shared with staff via email and discussed at team meetings. The strategy was supported by an action plan. Staff we spoke with were not familiar with this document but were generally well informed about national priorities and had been consulted with around local plans to implement new ways of working to improve continuity of care for women.

There was a long-standing plan to develop a midwifery-led unit. This was included in the trust’s five-year strategy and the director of midwifery was confident that this would be realised within this time span. There were early plans to utilise space which was to be vacated by infertility services. There were also plans to develop the bereavement suite on the labour ward, using charitable funds.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Managers and staff described the service as a happy place to work. Students who had completed placements in the service returned to work there after qualification. They told us they felt welcomed and supported.

Recent staff survey results (2018) had been mixed, and the service mostly scored lower than average for the trust. The service was reviewing this information to fully understand any areas of concern. A series of staff focus groups was planned to investigate areas of concern.

Staff at all levels told us they were valued and respected; there was mutual respect and cooperative and appreciative relationships between job roles and disciplines. The service participated in the trust-wide ‘Learning from Excellence’ system and regularly nominated colleagues for doing something excellent or ‘going the extra mile’. Cards were sent to the home address of the staff member so they would feel valued. Some staff showed us the thank you cards they had received from the trust’s Learning from Excellence team, which they told us, made them feel proud and valued.

Feedback given to peers included:

“…went above and beyond what is expected of a manager. She is so supportive, caring and professional”.

“…is just the most positive, charismatic and warming person to work with. Her love of the job and passion to provide great care never fails to go unnoticed”.

“Thank you for your fantastic support for a patient without a birth partner…you were lovely, taking photos, talking to the patient…to ensure it was a positive birthing experience”.
“Always makes you feel part of a team, understanding and works really well in a multi-disciplinary team”.

“…cared for a woman undergoing a pregnancy loss. Her work was to a very high standard and the thoughtfulness and caring she displayed when looking after the baby was second to none”.

Staff spoke with passion and pride about their service and there was a high level of job satisfaction and a desire to provide the best possible care to women and their families.

Staff felt confident and safe to raise concerns. Some told us they would approach their line manager, others said the professional midwifery advocates were a good source of support. However, not all staff were familiar with the trust’s freedom to speak up guardians.

There was a strong emphasis on staff safety and well-being. Professional Midwifery advocates were available to facilitate reflective practice when staff experienced difficult or distressing clinical situations. Although recent staff survey results indicated staff dissatisfaction with flexible working opportunities, staff and managers we spoke with were positive about this. There had been a significant number of staff on maternity leave in the last 12 months and they had been supported on their return to work in a way that allowed them to balance their work and child care responsibilities.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

During the last inspection the effectiveness of governance to manage risk and drive service change was not robust. During this inspection we found improvements and there were now well-embedded and effective governance systems. There was a meetings structure, supported by a system of regular audit and review, which reported from ward to board.

There were monthly clinical effective meetings, chaired by a consultant lead for governance. They were scheduled for the year ahead, when there were no clinical activities, to encourage maximum attendance. There was a standing agenda, which included a review of the service line performance dashboard, risk register, incidents, complaints and other feedback from women, guidelines for ratification, audits, maternity safety thermometer and quarterly workforce data. Minutes were circulated to staff via email and key messages were captured in the maternity newsletter and via a ‘theme of the week’, discussed at staff handover meetings. There was a rolling action log to ensure actions were progressed in a timely way.

Reviews of deaths and unexpected outcomes were discussed at regular mortality and morbidity meetings. Learning points were discussed and there was a prompt to consider inclusion on the risk register. There was an action tracker to ensure agreed actions were progressed. A copy of the maternity risk register was embedded within the maternity newsletters.

There was programme of clinical audit and regular audits took place to monitor safety performance. These included audits of infection control, records and the maternity safety thermometer. There was investigation and remedial action when data identified inconsistent or concerning performance. For example, recent audits of the completion of MOEWS charts had highlighted room for improvement. This was identified in the maternity newsletter in June and guidance was provided on completion and escalation. Further work was initiated through the newly established maternity and neonatal safety net meeting to improve compliance in this area. Similarly, recent infection control audits had highlighted some areas of concern regarding the use of cannulas and catheters and staff were reminded in the August newsletter about safe
cannula/catheter care. However, some completed audits had no outcomes or actions against them, and some current audits had been in progress for ten to 14 months.

Following our last inspection, the service had increased governance capacity to ensure better oversight and review of policies of clinical guidelines. There was a senior midwife and a consultant obstetrician with responsibility for audit and guidelines. We saw there were updates publicised in the June maternity newsletter

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were effective systems to ensure all incidents, including complaints, were investigated and lessons learned were shared with staff. There was a weekly obstetric risk review governance meeting, chaired by the director of midwifery and attended by the consultant obstetrician clinical governance lead, maternity risk midwife and senior midwives/matrons.

There were monthly clinical effectiveness committee meeting where incident themes were discussed. The service maintained a risk register, which was also discussed here each month and managed by the risk midwife. The risks recorded here mostly aligned with what senior staff told us they were concerned about.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had access to information which provided leaders with a holistic view of performance. A service line performance dashboard was maintained and reported each month. Managers told us data was readily available and reliable.

The risk register recorded an issue with regard to technology connectivity for staff working in the community. This meant there was a risk staff may not be able to access up-to-date clinical guidelines. The risk was mitigated by ensuring staff were informed of any changes to guidelines (this was communicated via the maternity newsletter. The service had recently procured a telephone application, which was to be introduced in coming months to ensure more reliable connectivity.

During our inspection we observed that staff were alert to their responsibility to protect personal data and took steps to ensure the safe storage and movement of records. We saw staff check that women’s hospital records corresponded with their hospital notes.
Engagement

Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

Public engagement

The service engaged with equality groups to plan and manage services. The service had a working group; Equality, Diversity and Inclusivity, which included terms of reference outlining the organisation’s aims around user involvement.

The service was committed to improving services by engaging with women and their families and capturing their feedback. The service worked with the Devon-wide maternity voices partnership, which was a collaborative of providers of maternity service, parents, parents-to-be and other stakeholders, reviewing local maternity care and supporting service users to share their experiences. We saw the launch of this collaborative in April 2019 was publicised on the service’s website and on posters in the maternity unit, but we saw nothing further to promote the activities or outcomes from this collaborative.

Matrons and ward managers routinely met and spoke with women and their families to capture their feedback. The service also used the friend and family test questionnaire to monitor feedback and this was reviewed at clinical effectiveness committee meetings.

The director of midwifery told us about plans to upgrade facilities to provide a bereavement wing on the labour ward. This had been made possible by fundraising led by a family who had lost their baby. An engagement event had been arranged, to which other bereaved parents were invited, to help to influence the design of the new facility.

Staff engagement

Staff felt informed and involved. Communication was good, and a maternity newsletter was produced bi-monthly and provided a range of news and updates. Key messages were also communicated at staff handovers and via email. Staff felt their views mattered and they were encouraged to contribute feedback and ideas to improve performance and the experience for women.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had recently introduced maternity and neonatal safety net meetings. These were drop in sessions led by professional midwifery advocates for staff to contribute to discussions about safety and make suggestions for improvements. A project looking at how to improve completion of MOEWS had recently been developed and had resulted in the introduction of new MOEWS charts printed on cardboard. The service was proud to report that the safety net meetings were well-attended with over 50 attendees.

We saw articles from the infant feeding lead in the maternity newsletter celebrating a recent successful visit to a local primary school providing pupils with a workshop on human milk.
Diagnostic imaging

Facts and data about this service

The University Hospitals Plymouth NHS Trust provides diagnostic imaging services to a wide range of patients across Devon and Cornwall. Services provided include services at Derriford Hospital, the Radiology Academy, South Hams Hospital, Tavistock, Launceston, Liskeard, The Cumberland Centre and Mount Gould Local Care Centre. During this inspection we inspected Derriford Hospital, we did not inspect any of the community-based services.

Diagnostic services we visited during our inspection at Derriford Hospital included:

- Computerised tomography (CT): a technique using cross-sectional images using x-ray. There are six CT scanners, two that run primarily for inpatients, three for outpatients, and one for biopsies/drainages.

- Magnetic resonance imaging (MRI): a medical imaging technique to form pictures of the anatomy and physiological processes of the body. There are two static MRI scanners, a dedicated extremity scanner and a mobile scanner based in the grounds of the Trust. The department offers a 24/7 service with an on-call out of hours service for emergency and life-threatening conditions.

- Ultrasound: sound or vibration using an ultrasonic frequency used in medical imaging. Ultrasound has nine ultrasound rooms as well as portable machines used in outpatients, wards and theatres.

- Plain film x-ray has three x-ray rooms in X-ray West and four rooms in X-ray East mostly used for inpatients. There are an additional four x-ray rooms used for the emergency department. The service also has mobile units and portable image intensifiers used on inpatient wards, theatres and in some departments.

- Nuclear medicine is the largest such department in the South West, with tertiary referrals from across the Peninsula. It has four gamma cameras and a Medicines and Healthcare Products Regulatory Agency (MHRA) - licensed radio pharmacy and dedicated medical and physics support. The full range of diagnostic procedures (imaging and non-imaging) is offered, together with thyroid clinics. There is shared access to a single treatment room on Brent ward for an increasing range of radioisotope treatments.

- Fluoroscopy: medical imaging showing a continues x-ray image on a monitor. There are two rooms dedicated to fluoroscopy imaging with access to shower and toilet facilities close by.

We also visited the interventional radiology department as staff working in this area are managed by the imaging services. However, our observations of care and treatment processes will be reported in the surgical services report in accordance with our inspection framework.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We spoke with 81 staff of varied seniority and across all services. We also spoke with 14 patients and two relatives and observed care and treatment given to patients attending the imaging services. We looked at eight electronic imaging patient records and other documentation such as minutes of meetings, audit results and investigations in incidents and complaints.
Activity:

In the last 12 months prior to our inspection (from August 2018 to July 2019), there were 363,275 diagnostic imaging procedures carried out across all services within the trust of which 6% were for paediatric patients. The three modalities (methods of imaging) who performed the most diagnostic procedures were:

- Radiology: 177,545 plain film x-rays
- CT: 48,461 CT scans
- MRI: 25,109 MRI scans

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, training compliance did not meet trust targets for all staff and across all modules.

Staff received and kept mostly up to date with their mandatory training. Most modules were e-learning, but staff also attended an annual face-to-face mandatory training day. The electronic training records system alerted staff and managers to when regular updates were due.

