Torbay and South Devon NHS Foundation Trust

Inspection report

Torbay Hospital
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Ratings

Overall trust quality rating	**Requires Improvement**
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Torbay and South Devon NHS Foundation Trust was created on 1 October 2015 bringing together adult social care, community and acute services. This brought together South Devon Healthcare NHS Foundation Trust, which ran Torbay Hospital, with Torbay and Southern Devon Health and Care NHS Trust, who provided community health and adult social care services.

The trust covers a wide geographical area including parts of Dartmoor along with Torbay and the South Devon areas around Totnes and Dartmouth. The trust delivers care in people's homes and across more than 15 sites. The trust's purpose is to support the people of Torbay and South Devon to live well. The local population has a significant level of health inequality and high levels of deprivation, with Torbay being the most highly deprived community in the South West. This includes many children who start their lives at a disadvantage, with high numbers of looked after children and children with protection arrangements. There are some of the highest rates of self-harm and suicide in the country. There is a larger proportion of older people than the national average.

The trust has more than 6,500 staff with an additional 534 people on bank only contracts and more than 400 volunteers.

The trust receives most income from NHS Devon commissioners, with the responsibility for the adult social care budget delegated via Torbay Unitary Council. There is a memorandum of understanding with Devon County Council to run social care services in a joined-up way. The trust is the lead provider for the Children and Family Health Devon service, in April 2019 the alliance of NHS providers was awarded the contract to provide community health services for children and young people across Devon and Torbay.

We carried out a short notice announced focused inspection of medical care, outpatients, and the emergency department on the 24 and 25 May 2023.

We inspected medical care based on concerns and information we had received around stroke performance, staffing, referral to treatment times and cancer performance.

Our findings

We inspected outpatients because of waiting times and waiting list management plus the associated risk of oversight and management of these lists.

We inspected the emergency department because of ongoing delays in ambulance handovers and emergency department waiting times. Additionally, the trust performance against the 4-hours standard continued to be challenged.

We carried out a short notice announced comprehensive inspection for the diagnostic and imaging service on 21 and 22 June 2023. We did this because we had not previously inspected or rated diagnostic imaging as a stand-alone service at this location.

We completed the well led inspection on 12 and 13 July 2023. We did this because we had not inspected well led since 2018 and there had been numerous changes in organisational structure and leadership since our last inspection.

Our ratings for the core service inspections:

Our core service inspections were based at Torbay Hospital, we did not visit other sites as part of this inspection although relevant trust wide information was used where appropriate to the services inspected.

For Diagnostic Imaging we rated the service overall as requires improvement. We rated safe and well led as requires improvement and we rated caring and responsive as good. We inspected but did not rate the key question of effective which was in line with our current methodology.

For Urgent and Emergency Care the rating remains as requires improvement. We rated safe as requires improvement which is an improvement from July 2020 when we rated it as inadequate. We had enough evidence to re-rate well led which improved and was now rated as good. According to our methodology the key questions of effective, caring, and responsive were 'inspected not rated' due to using the focused inspection methodology. Therefore, the July 2020 ratings remain of requires improvement in effective and responsive, and good for caring.

For Medical Care the rating remains as requires improvement. We rated safe and effective as requires improvement, this is the same rating as in July 2020. According to our methodology the key questions of responsive and well led were 'inspected not rated' due to using the focused inspection methodology. We did not inspect caring during this inspection. Therefore, the July 2020 ratings remain of requires improvement in effective and well led, and good in caring and responsive.

For Outpatients the rating went down to requires improvement, it was previously rated good in May 2018. We had sufficient evidence to re-rate safe and responsive, safe went down to inadequate and responsive went down to requires improvement. According to our methodology the key questions of caring and well led were 'inspected not rated' due to using the focused inspection methodology and therefore both remained as rated good. We did not inspect effective.

Our rating of the trust wide well led:

The well led inspection was trust wide and we spoke with groups of people from services we did not cover in the core service inspection.

Our findings

We rated the trust well led as requires improvement. We had not rated the trust well led since 2018 when it was rated as good, our planned inspection of well led in 2020 was cancelled due to the Covid-19 pandemic. Use of Resources was not assessed during this inspection and was last inspected in 2020 and rated requires improvement.

A summary of our findings include:

Trust wide

We rated trust wide well led as requires improvement because:

- The trust and Devon were in NHS system oversight framework segment 4 due to financial performance and delivery against performance targets.
- The trust had a challenging financial position but had a plan to address this.
- There were inequalities among the workforce and staff did not feel they were always treated equitably and shared negative experiences. Sufficient action had not been taken in a timely way to address the issues. There were poor results and outcomes for indicators across surveys, Freedom to Speak Up concerns and national workforce data sets, as well as in first hand experiences of staff who spoke with us. There was no equality, diversity and inclusion strategy at the time of the inspection, this was approved by the trust board in July 2023, and the resource available for the work was insufficient for the scale of the work needed. The equality business forum did not operate effectively and staff networks required further development and support.
- The IT infrastructure was outdated and provided barriers to sharing information and impacted on the confidence in the quality of data when pulling from lots of sources.
- Risk and governance discussions felt heavily acute focused rather than community and adult social care.
- Some staff felt depths of issues were not well understood by leaders or action taken in a timely manner to rectify or resolve issues and some board executives were not sufficiently aware of some of the key safety issues for clinical services at risk.
- Staff views and concerns were encouraged, but they were not always heard and acted on, staff were not consistently told about action taken to improve processes.

However:

- Leaders had the experiences, capacity, capability, and integrity to ensure the trust strategy could be delivered and risks to performance addressed.
- There was a clear statement of vision and values, driven by quality and sustainability. There was a realistic strategy with well-defined objectives and a focus on system-based working. These were developed in collaboration with people who use the service, staff, and external partners. The strategy was aligned to local plans in the wider health and social care economy.
- The governance and performance management had recently been reviewed and restructured to be strengthened. The new processes were clearly set out but were embedding across the organisation and staff were understanding where roles and responsibilities may have changed.