The mandatory training was comprehensive. This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust stated that the ‘Trust update’ module encompassed the following:

- Equality, Diversity & Human Rights
- Health, Safety & Welfare (including Medical Gases, Medical Devices)
- NHS Conflict
- Fire safety
- Infection, Prevention & Control
- Moving & Handling
- Safeguarding Adults (including Mental Capacity Act)
- Preventing Radicalisation
- Safeguarding Children
- Resuscitation
- Information Governance

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This was included in the safeguarding modules. However, staff did not receive specific training on how to recognise symptoms and signs of female genital mutilation (FGM), child sexual exploitation (CSE) or human trafficking.
Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 for qualified nursing staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</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>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust Update</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was met for three of the four mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</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>Safeguarding Level 1</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>119</td>
<td>132</td>
<td>90.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>104</td>
<td>118</td>
<td>88.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>103</td>
<td>118</td>
<td>87.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust Update</td>
<td>107</td>
<td>132</td>
<td>81.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was met for one of five mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from 16 May 2018 to 15 May 2019 for qualified allied health professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</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>Safeguarding Level 2</td>
<td>141</td>
<td>146</td>
<td>96.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust Update</td>
<td>140</td>
<td>150</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>137</td>
<td>150</td>
<td>91.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>115</td>
<td>149</td>
<td>77.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was met for three of the four mandatory training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Radiographers working in MRI completed immediate life support (ILS) training for adults. However, staff told us there was a lapse in attending the required refresher course. To mitigate this, they made sure a registrar was present if they scanned patients using contrast media out of hours. During day-time hours, more staff with the right skills were present in the department including registrars and consultant radiologists. Staff were aware of how to call for help using designated telephone numbers to do so. Data demonstrated 38 staff had completed ILS training in 2019 across all modalities.

Staff did not receive specific paediatric life support training. Staff completed basic life support training which included ‘adult basic life support, paeds (paediatric) & AED’ (automated external defibrillator) child specific’ training.

**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 and were mostly up to date with regular updates.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of signs or symptoms that would raise a concern if patients may be at risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns about potential safeguarding of patients. We noticed flowcharts were displayed in staff areas for easy access to important contacts to report safeguarding concerns. Staff had access to trust policies for the protection of patients including ‘Safeguarding Adults at Risk Policy (vulnerable adults) (2017)’, ‘Child Protection Policy (2018)’ and domestic abuse policy for managers and practitioners (2017). These policies were mostly up to date although the ‘Safeguarding Adults at Risk Policy (vulnerable adults)’ should have been reviewed and updated in November 2018.

There were specific radiographers trained to assist with imaging of children who presented to the emergency department with non-accidental injuries. There was a set of specific competencies for these radiographers to complete before they could lead a ‘skeletal survey’. The radiographers worked closely with staff in the emergency department to raise safeguarding concerns for these children when this was required.

**Safeguarding training completion rates**

Staff received training specific for their role on how to recognise and report abuse. Training information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust indicated ‘Safeguarding Adults’ and ‘Safeguarding Children’ were included in the ‘Trust Update’ training module.

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from 16 May 2018 to 15 May 2019 at trust level for qualified nursing staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>14</td>
</tr>
<tr>
<td>Trust Update</td>
<td>14</td>
</tr>
</tbody>
</table>
In diagnostic imaging the 95% target was met for the safeguarding training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from 16 May 2018 to 15 May 2019 at trust level for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Level 1</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>104</td>
<td>118</td>
<td>88.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust Update</td>
<td>107</td>
<td>132</td>
<td>81.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was met for one of the two safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from 16 May 2018 to 15 May 2019 for qualified allied health professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>16 May 2018 to 15 May 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Level 2</td>
<td>141</td>
<td>146</td>
<td>96.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust Update</td>
<td>140</td>
<td>150</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was met for one of the two safeguarding training modules for which qualified allied health professionals were eligible.  
(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff consistently confirmed three points of patient identity before carrying out any imaging procedures. The Society of Radiographer’s ‘pause and check’ posters were displayed in different imaging rooms to remind staff and this practice was clearly embedded and implemented by all staff we observed.

**Cleanliness, infection control and hygiene**

**Staff did not always follow trust policies and national guidance for the prevention and control of infection risks. However, the premises were visibly clean.**

All clinical areas we visited, were visibly clean and had suitable furnishings which were clean and well-maintained. Some but not all equipment was labelled with ‘I am clean’ stickers indicating the equipment had been cleaned and was ready for use. There were processes to manage imaging procedures of patients with known communicable disease. These patients were scheduled to have their scans or imaging processes at the end of the morning or afternoon list. Staff knew how to arrange for deep cleaning of the environment by an external company contracted to undertake all cleaning in the hospital.

Cleaning records were not always completed so did not always demonstrate areas were cleaned regularly. For example, it was not clear if toilets and shower facilities were clean. Not all toilets had a cleaning log. Patient shower rooms in the fluoroscopy (medical imaging showing a continuous X-ray image on a monitor) department were only cleaned once a week. We reviewed the latest
cleaning audits carried out in August and September 2019 across all modalities. The audits were carried out by staff who were rostered to do so to ensure they were carried out as planned. The audit looked at eight different aspects of the area they were auditing, including the entrance, clinic/treatment areas, storerooms, toilets and staff rooms. The lowest score was 73.1% compliance in X-ray East zone four and the highest compliance score was 94.7% in X-ray East zone one.

Staff did not always follow infection control principles. Staff did not always wash their hands or use sanitiser gel before and after each patient contact and not all clinical staff were bare below the elbows. Staff used personal protective equipment (PPE) when this was required in line with the trust’s ‘Infection Prevention & Control Framework (2015) and national guidance (National Institute for Care and Health Excellence: QS61: Statement 3, 2014).

Staff did not always clean equipment after patient contact in line with their trust policy. Staff removed the paper towel covering the scanner equipment/motorised bed, but they did not then clean the equipment in line with the trust’s infection prevention and control framework. Specific guidance displayed in the room stated the motorised bed and chair patients used, should be cleaned with a multipurpose wipe after each patient.

Staff did not always use wipes suitable for medical devices in all departments. We saw some staff used a general purpose/detergent wipes suitable for general cleaning and damp dusting rather than disinfectant wipes specifically designed for medical equipment. We were told staff could request disinfectant wipes if they had cared for a patient with known infectious diseases and that these would be available within ten minutes. However, there was a potential that this could cause delays to the list of planned scans and images.

Substances hazardous to health were not always stored securely and meant unauthorised persons could access these. Staff used a chlorine-based cleaning agent to clean some surfaces in clinical areas. However, the chlorine-based cleaning tablets were not always stored in cupboards designed in line with Control of Substances Hazardous to Health (COSHH) Regulations. Staff did not always label when the solution had been made. There was a risk the cleaning solution could lose its effectiveness if it was not made up every day in accordance with manufacturer’s guidance. We saw a solution which was dated 10 June 2019. Staff assured us the solution had been made up on the day of our inspection but not dated as such.

Daily cleaning records were not always maintained. The daily cleaning record for the sluice in the fluoroscopy unit showed the record had not been completed on 21 days between 16 July and 21 August 2019. In the x-ray department located close to the emergency department, the cleaning schedule for one of the mobile x-ray units showed the daily cleaning had only been completed on 22 days between 1 May and 21 August 2019.

Water outlets were not always flushed in accordance with national guidance. Regular flushing of infrequently used water outlets is essential to manage the risk of Legionella growth in stagnant water. In X-ray West, the record of tap flushing was last completed on 3 June 2019. Previous dates recorded were 20 May 2019, 31 December 2018 and 24 December 2018. This was not in line with national guidance which recommend that infrequently used outlets should be flushed at least weekly (Health and Safety Executive).

We noticed some posters and notices in various departments which were fixed with sticky tape, which had curled up on some of the displayed notices posing an infection control risk as the surfaces could not be cleaned effectively.
Environment and equipment

The design, maintenance and use of facilities and premises mostly kept people safe and staff managed clinical waste well. However, there was a range of ageing imaging equipment which was passed its end of life and as such prone to breakdown. Staff did not always check emergency equipment daily in line with trust policy.

The design of the environment followed national guidance (Department of Health Building Notes (HBN6): Facilities for diagnostic imaging and interventional radiology, 2001). For example, there was signage and warning lights in all department to ensure people did not enter procedure rooms when radiation was used. In plain film x-ray, there were control areas shielded by fixed led screens to protect staff from radiation. In the MRI scanning rooms, signs warned people of the magnetic fields surrounding the MRI scanners.

There were additional 'persons scanners' to ensure patients were safe to enter the MRI scanner room. The scanner picked up any metal objects that could pose a risk to patients and staff due to the magnetic field in the scanner room. However, although staff ensured patients were safe to enter the MRI scanner room, we observed one member of staff wear jewellery, which did not meet the MRI ‘staff permit to work’ safety checks.

Equipment in the MRI department was labelled ‘MRI safe’ including the anaesthetic machine which was used for patients having scans under a general anaesthesia. Helium levels were checked weekly and staff monitored oxygen levels in the MRI scanner rooms to ensure these met safety standards.

During our last inspection in August 2018, we found an x-ray room which had a lead curtain to separate two x-ray machines. However, we were concerned this did not ensure patient safety and did not ensure single sex conditions were met and patients’ dignity always maintained. There had not been a suitable solution found so if the room was used, only one of the x-ray machines was used ensuring patients’ safety and dignity.

Facilities did not always ensure the demand and capacity was met in X-ray West, there was an issue with the power supply in one of the imaging rooms. This led to x-ray images being of insufficient quality to use for diagnostic services. The power supply was also affecting other x-ray rooms although not to the same degree. There had been several external investigations into the reasons for this, but no solution had been found so this room was not being used at the time of our inspection.

In the fluoroscopy department, there were issues with the temperature control in one of the rooms used for fluoroscopy procedures. At times the room was too hot for radiographers to work comfortably as they were also required to wear lead aprons for radiation protection.

There was ageing equipment across all modalities which was passed its ‘end of life’. This meant the imaging machines were no longer manufactured and spare parts were limited and were no longer guaranteed. Ageing equipment identified during our last inspection had not been replaced. We discussed this with staff of different seniority who told us there were plans to replace aging equipment, but additional re-design of the environment was required. Following the inspection, we requested the business plans to support the replacement of ageing equipment which demonstrated there were approved plans for equipment replacement programme for the 2019/20 budget.

Imaging equipment sometimes broke down leading to delayed or cancelled appointments for patients. For example, the MRI East scanner had broken down 17 times between 1 January and 20 August 2019. In nuclear medicine the ageing equipment meant the quality of some particular
images was poor and had led to two patients being transferred to another NHS hospital for their scans. The nuclear medicine department referred patients requiring this particular scan to other healthcare providers. Staff called out engineers to mend the equipment, but they were not always available to attend on the same day leading to delays or cancellations.

Between August 2018 and July 2019, 790 appointments were cancelled by the trust. However, this data did not include cancellations that were re-booked before capturing the original appointment has been cancelled. This meant there were potentially more cancelled appointments than the data showed. It was not clear if these cancellations were due to equipment breakdown or because there was not enough staff to carry out the imaging procedures safely. During the same period, 7,784 patients cancelled their appointment.

The service monitored breakdowns and reviewed the impact on services. A service fault log from October 2018 to September 2019, demonstrated there were 150 equipment faults reported to engineers for remedial work.

Patients were not always given call bells to attract the attention of healthcare staff. Staff provided call bells for patients undergoing scans and assurance scans would be stopped if patients required this. However, inpatients attending for X-rays or MRI in the X-ray East department were not given a call bell while they were waiting. There was no CCTV monitoring and there was no designated member of staff allocated to look after and monitor patients while they were waiting. Staff told us patients only waited for up to 15 minutes and there were always members of staff walking around the area who would assist if required. However, we observed one patient who was trying to get out of bed on their own as they needed to use the toilet. The patient was unsteady on their feet and was at risk of falling. One of the inspectors alerted an imaging porter who provided support for the patient.

The trust had processes and procedures to ensure safety and servicing of medical equipment was maintained. We saw service records which demonstrated a clear overview of all diagnostic imaging equipment and that equipment had been serviced within the last 12 months. Most of the medical devices we checked had been serviced within the last year. However, we found an ultrasound machine where the portable appliance testing was last carried out in March 2017.

Quality assurance testing was not always carried out as often as it should be because there was not enough staff to do so. There was guidance for staff to follow to undertake different quality testing, which also provided guidance of normal reference values. Actions were documented if the results fell outside of normal values. We reviewed the quality assurance audits for 34 pieces of diagnostic imaging equipment and found quality testing was not always carried out as often as it should be. For example, in fluoroscopy testing was required every three months but we found one piece of equipment which was tested in January and then August 2019, when it should have been tested every three months. Minutes of the imaging clinical governance meeting in July 2019, demonstrated the infrequent testing issue had been raised and actions discussed to ensure this was addressed.

Staff did not always carry out daily safety checks of emergency equipment including checking of medicines stock on resuscitation trolleys to ensure they were fit for purpose in accordance with trust policy. There were three resuscitation trolleys placed in X-ray East, containing equipment for adult resuscitation. Each resuscitation trolley had a drawer with paediatric resuscitation equipment and there was a designated paediatric life resuscitation trolley in X-ray West. We checked emergency equipment in various departments and found these were mostly checked every day in line with trust policy. However, in the MRI Mansfield Unit the daily checks had not been carried out on 13 days between 12 March and 20 August 2019. However, the unit may not have been open
on all of these days. It was not clear from the records if the department was open on the days the equipment was not checked. In MRI East, the suction machine had not been tested on 20 days between 20 April and 20 August 2019. This unit was used for inpatients and should be checked daily in line with trust policy.

The service had enough suitable consumables to help them to safely care for patients. We checked randomly chosen consumables in different departments and found these were in date and in unbroken packaging. However, we found one ‘urinalysis multisticks’ in the ultrasound department which was out of date in May 2019.

Staff disposed of clinical waste safely. Staff separated waste products and disposed of these in the correct waste bins. Boxes containing used sharps were not overfilled and were closed between use to prevent accidental needle stick injuries. Advice was available to staff about safe disposal of radioactive waste.

Fire escape routes were well signposted and fire equipment was in good condition and within the planned replacement dates.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and minimised radiation risks. There were processes to monitor exposure of radiation to staff although not all staff were compliant with this. Staff were aware of processes to follow if patients deteriorated. However, inpatients waiting for imaging procedures were not monitored or given call bells to call for assistance if required.

Risk assessments were completed for each patient. For example, when referrals were received for patients awaiting an MRI scan, the referrals were vetted by a consultant radiologist who applied a priority level. These priorities could be routine, urgent or for research purposes, which determined how quickly the bookings team booked patients in for their scan. During the booking process, MRI safety questions were asked such as information about metal implants.

Radiographers received training to examine referrals to ensure these were justified on a sound rationale for exposure to radiation. Radiographers reviewed referrals and confirmed with patients the reasons for the referral such as their presenting complaints.

Staff had a clear understanding of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) but not all staff knew about the new IR(ME)R regulations 2017 (amended 2018), which came into effect on 6 February 2019. Staff in interventional radiology spoke with confidence of the new IR(ME)R regulations and the impact this had on safety within their service. But some staff told us they had not received updates or training which incorporated the additions to the new regulations such as justification of radiation exposure to ‘comforter and carers’. However, senior managers explained to us updates were provided in a mandatory training programme and the updates had also been discussed on continuous medical education days. Training records confirmed training had been completed by most staff.

Staff were clear about the rationales for actions they took to reduce the risks to patients and themselves during medical imaging procedures. For example, in X-ray West, a radiographer discussed with a patient the risks to their unborn baby of having an x-ray, in a manner that was easily understood. The radiographer provided a lead apron for the pregnant patient which was designed to protect the unborn baby. After the procedure, we heard the radiographer discuss with a student radiographer, the risks and rationale for undertaking an x-ray for a patient who was pregnant.
In the cardiac catheter laboratory, there were clear processes to take action if patients received high doses of radiation during a procedure. This included recording of radiation levels and exposure time. A full level report was stored with the patient electronic records. Reports were also sent to the medical physics teams for review and to ascertain if further patient follow up was required.

Staff knew about and dealt with any specific risk issues. For example, staff working in the CT and MRI departments were aware of the risks associated with the administration of a contrast medium for patients requiring this to optimise their scans. Staff used a checklist to identify if patients were at risk of contrast induced kidney injury. This was in line with national guidance (National Institute for Health and Care Excellence, clinical guideline 169, 2013). Staff followed a flowchart to identify when further authorisation from a radiologist was required before contrast could be administered.

The service had developed a ‘surgical safety checklist’ in line with the NHS World Health Organisation (WHO) for interventional procedures and scans performed under general anaesthetics. These checklists required staff to perform safety checks before and after the procedure to check the patient identity, procedure and the correct anatomy affected by the procedure. Following the procedure, the checklist was designed to ensure documentation was completed and all instruments, swabs and sharps were accounted for. We saw staff use the WHO checklist effectively and found some checklists had been appropriately amended to include some Ionising Radiation (Medical Exposure) Regulations checks. The checklists were signed by the person who performed the procedure and scanned into the electronic patient care records. The WHO checklist compliance audits from February to July 2019 demonstrated 100% compliance.

There was a radiation protection team to help provide a safe service to patients. The trust employed a radiation protection advisor and a medical physics expert to provide advice about radiation and ensure quality assurance of services provided by each modality. Each modality had a radiation protection supervisor.

There were processes to monitor and audit radiation exposure to staff. All staff directly involved with patients receiving radiation wore individual dosimeters to measure the radiation levels they were exposed to through their work. However, staff were not always compliant with this as there had been several incidences where dosimeters were lost. We spoke with the radiation protection advisor who was concerned about this and if staff were fully aware of the importance and the legal requirements. Staff received radiation safety training each year but there had been some incidents reported of five staff receiving higher than recommended exposure and cases of failure to return or lost dosimeter monitors. This had been raised with senior leaders and there was a proposal to add staff radiation exposure to WHO safety checklist where this was possible.

Staff were aware of how to respond to any sudden deterioration in a patient’s health. There were specific observation records (national early warning scores) designed for the recording of paediatric and adult vital observations if this was required. Staff were aware of how to call for assistance in the event of a medical emergency.

Staff briefings included all necessary key information to keep patients safe. We observed a staff huddle in the CT department. This was carried out in a professional manner and included required information to be shared with team members.

Not all departments followed national safety standards for invasive procedures (NatSSIPs), 2015. The NatSSIPs is a framework to build on the NHS/WHO safer surgery checklist and are designed to standardise key elements of procedural care. Lack of compliance was because senior clinical staff did not have enough time to review and implement these. However, each modality had local rules which were standard operating procedures for each imaging/scanning procedure which
provided staff with guidance of how to carry out the imaging process. Staff had to sign when they
had read the local rules.

There was no formal policy to advise staff on inpatient wards and in the imaging department about
when an escort for inpatients attending the imaging department was required. We were told there
was a historic agreement about when patients would be escorted by a healthcare professional
from the inpatient wards out of hours. Patients who were deemed clinically stable would be
brought to the department by a porter and without an escort. If patients were not clinically stable,
ward staff would escort patients and stay with them during the visit to the department. However,
the requirement for an escort was being reviewed and discussed in a meeting in September 2019,
with a view to review and amend the trust’s patient escort policy.

Staffing

The service did not have enough staff to meet the demand of the service. However, staff
had the right qualifications, skills, training and experience to keep patients safe from
avoidable harm and to provide the right care and treatment. Managers regularly
reviewed and adjusted staffing levels and skill mix.

The table below shows a summary of the nursing staffing metrics in diagnostic imaging at trust
level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>670.9</td>
<td>7.5%</td>
<td>5.5%</td>
<td>3.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>9.4</td>
<td>-11.5%</td>
<td>0.0%</td>
<td>3.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within diagnostic imaging were analysed for the past 12 months and no
indications of improvement, deterioration or change were identified in monthly rates for turnover.
Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses are not stable and may be subject to ongoing change.

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

Sickness rates

Monthly sickness rates over the last 12 months for qualified nurses shows a shift from November 2018 to April 2019.

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

We spoke with one agency/bank healthcare assistant who felt welcomed into the team and said the department was “one of their favourite places to work”. The had received an induction into the department including radiation safety but their duties did not include working in the imaging/procedure rooms.
Medical staffing

The service did not have 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave **locum staff a full induction**. The service did not have enough consultant radiographers to meet the demand for reporting on results from diagnostic imaging service leading to a potential delay in diagnosis and treatment of patients.