Our findings

- Safety remained a priority in the organisation and leaders aimed to achieve a balance between finance and quality. There were processes to identify, understand, monitor and address current and future risk. Performance issues were escalated to the appropriate committees and the board through clear structures and processes. There were processes for clinical and internal audit.
- The trust engaged with relevant stakeholders to build a shared understanding of challenges to the system and understood the needs of the population and engaged with patients, families and service users to gather feedback.
- There was a focus on continuous learning and improvement, including appropriate use of external accreditation and participation in research. There had been significant investment in quality improvement, but this was not yet fully embedded across the organisation and staff found it difficult to have time to engage in quality improvement work. Internal and external reviews were used to identify learning and make improvements.

Diagnostic Imaging

We rated diagnostic imaging as requires improvement because:

- Not all relevant safety checks were being completed. Staff did not always document pregnancy checks for all eligible patients and staff did not always perform patient identification checks, both in line with IR(ME)R 2017. Checks to ensure the correct patient received the correct scan were not always effective and previous images and information were not always reviewed by staff when vetting imaging requests.
- Medicines management was not always well managed. There was no Patient Group Direction (PGD) to support radiographers to administer saline. There were no records to show temperature checks of stored contrast media. Patients who received medicines as part of their test in nuclear medicine did have these prescribed in line with legislation.
- Areas were not always designed to meet people's needs. There were no dedicated waiting areas for children and CT scanners area did not have dedicated changing rooms.
- Governance and processes were not always clear, embedded or effective. There was no reject analysis audit programme. Standard scanning protocols used in MRI were not written down. There was no recorded process to show what non urgent routine CT and MRI scans could be vetted by non-medical staff. Some radiation risk assessments were out of date and needed reviewing. Some MRI equipment was not labelled as safe to enter the scan room.
- We found staff were not always up to date with manual handling and information governance training. Hand hygiene audits were not consistently carried out and some areas visited had no cleaning records. Information about chaperone availability was not on display in some patient areas.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs.

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services using information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services continually.

Medical Care

We rated medical care as requires improvement because:

- Mental capacity assessments were not always completed fully or contained the relevant detail required.
- Outcomes for patients were not always positive and consistent and did not always meet national standards. Patients were not always admitted to a stroke unit within 4 hours and did not always spend 90% of their time on a stroke ward in line with national guidance.
- Staff were not fully compliant in mandatory training and hand hygiene audits identified poor compliance.
- A dysphagia audit identified staff did not always provide patients with food and drinks in accordance with their care plan.
- There was not always enough staff with the right qualifications, skills, training and experience. Staffing numbers did not always meet planned levels and there was not always consultant cover out of hours. There was high use of agency, and we were not assured all agency had a full induction.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- The trust experienced pressures due to bed capacity, availability of onward care and timely discharge.

However:

- Staff understood how to protect patients from abuse, and managed safety well. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff assessed risks to patients and acted on them. They kept good care records in most cases. The service managed safety incidents well and learned lessons from them.
- The service provided care and treatment based on national guidance and evidence-based practice. Patients had enough food and drink to meet their needs and had their pain assessed and managed. It was ensured staff were competent for their roles.
- People could access the service when they needed and received care promptly.
- Leaders had the skills and abilities to run the service and understood and managed the priorities and issues the service faced. Staff felt respected, supported and valued. There were differences in governance processes, but the trust was undergoing a restructure which would help align governance. There were systems to manage performance effectively and identify, escalate and monitor risks.

Urgent and Emergency Care

Our findings

We rated urgent and emergency care as requires improvement because:

- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The design of the environment did not follow national guidance for children. The environment or estate that made up the emergency department was no longer fit for purpose. The area was not always maintained in good state to minimise the risk of cross infection.
- Patient records were not always stored securely. Some of the computer screens were left open by staff and unsupervised with patient records visible. The names and summary of a patient were shown, and we were able to enter and access the detailed records.
- Access and flow for patients remained a huge challenge for patients and staff. People could not always access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Some areas of medicines management were not operating effectively. We identified patient group directions which had passed their review date, expired sterile fluids and oxygen cylinders which were not stored securely and safely.

However:

- Staff had training available in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and managers monitored the effectiveness of the service and made sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Governance processes had improved since our last inspection and were effective in developing the service.

Outpatients

We rated outpatients as requires improvement because:

- Risks to patients on waiting lists were not always identified. Harm had come to patients waiting to be seen in ophthalmology.
- People could not always access the service when they needed it and had long waits for treatment.
- The design of the facilities did not meet the needs of patients. The layout of the department was difficult to navigate for some patients.
- The service used multiple information systems as well paper records to manage appointments which increased the risk of error. This meant there was an over reliance on some staff to ensure patients were notified of their appointments.
- Prescribing documents were not always stored securely and safely.
- Patients' privacy and dignity was not always maintained.

Our findings

- Some areas of training needed to be considered and improved, to include manual handling, learning disability and autism, and mental health awareness.
- There were not always separate or segregated waiting areas for children or a policy to guide staff on these procedures.