The service did not have enough consultant radiologists to carry out all their duties including reporting on imaging procedures. There was not enough radiologist within some specialities to report on scans in a timely manner both due to additional scans carried out and when radiologist go on leave. Radiologist consultants told us they could return to a backlog of 3,000 x-ray films to report on when they returned from a three-week holiday as in their absence no other consultant radiologists had capacity to report on these in addition to their own workload. To mitigate this, the trust outsourced reporting when this was possible. Registrars and some radiographers did also report on plain x-ray films within their role and competence.

The service had a high rate of vacancies within medical staffing. Prior to our inspection, the trust shared information about vacancy rates which was high at 10.5%. This had increased from 1% in May 2018 (prior to our last inspection).

The service always had a consultant on call during evenings and weekends. There was always a registrar on duty that radiographers could call out of hours and at night. In addition, there was a second registrar on call if required. Consultant radiologists were on call from their home and could be called for advice or would travel to the hospital to provide support if required.

The table below shows a summary of the medical staffing metrics in diagnostic imaging at trust level compared to the trust's targets, where applicable:

<table>
<thead>
<tr>
<th></th>
<th>Diagnostic imaging annual staffing metrics</th>
<th>May 2018 – April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual average establishment (All staff)</td>
<td>670.9</td>
</tr>
<tr>
<td></td>
<td>Annual vacancy rate (All staff)</td>
<td>7.5%</td>
</tr>
<tr>
<td></td>
<td>Annual turnover rate (All staff)</td>
<td>5.5%</td>
</tr>
<tr>
<td></td>
<td>Annual sickness rate (All staff)</td>
<td>3.2%</td>
</tr>
<tr>
<td></td>
<td>Annual bank hours (% of available hours)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual locum hours (% of available hours)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual unfilled hours (% of available hours)</td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>All staff</td>
<td>139.3</td>
<td>10.5%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>139.3</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within diagnostic imaging were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.
Monthly vacancy rates over the last 12 months for medical staff shows a shift from November 2018 to April 2019.

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

Sickness rates

Monthly sickness rates over the last 12 months for medical staff shows an upward trend from May 2018 to October 2018. However, sickness rates for medical staff remained under the trust’s target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Allied health professional staffing

The service did not have enough radiographers and sonographers. Most of the staff in the diagnostic imaging services were radiographers but there were also some sonographers (specialist in the use of ultrasonic imaging) employed to carry out ultrasound scans.

The table below shows a summary of the allied health professional staffing metrics in diagnostic imaging at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>670.9</td>
<td>7.5%</td>
<td>5.5%</td>
<td>3.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>141.8</td>
<td>3.6%</td>
<td>6.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Allied health professional staffing rates within diagnostic imaging were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use or agency use.

Vacancy rates

Monthly vacancy rates over the last 12 months for allied health professionals shows a shift from November 2018 to April 2019.

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

There was not enough staff (radiographers, sonographers and nuclear technologist) across different modalities to meet the demand for required imaging procedures. For example, there were eight vacancies in the CT department. Because there were not enough radiographers, imaging procedures were cancelled leading to prolonged waiting lists and potential delays to treatment for
inpatients. Scanners were sometimes closed when there was not enough staff. We met with modality leads who told us the trust was supportive of further recruitment and would support over recruitment due to national shortages of radiographers and high turnover of staff. Staff told us staffing levels were improving. The service was expecting 16 new radiographers to start in September which were largely by employing newly qualified radiographers. While this was appreciated by staff, there was a concern about capacity to teach and support new staff until they were competent. This was because of staff shortages and capacity for senior staff to support new staff as they did not have any protected time to do so. On call duties and out of hours were difficult to staff due to staff shortages across all modalities.

The service did not use agency radiographers to help cover gaps but relied upon staff to work additional hours. Some staff told us they were rostered to work additional hours rather than them volunteering to do so and this had become the norm. Staff felt this was having an impact on their work/life balance and they felt tired.

There were not enough imaging care assistants (ICAs) to support patient care and procedure lists. For example, there were not enough ICAs to provide chaperone service in the ultrasound services to meet demand, which meant sonographers would act as chaperones for each other and reduce the capacity to meet demand. The ICAs received additional training to cannulate (insertion of a small plastic tube into a vein) patients attending for scans where a contrast medium was required to be administered into a vein. There were not enough ICAs trained to meet the demand, which meant radiographers would cannulate patients and thereby procedure lists got delayed. However, we were told the service was interviewing candidates for three additional ICAs during our inspection.

There were not enough porters in the imaging department to meet the need of the service. Staff repeatedly told us there were not enough porters which meant there were empty imaging slots because patients were not ready in the department to receive their scans.

There were not enough sonographers to meet demand. Utilisation was hampered by staffing issues, although there was enough ultrasound equipment to increase the number of scans carried out if further staff could be recruited.

The service was reactive rather than proactive in managing staffing of different departments, leading to cancellations of lists on the day. Staff told us staffing levels were reviewed daily to ensure safe patient care even if this meant some scanners or departments would be closed. Staff were supported by service leaders to make these decisions to keep patients safe. We discussed staffing establishment reviews in line with increasing demand with senior managers. Actions had been taken to improve rotas and the service had employed a rota coordinator who was due to start in September 2019.

Staffing levels in each department were not routinely displayed or updated to inform patients if there were enough staff on duty and who they were.

We discussed staff shortages and increasing demands with senior and executive leaders. They informed us the imaging department was a high priority in the trust and increasing demand and capacity including staffing was recognised. Therefore, a substantial investment into increased staffing levels had been agreed and there was financial support to recruit 21 additional radiographers, eight radiologists and 12 imaging care assistants. It was recognised recruitment was challenging but the investment was ringfenced to ensure an uplift in staffing levels of nearly 20%.
Records

Staff kept detailed electronic records of patients’ care and treatment. Records were clear, up to date, stored securely and easily available to clinical staff providing care.

Staff used two electronic systems to record and store patient information and images. There was a radiology information system used to review individual patient referrals and to store scanned information such as safety checklists. Images were stored securely on an electronic picture archiving and communication system (PACS).

Patient notes met requirements for recording of diagnostic imaging procedures and all relevant staff could access them easily. When paper records were used to assess risks associated with imaging procedures, these were scanned into the electronic patient record system immediately and any handwritten notes were disposed of in secure wastepaper bins designed for confidential waste.

There were systems and processes to ensure patient information was transferred into the PACS system used across the trust for the storage of images. For example, staff working in the cardiac catheter laboratories had to transfer images as this department did not have access to the PACS system and could only hold images for a short period of time.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always check and record temperatures for fridges used to store medicines every day.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Contrast media were prescribed as part of the ‘vetting’ process by radiologists. When staff administered contrast, the contrast medium was checked by the two practitioners such as radiographers and radiologists. Staff recorded the volume/dosage given directly into the electronic patient records system including the date, time and who had given the contrast.

All contrast media used for scans, were prescribed rather than administered under a patient group direction (PDG). PDGs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

The trust used pre-filled normal saline syringes to the flushing for cannulas. As such, the syringes were viewed as a medical device rather than a medicine and could be administer without a prescription or PDG, providing staff were competent to administer it through a cannulation competency framework.

Medicines were stored securely in locked cupboards and medicines were mostly stored in the right conditions, but staff did not always check fridge temperatures as often as they should. Medicines fridge records showed that temperatures had been maintained within the recommended range. Staff in the Mansfield MRI department told us fridge temperatures were monitored electronically with staff recording lowest, highest and average temperatures once a day. Staff then reset the temperature monitoring device. There were no remote checking or alarms centrally to detect if fridge temperatures were in the correct range for the safe storage of medicines that required refrigeration and staff did not always check these daily. The fridge in the MRI Bee scanning department was not checked between 27 August and 2 September 2019. On further investigation, it was found that the MRI Bee scanner had not been in use for five days as the scanner broke
down and was out of use on 27, 28 and 29 August and the fridge was not checked over the weekend of 30 August and 1 September 2019 as it had not been used. However, there was a risk the fridge could be faulty in this time period and not detected in a timely manner.

Staff provided specific advice to patients and carers about medicines. Nursing staff introduced themselves to patients before offering them medicines. They explained what they were giving and observed patients take them. A pharmacist visited daily to prepare the medicines required for radiopharmacy prescriptions.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff asked patients about any allergies to medicines to ensure patients were not put at risk of severe allergic reactions for example to contrast media.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff did not feel learning from incidents was shared with all staff effectively.

Staff knew what incidents to report and how to report them. There was a good culture of reporting incidents. They told us there was a ‘no blame culture’ but did not always feel learning from incidents was shared effectively. Staff received instructions about changes but did not always understand the reason for the changes unless the incident had happened within their department.

Senior managers including the radiation protection advisor investigated incidents and looked for trends to address possible failures and enhance safety. For example, the radiation protection advisor discussed a trend of problems with referrals/vetting of referrals that had led to the wrong person being referred. Actions taken to address this included a change to the electronic requesting process and further analysis by IT staff to identify priority feedback to radiographers.

Staff did not always report staff shortages as an incident as this would be required every day. Staff felt staffing issues had become the norm and would only report if there was an incident which directly related to lack of staff.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Senior staff had a good awareness of duty of candour responsibilities and when and how these were applied. 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. We reviewed two duty of candour letters sent to patients in line with national guidance and regulations. These followed a standard format.

We reviewed two investigations into incidents where consideration had been given regarding duty of candour which demonstrated the process was applied when required. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents, but investigations were concise (short). We reviewed two investigations into serious incidents, and they followed a set standard for investigation. The root cause in both cases were identified as human error and discrepancy in reporting was an accepted risk. However, reporting discrepancy was not seen in a wider context to identify if other factors contributed to the missed diagnosis on the image such as operational pressures, the time of the
day it was reported and so on. There was an action plan attached to both incidents. Actions included presenting the images to the discrepancy meeting for review and discussion, as well as individual reflections by the reporting radiologist.

Incidents of accidental or unintended radiation exposure were investigated and reported externally in line with Ionising Radiation (Medical Exposure) Regulations, 2017 Regulation 8. These incidents were consistent with duty of candour and processes were formally aligned to exposure limits to ensure duty of candour was applied when this was required. Accidental or unintended exposure included events which were a consequence of equipment or procedural failures. The trust reported 15 incidents between August 2018 and July 2019 over the last year to the Care Quality Commission in line with reporting requirements.