However:

- Staff mostly had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients and acted on them.
- Staf treated patients with compassion and kindness and took account of their individual needs.
- Leaders operated effective governance processes and used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Diagnostic imaging:

- The department had developed dedicated training resources for staff involved in non-accidental imaging of children and had worked with a university to offer this training nationally.
- Radiography staff had established a non-medical multidisciplinary team programme which involved other specialities such as physiotherapy.
- The quality assessment manager had developed an inclusive pregnancy check form in line with guidance and has taken this one step further by consulting the trust LGBTQIA+ community for feedback.
- The service had developed training materials and posters to promote and clarify the use of inclusive language throughout the department and across all modalities which was being considered by a professional body for roll out nationally.
- The service utilised dedicated pre assessment clinics for patients attending for interventional procedures which included starting the consent process well in advance of the procedure.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust Wide

Our findings

- They have a stable financial position and systems and processes continue to ensure financial pressures are managed so they do not compromise the quality of care. **Regulation 17(1)(2)(a)**
- There must be an increased focus on equality, diversity and inclusion to address the increase in bullying and harassment across the organisation. The trust must implement their new strategy improve the effectiveness of the equality business forum and staff networks, ensure clear policies and procedures, support reasonable adjustments, and consider the resources to support this work. **Regulation 17(2)(b)**

Diagnostic Imaging

- Make sure all existing and new specialist equipment for use in MRI is clearly labelled as safe to enter the scan room. **Regulation 12(2)(e)**
- Make sure patient identity checks consistently take place. **Regulation 12(2)(a)(b)**
- Make sure all eligible patients have their pregnancy status determined in line with legal requirements. **Regulation 12(2)(a)(b)**
- Ensure previous images and information are reviewed when vetting imaging are requested, to ensure scans are carried out on the intended patients and at the intended time. **Regulation 12(2)(a)(b)**
- Make sure checks to ensure the correct patient receives the correct scan are effective. **Regulation 12(2)(a)(b)**
- Have Patient Group Directions or a scheme of delegation in place for all medicine administered by radiographers in the department and that these are up to date and regularly reviewed. **Regulation 12(2)(g)**
- Make sure processes to monitor and evaluate risk and information are effective and take account of all available information**. Regulation 17(2)(f)**

Urgent and Emergency Care

- Review all areas of the emergency department to maintain them in a good state and minimise the risk of cross infection. Some areas of the emergency department needed repair. The department was too small for its growing needs, and some areas were cramped, crowded with equipment, paperwork, and patients were sometimes too close together. **Regulation 15(1)(e)**
- Review paediatric waiting and treatment areas for children. The department does not meet The Royal College of Paediatric and Child Health Standards for Children in Emergency Care Settings recommendations for emergency departments, including waiting and treatment areas and those for families in a crisis. **Regulation 15(1)(e)**

Medical Care

- Ensure Mental Capacity assessments are completed fully and contain relevant detail. **Regulation 13(2)(5)**
- Ensure care and treatment provided to stroke patients meets national standards and guidelines. **Regulation 12(1)**
- Ensure that all mandatory training is completed. **Regulation 12(2)(c)**

Outpatients

- Continue to reduce patient waiting times to treatment and ensure people are continually risk assessed so they do not come to harm while waiting to be seen. **Regulation 12(2)(a)(b)**

Action the trust SHOULD take to improve:

Our findings

Trust Wide

- Continue to pursue and invest in improvements to IT systems to reduce the risks associated with the current IT infrastructure and support delivery of integrated care.
- Ensure personnel files include all evidence of recruitment in line with trust policy, to include interview and assessment documentation and 2 references.
- Ensure the board are sufficiently aware of the key safety issues for clinical services at risk and understand and can articulate the impact.
- Consider how to ensure the visibility and understanding of community, adult social care and mental health services at board.
- Consider how to ensure staff feel listened to and their ideas and solutions are well considered, and appropriate actions taken and monitored or feedback shared with staff.
- Consider the current resource for freedom to speak up. Consider implementing a long-term workforce plan across all roles in the organisation to address vacancies and succession planning.
- Continue to embed, prioritise and focus quality improvement across the organisation and support staff to be involved in this work, and to have clear processes and policies and hold a repository of quality improvement work.

Diagnostic Imaging

- Ensure staff undertake all relevant mandatory training for their role. **Regulation 12(2)(c)**
- Ensure all radiation risk assessments are reviewed and updated as highlighted by the previous radiation protection advisor. **Regulation 12(2)(a)(b)**
- Ensure temperatures for the storage of iodine-based contrast agents are carried out. **Regulation 12(2)(g)**
- Ensure all staff receive annual appraisals. **Regulation 18(2)(a)**
- Provide adequate changing facilities for patients attending for CT scans.
- Consider dedicated waiting areas for children.
- Continue to work towards meeting the week the 6-week diagnostic imaging standard.

Urgent and Emergency Care

- Ensure staff undertake all relevant mandatory training for their role. **Regulation 12(2)(c)**
- Continue to focus on improving patient flow through the emergency department.
- Consider the privacy of computer screens in the department. Some of the computer screens were left open and unsupervised with patient records visible. The names and summary of a patient were shown, and we were able to enter and access the detailed records.
- Review all patient group directions which have passed review date and ensure they are current and up to date.
- Review storage of oxygen cylinders and ensure they are consistently stored securely and safely.
- Rotate sterile fluids and ensure no products are held which are out of date.

Medical Care

Our findings

- Keep under review the actions from the speech and language audit for patients with dysphagia. Confirming fluid thickener is stored correctly and safely, ensuring staff are adequately trained and have the right equipment to care for patients with specific nutritional and hydration needs, and care plans are followed by staff. Continue to ensure there are suitable staffing numbers and vacancies are recruited to. **Regulation 18 (1)**
- Continue to audit hand hygiene compliance and improve compliance where wards are underperforming.
- Review agency staff induction and ensure they receive appropriate induction in all areas.
- Review the processes and action taken when temperatures for medicines storage are identified to be outside of the indicated range and confirm action is taken in accordance with policy.
- Continue to store hypoboxes contents consistently across the trust and in accordance with trust policy.
- Review the trust's locked door policy and relevant risk assessments and ensure patients are aware of how they can exit and enter ward areas.

Outpatients

- Ensure ophthalmology equipment is kept visibly clean. **Regulation 12(2)(h)**
- Ensure staff receive training in how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their role. **Regulation 18(2)(a)**
- Confirm staff are clear in how to access crisis management teams and have appropriate training in how to support patients with mental health needs.
- Continue to explore how it organises outpatient services to meet the needs of patients.
- Ensure the privacy and dignity of patients is respected at all times. **Regulation 10(1)(2)(a)**
- Ensure prescription pads are stored securely in line with guidance. **Regulation 12(2)(g)**
- Consider how it ensures training in manual handling is delivered to staff.
- Consider introducing separate or segregated waiting areas for children being seen in the department.
- Consider introducing a policy to guide staff on safe procedures for children visiting the outpatient department.
- Mitigate risks and the likelihood of error in the outpatient appointment booking process while awaiting the implementation of the electronic patient record system.

Is this organisation well-led?

The overall well led rating comes from the trust wide well led inspection which takes into account leadership at service level and the most senior level. We rated it as requires improvement.

Leadership

Leaders had the experience, capacity, capability, and integrity to ensure the trust strategy could be delivered and risks to performance addressed. However, some staff felt depths of issues were not well understood or action

Our findings

taken in a timely manner to rectify or resolve issues and some board executives were not sufficiently aware of some of the key safety issues for clinical services at risk. Individual director development and board development was well established, but the trust had only recently developed a framework for compassionate, inclusive, and effective leadership.

Leaders could demonstrate they had the skills and abilities, experience and capacity to manage the trust and we saw passionate and positive leaders. They were leading in a challenged trust and Devon system. There had been good appointments to the leadership team with the right skills among the board executives and non-executives, with succession planning evident. We heard about supportive challenging conversations to discuss difficult things and to make decisions. However, some staff felt depths of issues were not well understood by the leadership team and senior managers, or actions were not taken in a timely manner to rectify or resolve these issues. Conversations during inspection identified some board executives were not sufficiently aware of some of the key safety issues for clinical services at risk, particularly related to stroke services and some surgical networks such as urology. The impact of these weren't always articulated or well understood. We also identified equality, diversity and inclusion had not been given sufficient support and development, to address issues in a timely way.

Leaders were involved and invested in being system players and were forward thinking. This linked to where the organisation was and the reliance on a system approach for solutions to the challenges the trust faced. We heard about the future and the organisation's plans in a challenging environment, where system leadership was helping to take the trust there.

The board of directors, led by the chair of the trust included a collegiate unitary board. The executive leadership team was led by the chief executive and included the chief finance officer, chief operating officer, director of transformation and partnerships, chief nurse, chief people officer and chief medical officer. The medical director, health and care strategy director, and the director of corporate governance and trust secretary, were non-voting members of the board.

The trust was undergoing several changes to their executive team. The chief operating officer was interim and was in post as a turnaround director, a recent appointment had been made to a permanent position. The chief finance officer who was also the deputy chief executive was leaving the trust, an interim chief finance officer had been appointed and there were plans to recruit to a permanent position. A deputy chief executive was also planned to be appointed through an expression of interest process. The chief medical officer was due to retire and there were plans to recruit to a permanent position. Following a 10-year tenure the chair was coming to the end of their term in May 2024, the chair had been extended for consistency and longevity to support the trust with their challenges.

There were 7 non-executive directors and 1 associate non-executive director. The chair evidenced how the skills of the non-executive directors were matched to the challenges for the trust and had been clearly thought out to meet the needs of the organisation. For example, backgrounds included, clinical, financial, digital, and human resources.

There was regular board development and executive director development sessions scheduled across the year, structured around the trust's strategic and operational requirements. We reviewed a board development programme paper setting out what the board achieved to date and known areas for development.

There was a system to monitor and assess whether the board of directors were deemed fit and proper at the time of recruitment, and on an ongoing basis, to meet the fit and proper persons regulation requirements. Leaders followed the standards of business conduct policy and signed an annual declaration. We did identify gaps when reviewing executive and non-executive paper files, missing documents were found and added to the files. There were 3 examples where

there was no evidence of competency-based interviews for the chief executive, chief nurse, and chair, and one example where there was only 1 reference on file for the director of corporate governance and company secretary. Leaders had a regular one to one conversation, to provide support and raise issues and consider development and coaching opportunities, and annual appraisals with objectives set for each year.

The need to develop leaders was not always identified or action taken in a timely manner. The trust had just started a leadership development programme. The compassionate leadership framework had been in development for some time, in May 2023 this was signed off by the board. The workforce wanted a consistent and compassionate leadership style. Leaders reflected the trust hadn't developed the workforce but were on a committed journey to do so.

Leaders and managers demonstrated how they linked in within the local system and nationally, where needed, to network, learn and support them in their roles.

There was a variable response about the visibility of the leadership team. Some leaders reflected visibility could be better by both directors and senior managers. Some staff commented although leaders weren't always visible, they were contactable. The chief nurse had a good model for how they and their senior managers were visible, and staff commented on the chief nurse's visibility, accessibility, receptiveness, and engagement.

It was raised by clinicians, some of which were in or had been in management roles, how recruitment into senior medical leadership roles was difficult as it was not appealing, and people did not have the protected time to fulfil their management roles. Those who had stood down from these roles had not had an exit interview to help capture this feedback.

NHS Foundation trusts have public, staff, and appointed governors to represent the views of its local people and to help the trust shape its plans. There were 32 governor seats in total with a small number vacant. Governors' responsibilities included holding non-executive directors to account, overseeing appointments, remuneration and performance monitoring of the chair and non-executive directors, and approving the appointment of the chief executive. Governors spoken with said how they put forward effective challenge to people and engaged across the community. They said they were trying to get back into operation again to be more patient focused and have more contact, which had been restricted during the pandemic, this needed to be refocused and moved forward. The trust commissioned the good governance institute in 2022 to undertake a development programme for the council of governors.

Vision and Strategy

There was a clear statement of vision and values, driven by quality and sustainability. There was a realistic strategy with well-defined objectives and a focus on system-based working. These were developed in collaboration with people who use the service, staff, and external partners. The strategy was aligned to local plans in the wider health and social care economy. Leaders understood the strategy and their role in achieving this. However, staff did not always understand how their role contributes to achieving the strategy, and there were many strategy documents, plans and objectives to navigate and understand.