Staff involved received feedback from incidents on a case by case basis. Lead radiographers shared learning through huddles, but there was not a consistent approach for sharing learning such as in modality meetings. However, the re-introduction of an imaging newsletter shared to all staff by email was being considered. There were no specific trends in reported incidents, although there was a rise in the reporting of cannulas that were misplaced leading to saline flushes (and potentially medicines such as contrast medium) being administered into soft tissue rather than into the vein as was intended. The service reviewed the prevalence of this across the different modalities, and data showed this occurred in 0.8% of cases when reviewed against the total number of cannulas used.

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 April 2018 to March 2019, the trust reported no never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

However, there was one never event which occurred in July 2019 where a wrong joint was injected with steroids for symptom/pain relief. The incident was in the process of being investigated, and duty of candour applied in line with legislation.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in diagnostic imaging which met the reporting criteria set by NHS England from April 2018 to March 2019.

The incident types were:
- Treatment delay meeting SI criteria
- Confidential information leak/information governance breach meeting SI criteria
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results)
- Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

There were evidence changes had been made because of feedback from incidents to enhance patient safety. Staff in MRI East told us a ‘hover mattress’ had been introduced to transfer
inpatients from their beds on to an MRI safe trolley. The hover mattress enabled two members of staff to transfer the patient and reduced manual handling risks. This had been introduced because of an incident where there had been a possible delay in a time critical scan as all staff present were not safety checked to enter the MRI scanning room, which meant they could not assist staff to move the patient onto the motorised scanner bed.

Safety thermometer

The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, patients and visitors but this was not consistent across all departments.

The service continually monitored safety performance through a monthly ‘saving lives’ audit similar to the NHS safety thermometer. The ‘saving lives’ audit data showed the services achieved over 95% harm free care for the last 12 months. Staff used the safety thermometer data to further improve services, but information was not routinely displayed in all departments.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, trust policies, local rules and scan sequencing protocols were not always reviewed when they were supposed to be.

The service participated in clinical audits. There was an audit programme which included 27 active clinical audits such as audits required to comply with Ionising Radiation (Medical Exposure) Regulations and to evaluate compliance with national standards such as Clinical standards set by Royal College of Radiologist (RCR) or the National Institute of Health and Care Excellence (NICE). In addition, there was an audit programme for internal/trust audits, which included monthly hand hygiene audits, matron’s ward inspections and ‘imaging and therapies audit’. Staff followed trust policies to plan and deliver high quality care according to best practice and national guidance. Policies were accessible to staff on the trust’s internal electronic platform known as Q pulse. Staff knew how to access these but told us it was a difficult system to use. We observed staff ‘struggle’ to access policies although they managed it in the end. Trust policies were not always reviewed and updated as often as they should be in accordance with their procedures.

Local rules were not always reviewed when they were supposed to be. Local rules summarise the key working instructions to restrict exposure in areas where radiation is used for diagnostic purposes. We reviewed local rules available to staff in folders kept in most departments, with the exception of nuclear medicine whereby staff accessed these on the trust intranet. We found some of these had passed the planned review dates. For example, the local rules for cardiac catheter laboratories were activated in 2013 and should have been reviewed in 2016. This was a breach of the Ionising Radiation (Medical Exposure) Regulations (2017) Regulation 6 (5)(b). We could therefore not be assured staff had access to up-to-date safe working instructions to minimise exposure to radiation. We discussed this with some modality leads, who were aware, but did not have enough time to review and update these.

Some staff found it difficult to access protocols on the trust’s intranet and some protocols had passed their review date. Protocols are a set of instructions providing radiographers with
information about different scans that may be required for a certain scan sequence. Protocols were not printed off and some staff had trouble locating them on the intranet. We were therefore not assured staff had easy access to scanning sequences for specific imaging scans. We reviewed some of the protocols and found they were not all signed and lacked details about who the responsible radiologist was. Some had last been reviewed in 2015: ‘Triple abuse liver protocol’ which we reviewed on the trust’s intranet.

Staff monitored and recorded the level of radiation patients were exposed to. There were dose reference levels (DLR) available in the different departments where radiation was used. Staff used radiation levels as low as were reasonably practicable to reduce the risks of exposure in medical imaging. Local diagnostic reference levels (LDRLs) for routine were reviewed at least every three years in line with trust policy. The service had a three year ‘dose audit programme’, which provided a scheduled approach to which dose audits should be carried out at different times from 2019 to 2021 (inclusive).

There was a radiology dose reference group which met to discuss dose reference audits from different modalities. Minutes of meetings held quarterly, confirmed audits were discussed and actions taken to improve compliance with national reference levels where this was required.

**Nutrition and hydration**

Refreshments were available to patients from vending machines in outpatient waiting rooms and water was available from drinking fountains. Some patients were offered a cup of tea while they were recovering following their interventional procedure.

**Pain relief**

**Staff ensured patients were comfortable when they were attending for scans which could sometimes be quite lengthy.**

Staff supported patients to evaluate the effectiveness of treatment to control pain. Patients attending for steroid injections to joints were asked to keep a musculoskeletal pain diary for four weeks following their treatment. Staff explained to patients how to assess their pain level using a numeric scale in accordance with national guidance. Patients were asked to return the pain diary to the musculoskeletal office, but staff were unsure about how the information was used.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. However, actions were not always completed to improve the service and they had not maintained accreditation under a relevant national clinical accreditation scheme.**

There were opportunities to follow up the effectiveness of steroid joint injections for patients attending for muscular skeletal procedures. Patients were given a pain diary to complete for four weeks following the steroid injection and asked to return the pain diary to the muscular skeletal office. The return rate was not monitored but staff were able to run reports for specific auditing purposes such as patients receiving steroid injections to their hip (2014), which demonstrated a 60% positive effect of the treatment. Subsequently a further audit was completed in 2017 (for patient receiving steroid injections to their shoulder) and in 2018 for patients receiving symptomatic treatment for a heel complaint, the results of this audit was not yet available. Audit results were presented to the imaging clinical governance group once completed.
Missed diagnoses were discussed in regular discrepancy meetings which were held monthly. Discrepancy meetings reviewed reports and scrutinised these for missed diagnosis on the reporting of images. Discrepancies are a recognised risk within imaging services however lessons should be learnt to minimise these. The service audited in 2018, their compliance with national guidance: RCR Standards for learning from discrepancy meetings (2016), which included seven standards. The service was compliant with five standards in accordance with the audit they shared with us following the inspection. The audit identified the service was not compliant with standard 6 as the facilitator (known as the convener) did not produce a formal bi-monthly report documenting key learning and action points (standard six 6). We requested the latest formal discrepancy report in line with RCR standards, but this was not produced and demonstrated the service did not always implement actions to improve compliance with national standards.

The discrepancy meeting was chaired by the clinical governance lead, this was a vacant position at the time of our inspection. In their absence, the meetings were chaired by a consultant radiologist. There were some processes for double reporting (images being reported by two) for registrar radiographers, but because of lack of consultant radiologists this was not carried out as often as they would like to. However, there were no formal processes or strategy for double reporting of radiologist reports to ensure the quality of reporting and to learn from discrepancies. This was because the service did not have enough radiologists to facilitate this.

Time critical scans were carried out in line with national guidance for stroke. We reviewed compliance with national guidance: Royal College of Physicians: National clinical guidelines for stroke (2016). Standard 3.4.1 recommends patients with suspected acute stroke should receive brain imaging urgently and at most within one hour of arrival at hospital. The Sentinel Stroke National Audit Programme (SSNAP, October 2018) demonstrated the trust received the top score (A) for domain one, meaning suspected stroke patients received brain imaging within one hour.

The trust did not maintain accreditation by the Imaging Services Accreditation (ISAS), which has been changed to Quality Standards for Imaging (QSI), 2019 accredited by the United Kingdom Accreditation Service. The last assessment by accreditation assessors was undertaken in June 2018 where the trust failed to maintain its accreditation status. The trust was issued with a report which included a range of mandatory findings which had to be addressed before accreditation could be considered. At the time of our inspection, there were no plans for a re-visit by accreditation assessors to regain accreditation. This was because other issues such as staffing levels and those raised in our last inspection had taken priority above seeking re-accreditation.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance. However, chaperone training was not offered to imaging care assistants.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had the opportunity to discuss training needs with their line managers and were supported to develop their skills and knowledge. They told us of support provided by the trust to gain additional skills required for their role. Imaging care assistants were supported to attend and complete additional competencies for their role and some radiographers had received support to complete post graduate training courses to further extend their knowledge. However, some staff explained it was difficult to get the practice hours to complete their competencies such as radiographer reporting competencies. Imaging care assistants did not receive additional training in
the chaperone role, despite assisting registered practitioners with intimate medical imaging procedures.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with newly qualified radiographers who felt welcome into the teams and had been given a comprehensive induction programme.

Appraisal rates

From 16 May 2018 to 15 May 2019, 87.9% of required staff in diagnostic imaging received an appraisal compared to the trust target of 95%.

Following the inspection, we asked for up-to-date appraisal compliance across all staff groups and in all modalities in the diagnostic imaging service. As of 1 August 2019, the overall compliance rate was 93.9%. Compliance varied between 84% (MRI) and 100% for staff working in CT.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>16 May 2018 to 15 May 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>73</td>
<td>79</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>93</td>
<td>102</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>118</td>
<td>137</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>108</td>
<td>128</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>415</strong></td>
<td><strong>472</strong></td>
</tr>
</tbody>
</table>

The completion rates should be interpreted with care as the low numbers of staff will have impacted on the rates.

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

Managers supported radiographers to develop through regular, constructive clinical supervision of their work but this was often difficult due to staff shortages. However, cardiac consultants were present to provide support and supervision for staff carrying out complex cardiac scans to ensure these captured the required anatomy/physiology.

There were clinical educators to support staff learning and development. However, they were not given enough non-clinical time to review competencies and support staff to complete these.

All staff attended regular continuous medical education days (CME) which were held one morning every month. The CME sessions provided an opportunity for staff to attend additional training and updates. Staff spoke about the last CME day, which was held 16 August 2019, and provided additional training and information about how to support patients living with autism. Staff working in the MRI departments also used CME meetings for evacuation training of patients from MRI scanners. Staff valued these CME days and the additional opportunities for training.
Some staff felt they were asked to carry out tasks they did not feel competent to do. This was because of staff shortages which meant they were pressured to undertake these tasks. However, other staff felt they used to feel pressured but now would decline to undertake roles they were not competent or had not been signed off to carry out.