The trust had realistic strategies with defined objectives and supporting plans which were developed in collaboration with people who use the service, staff, and external partners. The strategies were aligned to local plans in the wider health and social care economy and services were planned to meet the needs of the relevant population. Progress against delivery of strategies and plans were monitored and reviewed, and we saw evidence of this. Leaders discussed

the journey the organisation was on, and the continuous improvements being made. Some strategies were in their infancy and embedding across the organisation. There was variability in the understanding of the strategies and plans by staff across the organisation due to the number of different strategies and plans, but all staff had access to documents setting out the vision, values and strategy purpose, goals, and priorities, with supporting information.

The strategy and plans were being developed to be system based. There was the right strategic direction in the system. The leaders in the trust were involved in system leadership and work to help push through strategic aims. The trust has a difficult geography and demography. Clinical sustainability issues impacted on the ability for the trust to deliver. Fragile services included stroke, urology, interventional radiology, microbiology, and oncology. The trust needed to work across organisational boundaries to ensure sustainability of the fragile services. The demography and health inequalities were still being considered and planned out, for example how to access services when they are spread across Devon and the provision of specialist transport to support this.

In January 2022 the trust published their first formal strategy refresh since forming the integrated care organisation in 2015. The strategy continued to support the trust's direction of travel towards greater integration and moving services closer to people's homes. At the core of the strategy was the purpose, 3 strategic goals and 6 priorities. These drew on the understanding of local communities' wants and needs, and staff and partner organisations were engaged in their development. The 6 priorities had enabling plans and aligned to the board assurance framework to ensure a line of sight into delivery and risk. They included:

- What matters to you matters
- Building health communities
- Thriving people
- Improving quality
- Creating partnerships
- Improving sustainability

A report presented to the trust management group in July 2023 highlighted key achievements and progress to date of the strategy and supporting strategies. We were told the trust continuously monitor their strategies and ensure alignment with the integrated care board and Devon's joint forward plan.

Strategic objectives in 2022/23 included the recovery and restoration following COVID-19 pandemic and developing and delivering a single improvement plan. For the current year 2023/24 objectives included exiting system oversight framework 4 through the delivery of the single improvement plan and progressing ongoing procuring of an electronic patient record, in line with board objectives. For 2024 and subsequent years the objective is for wider integration and network development within the Devon health and care system.

The trust's single improvement plan sets out a framework of executive director owner supporting strategies to include health and care, quality, learning and education, people, finance, estates, green, transformation engagement and partnerships, digital, and building brighter future programme. Each supporting strategy had clear actions and objectives aligned with them. The trust's assessment of these demonstrated they were on track with delivering objectives set out by supporting strategies, although there were several areas where further attention was warranted.

Our findings

Together with partners in Devon and Cornwall, the trust had established the peninsula acute provider collaborative, to help agree and deliver new ways of delivering services in collaboration. This allowed consistent quality across catchment areas, coherent network service models to improve operational effectiveness and improve productivity and efficiency for greater economic sustainability.

The trust had a quality and safety plan which was a key enabling plan for the strategy set out in 2022 and revised annually, it was aligned to the NHS national patient safety strategy and was delivered through 6 core pillars underpinned by the set of priorities. It set out 4 quality and safety goals against priorities:

- Zero avoidable deaths
- Continuously seek out and reduce harm
- Excellence in clinical outcomes
- Deliver what matters most to our people

The trust and the Devon system were in the NHS system oversight framework segment 4 (SOF4) due to financial performance and delivery against performance targets. The trust had an improvement plan to meet the SOF4 exit criteria. The plan was focused on:

- Strong system leadership to improve services across the whole of Devon
- Urgent and emergency care recovery
- Planned care and cancer performance recovery
- Delivery of financial targets
- Ensure that workforce plan delivers financial efficiency target

Other strategies included the learning and education strategy 2022-2027 and the digital strategy set out in 2021.

The CQC team reflected that although strategies and plans identified appropriate objectives there was a query why things only appeared to be happening now, for example why were networks and pathways not developed previously due to the issues of clinical sustainability and why were the trust behind with things such as IT and building of theatres.

Culture

There were inequalities among the workforce and staff did not feel they were always treated equitably and shared negative experiences. Sufficient action had not been taken in a timely way to address the issues. There were poor results and outcomes for indicators across surveys, Freedom to Speak Up concerns and national workforce data sets, as well as in first hand experiences of staff who spoke with us. There was no equality, diversity and inclusion strategy at the time of the inspection, this was approved by the trust board in July 2023, and the resource available for the work was insufficient for the scale of the work needed. The equality business forum did not operate effectively, and staff networks required further development and support.

An increased trend of racism, discrimination, bullying, and harassment was identified from the trust's national staff survey, workforce equality standard reports and through freedom to speak up routes. The board agenda on inclusion wasn't yet matured and they aspired to have a just learning culture. As part of the board assurance framework an

objective was for people and to build a culture at work where people felt safe, healthy, and supported. Equality, diversity, inclusion and bullying and harassment were captured within this risk profile. However, this was not captured on the corporate risk register. This was discussed in the June 2023 people committee as the risk score had not met the threshold for the corporate risk register and the risk and scoring was being discussed further.

The chief executive told us one of their worries was around workforce and the challenges experienced by people who come from a diverse range of backgrounds and with specific protected characteristics, particularly staff from ethnic minority groups. They said this was evident from staff surveys and people reporting their experiences and there were plans to address this.

Listening sessions had been held with the chief nurse officer. People were becoming psychologically safe enough to speak, but not yet safe and confident to do so in a board arena. For example, staff from ethnic minority groups were invited in June and July 2023 to hold a conversation with the chief nurse officer and the diversity and inclusivity lead to discuss their experiences of working at the trust. It was evident the chief nurse was investing time, and the board was listening to understand the needs of people.

Staff satisfaction was mixed. People were proud of their teams, and recognised the fatigue staff were experiencing due to the pressures and challenges of their roles within the NHS. Overall, people spoke about a friendly and supportive environment they worked in. People were proud and did their best despite the conditions they were working in. They were dedicated and patient focused. However, they were concerned they could not always give the quality of care they would like to.

We met with a group of allied health professionals who found their voice was not always heard in a medical and nursing focused organisation, where there was focus on the front door and a lack of acknowledgement of community teams. Smaller teams had difficulties getting their voice heard. A chief allied health professional had been in post for 2 months and staff were hopeful this would promote the allied health professionals and give them a consolidated voice.

The NHS staff survey showed overall an inclusive culture. However, there were pockets where the community staff did not feel included. There was a declining sense of satisfaction and increasing reports of bullying and harassment from staff from ethnic minority groups. Leaders recognised there was more to be done for everyone to feel included. The 2022 national staff survey report was presented to board in April 2023, with a 38% response rate from staff. The trust was performing below the national average in 4 of the 9 elements, including staff engagement, staff morale, ‘we are safe and healthy’, and ‘we are always learning’, and had seen a decline in these scores compared to the previous year. The trust’s ‘regain and renew’ plan priorities responded to the survey to include defining and delivering an inclusive leadership and management approach, recognising the single biggest impact on staff engagement and organisational culture is leadership, and ensuring there is sufficient capacity for teams to work in a calm and safe way, as well as recognising the way in which people work has the biggest impact on their wellbeing.

The trust recognised they needed to prioritise staff experience and wellbeing and had set out a people promise and plan for 2021-2024. The trust’s people promise was based on NHS values, including their commitment to each other, and prioritised building a healthy culture at work where people felt safe, healthy and supported. The trust had over 70 wellbeing buddies in clinical and corporate teams across trust sites who offered wellbeing support and signposting to colleagues.

There was significant work to do on the equality, diversity and inclusion agenda, this was acknowledged by senior leaders and there was a direction of travel to address this. A culture shift and education programme across the

organisation was needed to help build confidence in managing and talking about equality, diversity and inclusion matters and being confident in the language used. It was evident there were increasing equality, diversity and inclusion risks and active cases around bullying and harassment. This included tribunal case losses relating to racial discrimination.

Staff felt equality, diversity and inclusion was moving in the right direction but not at pace. Cultural shifts take time but staff were not always clear what was happening. People were opening themselves up and showing their vulnerabilities but they were not seeing actions to address their concerns.

The trust did not have an equality, diversity and inclusion strategy at the time of the inspection. The strategy had been approved by the people committee in June 2023 and was on the agenda for approval at the trust board at the end of July 2023. The trust had a cultural improvement plan for 2023/24, identifying the main areas of concern which required improvement and embedding a just and learning culture. The trust had completed a cultural assessment to identify the extent of any cultural misalignment with the trust's inclusive values.

For the extent of the work required, the equality and diversity team appeared under resourced. The equality and diversity lead was a band 6 post, working 0.8 whole time equivalent hours, and there was no supporting team. This was not a recognised risk requiring further staffing or resources. The role was staff focused and did not focus work on patient experiences.

We were told a health and inequalities dashboard was being considered, to be able to regularly present to board and have all relevant information in one place. There was a plan for inclusion champions to be recruited to advocate for equality, diversity, and inclusion across the trust, but we were unclear of timeframes for this.

Staff had annual equality and diversity training, and training available on bullying and harassment, and there were videos to access and information shared in a newsletter. New equality, diversity and inclusion training was planned to be rolled out, strengthening the existing inclusion training. There was a plan to start with leaders and managers in September 2023, with a phased period roll out across the whole organisation. It was recognised the need to support individuals and teams to have uncomfortable conversations and provide support without a blame culture.

When asked about equality, diversity and inclusion support and training, community staff regularly referred to the local council training and information rather than the trust. They found the work from the local council was helping them open their eyes to being fully inclusive.

The workforce demographics had changed and there was an increase in the diversity within the organisation since the increase in recruitment of internationally trained staff. There had been work completed with internationally recruited nurses around cultural shock to prepare them for joining the organisation. However, it was recognised the trust did not prepare the rest of the workforce for the internationally recruited nurses joining the organisation to help ensure an inclusive culture and understanding of diversity. This was being addressed in training modules and culture work.

The trust used surveys and reports to help them identify areas for improvement and areas for action. For example, a just culture survey had been completed. This was an anonymous survey to support the patient safety incident response framework, with an aim to give a broad understanding of culture within teams and departments and provide evidence where there are significant challenges.

The NHS Workforce Race Equality Standard (WRES) was reported annually and reviewed 9 indicators around workforce, staff survey and board representation. The data for the trust identified a need to improve the experience of staff from

ethnic minority groups and focus on closing the gaps in workplace inequalities between staff from ethnic minority groups and white staff. The trust set out a WRES action plan for 2022-2023 around 4 key priorities: recruitment and promotion, development, and progression, creating culture of inclusion, and leadership. There were clear objectives with outcomes and success measures recorded. However, progress against actions were still being made and had not always met timescales identified.

The trust's 2022 report (including data from 2021/22) key headlines areas of strength included:

- The likelihood of staff from ethnic minority groups entering the formal disciplinary process compared to white staff remained at 0.
- The likelihood ratio of white staff accessing non-mandatory training and continuing professional development compared to staff from ethnic minority groups was 1.01 (this was at 0.95 in 2022 data).
- Percentage of staff experiencing harassment, bullying or abuse from staff was similar for white staff (24.1%) and staff from ethnic minority groups (25.2%). In the most recent 2022 data white staff was 22.3% and staff from ethnic minority groups 24.6%.
- The percentage of staff who believed the trust provided equal opportunities for career progression or promotion was similar for staff from ethnic minority groups (75.7%) and for white staff (85.7%). However, more current data in 2022 has shown a decline with 51.0% for staff from ethnic minority groups and 57.3% for white staff. This is therefore no longer an area of strength for the trust.