The trust supported staff to receive specialist training for their role. The trust had supported two radiographers to extend their scope of practice as advanced radiographers. A further two radiographers we spoke with were supported to study for their master’s degree in their field of expertise. However, some staff felt there was little recognition of their achievements and limited scope for career progression.

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Patients could see all the health professionals involved in their care at one-stop clinics. For example, the service provided one stop clinics for patients with musculoskeletal complaints. Patients were assessed, received diagnostic imaging and then saw a consultant for their ongoing treatment plan all within one trip to the hospital.

Staff worked across health care disciplines and with other agencies when required to care for patients. Referrals from the emergency department or inpatient wards were ‘vetted’ by a radiologist to ensure scans were carried out in a timely manner. A duty floor radiologist graded referrals to be urgent, ‘today’ or routine and checked if patients had previously had a scan to ensure they were not unnecessarily exposed to additional radiation.

Paediatric radiologists worked with staff across the Peninsular to provide imaging of children with non-accidental injuries. There were processes and competency frameworks for radiographers who assisted with this work. Records were kept securely in locked cupboards with restricted access only.

There were processes to share outcomes of patients’ diagnostic screening procedures with their GP. If urgent feedback to GPs was required, medical secretaries would request a call back from the GP which would receive verbal feedback from the duty floor radiologist.

**Seven-day services**

Key services were available seven days a week to support timely inpatient care. However, staff shortages impacted on the capacity to deliver full seven-day services. The trust was compliant with the national priority standard five (NHS England 2017). Inpatients could access scheduled lists in X-ray, CT, MRI and ultrasound although these services were not running at full capacity. Scans were available 24/7 for patients with critical and urgent needs.

Staff shortages impacted on the services’ capacity to deliver full seven-day services. Consultant radiologists were not a full establishment and felt a further 13 consultant roles would be needed to deliver full seven-day services. Some staff were concerned seven-day working would be brought in although they did not have the staffing to cover this.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff confirmed with patients their understanding of the imaging procedure they were attending for. Staff explained what to expect, possible risks and obtained verbal consent. When patients attended for some interventional radiology procedures, written consent was obtained in line with trust processes. There was a trust policy: Consent to examination or treatment policy (2016) which provided information and guidance to staff about definitions and roles of responsibility.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. When patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions. Staff we asked, were confident in discussing patient’s right to refuse diagnostic imaging procedures. Staff understood Gillick Competence and supported children who wished to make decisions about their treatment.

Mental Capacity Act and Deprivation of Liberty training completion

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of mandatory training and regular updates.

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

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All relevant clinical staff had access to an electronic patient records system that they could all update.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness but did not always keep patient care and treatment confidential.

Staff introduced themselves to patients attending for imaging procedures. Staff made sure patients were introduced to all staff present when they entered imaging procedure rooms, and this included introducing CQC inspectors. Staff explained the roles of each person present in line with national guidance (National Institute for Care and Health Excellence: QS 15, 2019).

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were courteous and professional when interacting with patients. Some patients told us “all staff were wonderful” and “staff were professional and made them feel completely relaxed and well looked after”.

Patients said staff treated them well and with kindness. Patients told us care was “as good as it could be” given the relative short time staff spent with patients. Patients also confirmed all staff
introduced themselves when they first met them. One patient told us the “porters are pleasant …they have a conversation with you”.

Patient feedback through the NHS friends and family test scored 94% for satisfaction of treatment and care provided in the diagnostic imaging services. This was based on 623 responses between 1 September 2018 and 22 August 2019.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There was information displayed encouraging patients to ask for a chaperone if they wished to do so. If a chaperone was requested, staff made sure as far as possible that this was a chaperone of the same gender as the patient wherever possible.

Staff responded to patients who felt anxious about their procedure. We saw example of how staff made patients feel at ease and used appropriate humour to distract patients. Staff were engaged with patients during the imaging procedures and thereby monitored patients’ anxiety levels throughout.

Staff did not always keep patient care and treatment confidential. In the ultrasound department, we observed inpatients waiting for their scan. The ‘holding areas’ were small and meant one of the bed spaces was very close to the desk staff used to access information on a computer. We overheard staff on one occasion, discuss confidential information about patients, talking across patients waiting for their scan.

**Emotional support**

*Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.*

Staff gave patients emotional support and advice when they needed it. They spoke with patients in a kind manner to distract them from possible pain or distress during interventional procedures. Staff understood the possible distressing claustrophobic feelings scanning equipment could have on patients. They provided information such as how long the scanning intervals would last through intercom systems and offered to play music to patients through earphones.

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

*Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.*

Staff made sure patients and those close to them understood their care and treatment. They provided clear explanations of the imaging procedure patients were having and took time to answer questions. Staff confirmed with patients they were aware of the noise levels they would experience during MRI scans.

Staff gave patients clear instructions about when and how to obtain feedback about the results of their imaging procedure. We heard staff explain to patients their imaging results would be sent to their GP and they should make an appointment with their GP to discuss the imaging results.

Staff spoke with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were alerted to communication need through the electronic patient record system where these were flagged by the bookings team and knew how to access interpreters if this was required.
Service delivery to meet the needs of local people

The needs of local people were not always met. Some patients had to wait longer than intended to receive diagnostic imaging procedures. The service worked with others in the wider system and local organisations to plan care. Some routine scanning procedures had been outsourced so complex and medical imaging procedures for inpatients could be managed mostly in a timely manner.

Managers planned and organised services, so they met the changing needs of the local population as far as possible, but demand was increasing which impacted on the services capacity to meet this. Patients told us they were having their scan “faster than expected” and it had been a “speedy” process, with routine appointments offered within two weeks of referral.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. The service provided ‘one stop clinics’ for example patients presenting with musculoskeletal complaints.

Facilities and premises were not always appropriate for the services being delivered. The increased demand meant the services had ‘outgrown’ their physical departments. Staff in nuclear medicine were working with the trust on plans to expand facilities although the department would remain in the same place. This was because of recent investment in a nuclear radiopharmacy which was highly specialised. We discussed this with service line managers who shared plans for capital investment and projects to improve and develop services to meet increasing demand.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients attending for x-ray were not given specific appointments but could turn up at any time when the x-ray department was open. This meant it was difficult to predict required staffing levels, and to manage waiting times on the day, as there could be sudden surges in attendance at different times during the day.

Staff made sure patients living with learning disabilities or dementia, children or any other person, received the necessary care to meet all their needs. There was a scanner model which staff could use to help people become familiar with CT or MRI scanners. Patients could be booked in for twice weekly ‘patient experience’ sessions.

Staff had access to communication aids to help patients become partners in their care and treatment. The imaging departments had made some adjustments to meet the needs of patients living with dementia and other healthcare or communication needs. For example, all patient toilets had large signs on the door with a picture and text to signpost patients to the facilities.

Staff enabled parents to be with their child during different imaging procedures providing it was safe for them to do so. Staff carried out risk assessments of parents or carers wishing to be present in the MRI scanner room during the planned scans. Following the scan, children received a certificate or special sticker for being brave during the imaging procedure. In X-ray West there was a designated x-ray room used for children and a separate waiting area away from other
waiting areas. There were toys for children and posters displayed that were suitable for children. There was a paediatric imaging radiographer lead who had recently been appointed. They had plans for how the experience for children could be improved but was lacking time to carry out the additional tasks needed to implement the action plan.

There was a facility on level 12 where a play area had been set up to enable children to become familiar with the MRI and CT scanners before their appointment. Staff in the MRI department spoke of referring children to the model MRI scanner based on level 12 in the children’s department. The model scanner was made of wipe-clean soft play equipment. It provided a space for children to practice laying still whilst in an enclosed environment like an MRI scanner. Specialist play therapists described using an electronic tablet to play the noise of an MRI scanner whilst the children would lay in the MRI model, making it as realistic as possible. Parents were able to self-refer to the model MRI scanner and familiarise their child with the MRI process. Staff explained how the model would help assess whether a child required a general anaesthetic or sedation to perform the scan. We also saw a head cage for children expecting a head MRI, although in places the model was very worn, and the fabric needed renewing. We saw miniature handheld MRI and CT scan models. Staff described how children engaged well with these models and afterwards found the scanning process to be less frightening.

There were processes to identify, flag up and make reasonable adjustments to meet specific needs of patients. During the booking process, staff asked patients for information about their communication needs. This included if an interpreter was required and other specific needs such as people living with a learning disability or dementia. Information was recorded on the electronic patient records system and flagged up to radiographers who would be carrying out the imaging procedures. Hospital records for patients living with dementia were also marked with a ‘forget-me-not’ symbol, which highlighted the patient’s dementia diagnosis to other healthcare professionals.

Waiting rooms were tidy with enough chairs for outpatients to sit while they were waiting for x-rays in X-ray West. The fabric of the chairs was wipeable in line with national recommendations. In some waiting areas there was access to water and or vending machines for refreshments. There were suitable magazines available for patients to read while they were waiting. In the children’s waiting area, there were toys and child friendly pictures painted on the walls. However, in the waiting area for ultrasound there was no separation of children and adults. There was information available and posters to display imaging related information. However, there was no display of how long patients had to wait or if appointments had been delayed.

Staff did not provide dignity shorts for all patients attending for imaging/scanning procedures which required the application of medical gas into their back passage. We observed one patient who had not been given the opportunity to change into a hospital gown and use dignity shorts but was asked to pull down their trousers.

**Access and flow**

**People could not always access the service when they needed it to receive the right care promptly.**

Managers monitored waiting times and worked hard to enable patients to access services when needed and received treatment within agreed timeframes and national targets. Most referrals were electronic referrals which were vetted by consultant radiologists. Patients could be referred by their GP, from outpatient clinics or from medical staff working on the inpatient wards. There was a bookings team who coordinated all referrals.
Inpatients did not always receive diagnostic imaging in a timely manner. Staff told us the inpatient x-ray facility was sometimes closed during the daytime due to staff shortages. This meant inpatients were attending the department out of hours, but staff could not keep up with the demand as this happened on a regular basis and staffing levels were reduced out of hours with no outpatient facilities open to scans. X-ray East (inpatient x-ray department) was closed during our inspection on Wednesday 21 August 2019 due to staff shortages. On Thursday 22 August 2019 the department had reopened. When we visited this in the morning, there were 60 inpatients awaiting imaging of which nine were ‘discharge dependent’. Staff told us the number of waiting patients would increase after 3pm as new referrals would come in following ward rounds. However, senior leaders informed us a rota coordinator had been employed to oversee planning of staff rotas and hoped this would have a positive impact to avoid closure of the inpatient x-ray department. They were due to start 2 September 2019.