Areas for improvement included:

- Staff from ethnic minority groups represented 7% of the trust total workforce, compared to 1.2% in the South West and 22.4% nationally. In terms of non-clinical staff, staff from ethnic minority groups were underrepresented at band 3 and 4, but proportionally at band 5 and above. Conversely, for clinical staff, staff from ethnic minority groups were proportionally represented at band 4 and under but underrepresented at band 6 and above. Amongst medical and dental staff, staff from ethnic minority groups were underrepresented at consultant level and above.
- The likelihood of appointment from shortlisting had inequality of a small degree. It was 1.73 times more likely a white candidate would be appointed from shortlisting compared to an applicant from an ethnic minority group. This was a significant increase compared to the previous 2 years and higher than both the South West and national ratios.
- Percentage of staff who personally experienced discrimination at work from a manager, team leader or other colleague was significantly higher for staff from ethnic minority groups (15.1%) than for white staff (5.8%). This was lower than the South West and national averages, but had increased for the trust and showed disparity between groups of staff.
- Staff from ethnic minority groups representation on the board was lower than the workforce.

We met with a group of staff representing the staff from ethnic minority groups across the trust. Some toxic cultures were described by these staff, and it was felt there was no level of accountability or consequences for actions of individuals. People were getting braver and speaking up about their experiences, but it was felt the organisation needed to be quicker with their actions and create a culture of inclusion. There was no representation of staff from ethnic minority groups at board level and it was felt the required culture change needed to come from board down. There were examples where people felt they were unable to progress or had received comments which demonstrated microaggressions, bias and lack of understanding by colleagues and management. It was felt middle managers lacked an understanding about differences in culture within the trust.

Our findings

The NHS Workforce Disability Equality Standard (WDES) was also reported annually reviewing 10 indicators. The trust set out a WDES action plan for 2022-2023 against each of the 10 indicators and included objectives, action, timescales and leads. It was noted timescales had not been met and progress and developments were still being made against actions. The 2022 report (data from 2021/22) showed a need to improve the experience for disabled staff and focus on how to assist them to remain well and feel valued. Areas of priority included networks, recruitment practices, developing career pathways, education, and employability.

Areas of strength included:

- There were small improvements in the levels of harassment, bullying and abuse towards disabled staff from managers (16.3% down from 19.4%) and colleagues (24.5% down from 26.8%) from the previous year.

Areas for improvement included:

- There was under representation of disabled staff at higher pay bands for non-clinical, clinical, and medical staff. The higher proportion of disabled staff were at lower pay bands.
- Non-disabled staff were more than twice as likely to be appointed from shortlisting than disabled staff.
- Disabled staff were nearly 4 times more likely to enter the capability processes as their non-disabled colleagues.
- A lower number of disabled staff (49.7%) said their organisation provided equal opportunity for career progression compared to non-disabled colleagues (59%).
- Although there had been a significant improvement in the number of disabled staff feeling pressured to come to work despite not feeling well, there remained a disparity between disabled staff (25.1%) and non-disabled staff (19.8%).
- There were no board members with a declared disability.

We met with a group of staff representing disabled staff, and they largely felt unsupported by the trust. Staff felt there was a poor culture and attitude by the trust around disabled staff. They shared how there were inconsistencies across management with the level of support given. They told us that career progression was not easy and reasonable adjustments were not made to support career progression, as individuals had been told they should not apply as they were unable to do the roles. We were told there had been no disability network for 2.5 years and therefore concerns were not being raised or going anywhere. The need to disclose disabilities to attend the disabled staff network prevented people from attending. We were told the trust believed there was a zero tolerance to bullying, however staff we spoke with told us there had been a culture of mocking and making fun of disabled staff and examples were provided where people had experienced this from both peers and managers. It was felt managers were not clear on policies for sickness and disability leave and struggled finding clarity even when requesting support from human resources, as it was felt policies were outdated and contradictory. There was no process to support staff with long COVID despite this being requested. We were told there was no provision for neurodivergent staff.

We met with a group of managers who told us HR support was difficult with no continuity, they were unable to access face to face support, and policies and procedures were not up to date and difficult to access. This meant it was difficult for managers to provide the correct and consistent support to their staff.

The equality business forum did not appear to be operating effectively. The purpose of the equality business forum was to monitor, develop and improve the trust's work on the workforce equalities and inclusion agenda on behalf of the trust board. The equality business forum was attended by chairs of networks and reported to the people committee. They

aimed to meet monthly, but we were told it had not run as frequently due to capacity. In May 2023 we requested the last 3 meeting minutes and were provided with meeting minutes from only November 2022. These were typed notes which did not appear to follow a formal agenda, 6 people were in attendance but it was not clear of their role or who they were representing. There were no action plans for the group.

The trust had 6 staff networks to include staff from ethnic minority groups, lesbian gay bisexual transgender queer or questioning and two spirit plus (LGBQT+) staff, disabled staff, staff under 30, mental health and menopause. The disability group did not currently have a chair and people were not attending, and this needed review and support to get the group back up and running. We asked whether leaders and managers supported staff attending networks, and we were told the intent is there for people to attend but this is not reinforced. It was acknowledged the profiles of the networks needed to be raised and support provided to people to attend and value the network as a safe space for staff to share their experiences. The chief people officer recognised the challenge with the networks where people did not have protected time to attend, and they were looking to understand this so people can go to their managers and be able to increase the visibility of the networks.

There was no mandate for minutes to be taken in individual network group meetings due to personal, confidential, and emotive topics discussed. The decision to minute network meetings was at the discretion of the individual chairs based on preference of network members. We were told areas that required escalation to the equality business forum were raised with the consent of the concerned individual and escalated. The trust said they were in the process of strengthening governance processes as reflected in the cultural inclusion action plan and would collaborate with network members, the equality diversity and inclusion lead and executive sponsors to co-design the process, whilst remaining mindful that formally minuting network group meetings could negatively impact attendance.