Managers monitored waiting times and had made improvements to enable patients to access services when needed and most patients received treatment within agreed timeframes and national targets.

**National two-week cancer target performance:**

The service did not meet its internal two-week cancer target performance but there was improvement across all modalities. However, data demonstrated almost all patients received their scan within two weeks of referral. Managers and staff were proactive to understand why targets were not met and took action to improve services.

Following our last inspections of diagnostic imaging in August and December 2018, we issued Warning Notices to the trust as the two-week cancer wait target was not met. The service took action to improve compliance with the national target and had employed a coordinator who was responsible for reviewing and booking patients in for scans within the national target. The trust had set an internal target (85%) of diagnostic imaging procedures to be carried out within 7-10 days (depending on the scan) to help ensure the trust met the two-week cancer wait target. The trust also reported a 16% increase in referrals on the two-week wait cancer pathway. During this inspection, we found an improvement across all modalities.

For example, results for the week commencing 29 July 2019 reported:

- CT (seven day internal target): 84%
- Colon CT (ten day internal target): 57%
- Ultrasound (nine day internal target): 90%
- MRI (seven day internal target): 70%

Results from the week commencing 5 August 2019 reported:

- CT scans: 80%
- Colon CT: 69%
- Ultrasound: 82%
- MRI: 78%

This was an improvement since our last inspection in December 2018, where we found the following compliance: CT 55%, MRI 62% and ultrasound 55%.
Data confirmed compliance between 86.5% and 96.7% of patients referred on an urgent two-week cancer pathway, received their scan within 14 days across all four modalities between April and August 2019. Trust data demonstrated the hospital mostly met national operational standards for all two-week cancer pathways from April to August 2019 with between 92% (April 2019) and 94.9% (national standard 93%) of patients referred seen by a specialist within two weeks of referral.

The service had found it challenging to improve the compliance rate for colon CT scans. The service had mapped out the patient pathway for colon CT as this scan had the lowest compliance rate against national targets. The mapping process looked at each stage of the patient pathway to identify the reasons why the national target was not met. One of the main issues was ensuring patients had the right medicines to clear the bowel to prepare for their scan. Identified issues included incomplete prescription – particularly if this was issued by the referring GP, and incorrect dispensing. To improve this, further information had been shared with referring GPs, and medicines were delivered to patients’ home addresses to reduce the risk of patients not getting the medicines in a timely manner. However, most patients were referred from outpatient appointments where they would be given the medicine before they left their appointment.

**Diagnostic six week waiting lists:**

**The service did not meet the six-week national standard for diagnostic tests although there was some improvement.** In June 2019, 10,114 patients were waiting for a diagnostic test within six weeks of referral. Of these, 1,464 patients (14.5%) had waited for more than six weeks. The three modalities who had the most patients waiting was CT (629), MRI (242) and ultrasound (428). Actions taken by the trust to improve compliance included acquisition of an additional MRI scanner, outsourcing of reporting to free up radiologists, and a continuation of staff recruitment.

The service was working with NHS Improvement to improve performance and meet the trajectory (target for agreed performance) for six week waits. There had been some improvement in performance to meet the improvement plan. However, due to staff shortages, the ultrasound service did not meet its trajectories, and there was a plan to outsource a proportion of scans to meet the trajectory agreed.

Performance for six week waits at the end of July 2019 was reported as below:

- In CT there were 451 breaches which was performing better than the trajectory of 550 breaches.
- In MRI there were 109 breaches which was performing slightly better than the trajectory of 114 breaches.
- In ultrasound there were 717 breaches which was performing worse against a trajectory of 590 breaches.

Between 01 May 2018 and 30 April 2019, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows 6+ weeks percentages over time.
Did not attend rate

The service had introduced a pink notice which was sent out with all appointments, urging patients to contact the hospital (details provided) to reduce the number of missed diagnostic procedures. The notice included information about how much a missed appointment would cost the NHS.

The service routinely monitored how well the equipment and imaging rooms were utilised to meet the demand of imaging services. Data was collected weekly and demonstrated utilisation of rooms and equipment across different modalities. For example, MRI utilisation was 61% to 72% between 29 April and 19 August 2019. Utilisation of ultrasound was the most challenging and demonstrated 35% to 42% utilisation in the same period. During the inspection, we noted the imaging rooms used for fluoroscopy did not have scheduled lists morning and afternoon each day during the week of our inspection. Room 15 was used for injection of muscular skeletal complaints under imaging but did not have scheduled lists on one morning and three afternoons of our three day inspection. We asked to review the waiting list for patients waiting for symptomatic treatment of their conditions and noted there were 311 patients waiting some of whom had been waiting since May 2019. Modality leads, and senior leaders said this was a project in progress. We discussed this with senior managers who confirmed this was an ongoing project and they were working towards 85% utilisation across modalities. However, this would be challenging due to poor staffing levels and capacity to staff different imaging procedures safely to achieve 85% utilisation.

There were not enough consultants to report on images to meet demand. An audit submitted to us prior to the inspection showed the percentages of reporting within the target reporting time frame: The time frame for reporting varied from time critical (within one hour) to routine imaging which had a target reporting time of 14 days.

- Compliance varied between inpatient plain x-ray (20.6% reported within 48 hours),
- Plain x-ray for the emergency department (26.3% reported within one hour) and
- Routine imaging reported across all modalities within 14 days (93.7%).
- Time critical reporting within one hour was achieved in 65.7% (CT of the chest) and 73.5% for patients presenting to the emergency department with a possible stroke.

In CT, three patients were scheduled for a CT scan each hour and a list or a session lasted four hours. This usually created between 12 and 15 CT scans to be reported on by radiologists.
Because there were not enough radiologists to report on scans, this led to a backlog of reporting of scans. At the time of our inspection, the backlog of reporting of CT scans was approximately 500 scans. We discussed this with senior managers who told us work was in progress to outsource reporting for modalities where the reporting led to backlogs. The service already outsourced some reporting of scans, but this was not sufficient to meet demand. Meetings were scheduled for August 2019 to agree outsourcing contracts with a view to implement these as soon as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. However, lessons learned were not shared effectively with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified learning or service improvements to ensure a similar episode of care did not occur again. We reviewed two examples of complaint responses sent to patients and/or their next of kin. These demonstrated learning from the feedback was identified and actions planned to improve services. However, staff were unable to give examples of feedback from other modalities.

Summary of complaints

From June 2018 to May 2019, the trust received 26 complaints in relation to diagnostic imaging at the trust (3.7% of total complaints received by the trust). The trust took an average of 23.5 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be closed within 40 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments</td>
<td>8</td>
<td>30.8%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>8</td>
<td>30.8%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>7.7%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>2</td>
<td>7.7%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>3.9%</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>3.9%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>26</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From January to December 2018 there were three compliments received for diagnostic imaging at the trust (1.3% of all received trust wide).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Leaders mostly had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, senior staff did not have protected time to carry out management duties.

The trusts leaderships structure consisted of four care groups: medicine, surgery, women’s and children’s, and clinical support services. The senior leadership structure of diagnostic imaging services had been reviewed and changed since our last inspection in August 2018. The care group director post had been created following our last inspection to help the service develop and to raise the status of the department across the trust’s executive leadership group.

Leaders understood the challenges to quality and sustainability and identified the actions needed to address them. The diagnostic imaging service was within the clinical support services care group. The care group had its own leadership team which included; a services manager, principle radiographer and initially their own care group director, who reported to the care group management team.

We met with the executive leaders to discuss how the trust had supported the diagnostic imaging service since the last inspection. Several actions had been taken at trust level to support the service to improve. This included:

- Appointment of a care group manager for diagnostic imaging.
- Appointment of a band seven to manage equipment safety.
- Development of the Imaging Board which all other diagnostic imaging groups fed into.
- A business plan for the procurement of new equipment and a service development plan to improve the environment.
- Considerable investment plans into the service.
- Open approval to recruit new staff.
- Enhanced visibility of diagnostic imaging at board level.

There were unfilled vacancies in middle management positions. There was no clinical lead at the time of our inspection. This position had been vacant since June 2019 and medical staff were beginning to feel the effects of the lack of clinical leadership across all departments. The service manager was on long term sick leave which meant the deputy service manager was acting up as well as carrying out their own roles and responsibilities. Following the inspection, we spoke with the care group director, who described additional changes to the service leadership. This included additional responsibilities for the clinical governance lead and the manager for equipment. These additional responsibilities had been created to allow more senior leaders to drive strategic service improvement projects and was due to be implemented during September and October 2019.

There was a lack of leaders with knowledge and experience in some modalities to lead teams efficiently. There was no senior clinical lead to provider leadership for medical staff and governance issues. There was no band eight modality lead in MRI to provide overall oversight and
responsibility for ongoing sustainability and planning of the service. Their responsibilities had been disseminated to band seven practitioners who were all relatively new in their roles.

There was one supervisor to supervise imaging care assistants (ICAs) but they were not given enough support in doing so. The number of ICAs was increasing and with the latest recruitments one person would be responsible for managing 35 people. This included supervision of new skills, induction and appraisals. The ICA’s repeatedly told us the supervisor was doing a good job but needed more support as they were also rostered into clinical working rotas.

Executive leaders were not visible in the department. Some staff told us they were not aware of who the trust senior management team were as they had never visited their departments. This was also the case for executive leaders. Many staff we spoke with felt the diagnostics department was ‘forgotten’ and not seen as priority in the wider hospital community. There was a matron who covered the operating theatres, outpatients and diagnostic imaging. Staff did not often see the matron in the department and described them as being “a very busy person” as they were covering three busy areas.

Some staff did not feel there was sufficient feedback from senior leaders’ meetings and did not feel well informed of plans for the service. We discussed this with some senior leaders who told us the service used to have a newsletter which helped to keep staff updated.

Vision and strategy

There was no overall vision and strategy for the development of diagnostic services. However, there was a clear equipment and workforce strategy to help improve the service. Executive leaders explained how they had focussed improvements on the areas of concern which were identified in the Warning Notices following the last inspections.

Not all staff felt well informed of the plans for the service. Staff told us they knew money had been allocated to make improvements, but they were not aware of plans of how to spend the money. Staff generally felt they were not consulted when plans were made for improvement projects. For example, the redevelopment of the emergency department and the impact this would have on x-ray services provided in this department. However, staff working in CT felt they were kept informed of projects and how this would improve their service. In the ultrasound department we saw written information “our strategic directions #1bigteam” available for staff to read.

Culture

The culture and morale among staff were slowly improving. However, staff did not always feel supported, respected and valued. Some diagnostic imaging leaders did not feel the service was valued and supported by the trust. Some staff felt they were not valued for the roles they carried out.

Senior diagnostic leaders expressed concerns about what they described as an acute on chronic situation regarding lack of staff, increased demand and ageing equipment. They felt there was little support from the trust executive level in what they described as a crisis. Staff at all levels stated many actions were reactive rather than proactive, meaning little planning went into managing the department and there was limited forward planning. They described managing the service was ‘ad hoc and an unstructured response to demand’ and saw resilience of the service to be at a low point. Staff felt with more planning, demand and capacity could be managed better rather than
same day closure of for example a scanner due to staff shortages. Consultant radiologists were concerned about lack of succession planning to ensure a sustainable service in the future.

The culture encouraged openness and honesty at all levels. Staff at all levels spoke of a slowly improving culture within the service and all staff felt able to speak up about concerns they may have. However, some staff told us although they felt able to speak up without fear of retribution, they did not always feel their concerns were listened to. Not all staff were aware of who the freedom to speak up guardians were although staff told us they would be able to find out if they needed to.

**The culture of the service was centred on the needs and experience of patients.**

Staff felt positive about their work. Staff spoke of their compassion for patients and that patients were at the centre of their role and the services they provided. Staff received positive feedback from many patients, but they were not assured this was passed on to management. Some staff felt the imaging department was forgotten and not seen as a priority in the wider hospital context. In an NHS staff survey (2018), 73.4% stated they were enthusiastic about their job which was above the trust’s average. This information was collated from all staff working in the clinical support services care group and not specific to the imaging department.

There were cooperative, supportive and appreciative relationships among staff. Staff spoke of good teamwork where teams worked hard and well together. Some staff described colleagues as “a good bunch of people”. Some staff in MRI stated” morale was pretty good” and it was an “open team”. In CT, staff told us they were more engaged and there were improved career progression opportunities for staff across all modalities.

Consultant radiologists felt they had pulled together as teams to prevent the service from falling over. They were confident patient safety and care had not been compromised but the service was not sustainable for the future with the investment and staffing shortages they had experienced.

All senior clinical staff (band seven and eights) we spoke with stated they had “fantastic teams” and that all staff were hard working and committed to patient care and their jobs. However, some staff told us they did not have regular team meetings so felt less aware of issues affecting their department.

Student radiographers and return to practice radiographers we met had only recently started their placement. They felt welcome and were positive about their placement.

Imaging care assistants were positive about their work and their roles to support patients. The ICAs stated they felt respected and valued by the radiographer colleagues and some ICAs described their department as “a lovely place to work”.

**Governance**

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. However, meetings were not always well attended, and staff did not always get feedback from audits and incidents to enable improvements.

There were effective structures, processes and systems of accountability to support the delivery of good quality services. However, vacancies at middle management level impacted on leadership and governance. The service had a governance structure to clearly demonstrate the communication pathway from modalities to board and vice versa. However, at the time of our inspection, the service had not had a clinical governance lead in post since June 2019. This had an impact on leadership and governance of the service. The service had set up specialist interest
groups (SIG) for each modality which fed into an imaging clinical governance meeting – this meeting was chaired by the clinical governance lead. The imaging clinical governance meeting fed into an imaging board and a care group governance meeting, chaired by the care group manager.

Imaging clinical governance meetings were not always held monthly as intended. We reviewed minutes of the last two imaging clinical governance meeting held 30 May and 25 July 2019. The minutes of the meetings and associated action log held information about escalation of governance or safety issues and approved policies. Lack of key attendances meant the meeting was not always quorate which meant decision could not be made and actioned. This meant decisions and policies were signed off and distributed without the correct governance processes to support this.

There was a quarterly governance report. We reviewed the report covering from April to June 2019. This demonstrated oversight of incidents, audits, risks, patient feedback/complaints, radiation protection, equipment and IT.

The service had a full-time governance lead who attended both the clinical governance meeting and the imaging board. They were working on standardising the terms of reference for the modality SIG groups and the agendas to ensure relevant topics were covered consistently across all modalities. This project was planned to be completed by January 2020.

Each modality held regular modality meetings to discuss issues pertinent to their services. The agendas were not standardised but mostly covered similar issues such as the current challenges including demand and staffing issues. However, the minutes of the meetings did not consistently include any information about learning from incidents, complaints or feedback from patients.

There was a clear structure to review incidents in the service. The governance lead reviewed all recorded incidents daily in line with the trust’s incident management policy. They then allocated incident investigations according to the seriousness of the incident and who would be best placed to investigate the incident. Serious incidents were discussed in the risk and incident team at trust level and presented to the executive review meeting which happened every Monday. The purpose of this was to ensure the incident was correctly graded and to consider duty of candour responsibilities.

We discussed a trend of missed lung pathology on chest x-rays which had raised serious incidents. This had been investigated and a new lung cancer pathway had been rolled out. This included ‘hot’ (immediate reporting) reporting by the chest speciality radiologists and next day appointments were arranged in the outpatient department.

Staff at all levels were clear about their roles and understood to what they were accountable for and to whom. All staff were clear about their roles in delivering high quality care. However, some senior staff were new in their roles and did not have an immediate line manager but reported to the deputy service line manager. We were concerned about how support for the band seven practitioners was met. The band seven radiographers across all modalities did not have enough non-clinical time to undertake additional tasks other than the most necessary tasks to maintain service as best as possible.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
There were systems to monitor performance. There was a programme of clinical and internal audits to monitor quality and operational pressures. Actions were identified, and improvement was checked and monitored in the imaging clinical governance meeting. We reviewed a log/overview of active clinical audits and noted these were audited for compliance with legislation or national standards such as Ionising Radiation (Medical Exposure) Regulations or Royal College of Radiologists (RCR) standards. Each audit had a designated clinical lead and identified key success, areas for concern and key actions to address these. For example, we noted there was a re-audit of ‘actional reporting’. The audit log demonstrated the national RCR standards had been achieved but also identified where further improvements could be made.

Managers shared and made sure staff understood information from audits. We saw examples from audits, where improvements were identified, and actions were implemented.

There were arrangements to identify, record and manage risks. Risks were added to a local risk register specific to each modality. The risk register was reviewed regularly and included a named responsible person and mitigating actions. Risks considered high risks were added to the trust’s corporate risk register.

Risk were reviewed and discussed in clinical governance meetings, the imaging board, the care group governance meetings and the care group board. Staff across all modalities stated staff shortages and ageing equipment were the two biggest challenges for the service. Both of these risks were added to the corporate risk register.

Staff in nuclear medicine identified the impact of Brexit on availability of radiopharmaceuticals. There was a risk some nuclear medicine procedure could be delayed. Staff discussed the actions taken in line with national guidance. This was added to the corporate risk register.

**Information management**

The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards. Information required was available electronically for staff which they could access using password protected access codes. However, some local rules, sequencing protocols and trust policies needed to be reviewed and updated as they had passed their expiry date.

Paper and electronic patient records were managed and stored securely. Staff had access to the trust’s intranet for access to policies, protocols and local rules. Information about patients was stored in electronic patient records used within diagnostic services. Images were uploaded to an electronic archive and communication system which was password protected. This information was accessible to other designated clinicians in the trust and ensured effective sharing of patient information.

Information leaflets for patients were not always reviewed and updated in a timely manner. This was because senior clinical staff did not have enough time to do this. We reviewed online patient leaflets available to the public on the trust’s website. They were easy to find but there were only two leaflets available both of which had passed their review date. When patients left the imaging department, they were sometimes given written instructions and aftercare information. However, these were not always dated, and version controlled, so we were not sure when they had last been reviewed. Senior managers knew they needed to review patient leaflets and update these.
Engagement

Some staff did not feel they were kept informed about plans of how to develop the service. Staff felt engaged but stated there was not enough time to engage properly with service improvement projects. Each modality held staff meetings which were mostly held monthly although sometimes meetings were cancelled. Meetings were minuted and although not following a standardised format, the minutes of meeting showed issues such as performance, quality audits and education opportunities were discussed in most modalities. Each modality had a rolling action plan which demonstrated actions required, who was the lead, target date and evidence action plans were reviewed regularly, However, learning from incidents and complaints were not included in any of meeting minutes we reviewed.

The service had recently introduced specialist interest groups (SIG) in each modality. The SIG was a forum where nurses, radiologists and radiographers met monthly to review polices, local rules and patient information leaflets and appointment letters. Clinical leads felt this had a positive impact on morale in the department as staff felt empowered to influence change.

Staff involved with service improvement projects felt positive about their contribution to developing the service. However, staff said they did not have enough time to do as much as they would like to do, to improve their services. In an NHS staff survey (2018), 78.5% (above trust average) stated they were able to make suggestions to improve the work of their team and/or department. In the same survey, only 41.9% felt they were able to meet all the conflicting demands on their time at work which was similar to the trust’s average. This information was collated from all staff working in the clinical support services care group and not specific to the imaging department.

Learning, continuous improvement and innovation

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The CT department had a service improvement project wall which demonstrated a project concentrating on improving utilisation of one inpatient scanner to 85% and improve how quickly inpatients would receive a CT scan. The starting position was that 45% of inpatients waited more than 24 hours for a CT scan. It was an eight-step process and included daily huddles each morning and at 4.30pm. The service aimed to identify 'early bird patients' who would be scheduled for CT scan at 8.45am, 9am and 9.15am the following day. Progress was evaluated each week, and this was shared with the care group manager and the executive team by weekly ‘board/wall rounds’ which included an update on each service improvement project in different care groups across the trust. This meant there was regular contact from the department to the executive team if authorisations were required for any new actions. Results demonstrated improved utilisation of nearing the 85% target. The service was committed to a service improvement agenda and was planning to recruit a band seven service improvement lead which had been authorised by the trust. The project was described as a “bottom up” project, meaning it was staff working in the CT scanning department for inpatient who were driving the improvements through identifying where improvements could be made and engaged with the implementation of action plans.