We reviewed minutes for the monthly LGBQT+ meeting. They raised the difficulties recruiting chairs to networks due to the lack of protected time or time for chairs to take forward actions, this also affected the ability for members to attend. They shared concerns on how the network raised issues, but actions were not taken forward through the equality business forum.

There were examples where networks had presented to the people committee, and we saw an example of the menopause support network presenting in April 2023. The menopause support network had over 400 members who got together every couple of months and had routes to contact for information and support. Challenges raised included funding, time, support, and more recognition from upper management.

The Equality Delivery System is mandated for NHS providers and designed to encourage the collection and use of better evidence and insight across the range of people with specific protected characteristics and considers people within social inclusion groups. Trusts were required to select 2 services for review and the trust selected maternity services but did not select a second service due to lack of time and resources. The outcomes for this review identified maternity services were still developing in this area.

The trust had 1 full time freedom to speak up guardian, which we were told was consistent with the region. They reflected they had a big workload and received approximately 6 concerns a week. There had been a growth in the number of concerns being raised, with further support for the role being considered by the board.

Our findings

There was a process for confidentially logging information brought to the freedom to speak up guardian and people were able to anonymously communicate through an electronic platform. It was recognised the freedom to speak up guardian did not have access to agency staff or a forum to link in with bank staff except at induction. The freedom to speak up guardian was going to explore this, although did have examples where bank and agency had approached them.

Freedom to speak up reported to the board every 6 months with numbers and themes. Between October 2022 and April 2023 there had been 50 cases, 27 of which related to bullying and harassment, 9 failure to follow process, 5 patient safety, 3 staff safety, 3 culture of organisation, 2 diversity and inclusion, and 1 other. The bullying and harassment themes were consistent with the staff survey. Other themes included a lack of interest in trying to find an early resolution and managers ignoring the problem rather than addressing it. There were pockets of racism and discrimination reported which were not always well managed with no solution or learning, or these were not done at pace. Failure to follow processes relating to recruitment were also reported, alongside the culture of the organisation having a lack of flexibility and wellbeing support in place for teams. Patient safety concerns related to inconsistences in investigating patient deaths, and the competency of staff. Diversity and inclusion concerns related to lack of support for reasonable adjustments in the workplace.

The trust had a staff side representative who provided an interface between the various unions and recognised professional bodies. The top concerns from staff were culture, patient safety and staff feeling safe to carry out their clinical role in a challenging environment.

Governance

The governance and performance management had recently been reviewed and restructured to be strengthened. The new processes were clearly set out but were embedding across the organisation and staff were understanding where roles and responsibilities may have changed. However, risk and governance discussions felt heavily acute focused rather than community and adult social care.

Governance systems had been strengthened but weren't yet fully embedded across the organisation and the trust was working through the process to continue to make improvements. Risk and governance discussions felt heavily acute focused rather than community and adult social care. Mental health was not always visible, although discussions with key staff demonstrated a commitment to developing the mental health strategy.

The organisational structure was undergoing change at the time of our inspection, following a review and restructure, with the new structure launching on 1 July 2023. There had been extensive co-design in the organisational structure, which was previously arranged into five integrated service units. The previous structure staff had found difficult to navigate, confusing and their voices fragmented. The new structure simplified governance and enabled identity of teams. Most staff spoke positively about the new structure and felt this streamlined governance channels. The new structure integrated in to 4 care groups led by a care director with triumvirate teams. There was a clinical leadership ambition for the triumvirate which was currently operational. The 4 care groups included:

1. Families and Communities
2. Planned care
3. Medicine and Urgent Care
4. Children and family health Devon

Our findings

The new structure was clearly set out but was in its infancy and therefore needed time to embed and align the new governance reporting lines. Staff were understanding where roles and responsibilities may have changed. Previously staff spoke of inconsistencies and differences in the way meetings were named and structured, community staff spoke about the new structure helping to align their governance.

From the 3 July 2023 a new corporate governance reporting structure for oversight and assurance was established. The governance structure was aligned to 5 tiers to include tier 1 corporate governance, tier 2 executive governance, tier 3 trust senior leadership, tier 4 functional leadership, and tier 5 any group or meeting reporting to tier 4.

Board subcommittees provided assurance to the board. The corporate governance structure included 8 committees which fed into the board; quality assurance, charitable funds, ethics, audit, non-executive director nominations remuneration and terms of service, people finance performance and digital, and building a brighter future. Each had its own terms of reference and work plan. We reviewed minutes and saw appropriate agenda items and reports and data presented, with relevant escalation to the board.

We observed the June 2023 board meeting and found it was effectively chaired and people provided constructive challenge with trust and respect around the table. The papers presented to board were clear and included appropriate level of detail. Report authors articulated the key headlines and the board appeared familiar with the papers to ask relevant questions and identify issues which needed further and continued scrutiny.

There was an integrated framework for adult social care. Performance and activity were governed through the adult social care operational oversight, and performance and transformation committees. There were a set of metrics and dashboards to monitor quality and safety and an adult social care assurance report presented quarterly to the quality assurance committee.

The chief nurse led on clinical governance. There was no head of governance to lead on and help link clinical effectiveness, risk, clinical outcomes, policies and procedures, and patient information. We found the complaints, patient experience and quality improvement teams appeared to work in silos, there wasn't a flow of work which appeared to come together.

Management of risk, issues and performance

The trust and Devon were in NHS system oversight framework segment 4 due to financial performance and delivery against performance targets. The trust had a challenging financial position but a plan to address this. Safety remained a priority in the organisation and leaders aimed to achieve a balance between finance and quality. There were processes to identify, understand, monitor and address current and future risk. The main risks were associated with the estates, finance and the IT systems. Performance issues were escalated to the appropriate committees and the board through clear structures and processes. There were processes for clinical and internal audit.

The trust and the Devon system was in NHS system oversight framework segment 4, due to financial performance and delivery against performance targets. Torbay and South Devon NHS Foundation Trust was placed into NHS system oversight framework segment 4 in November 2022 and received support from the recovery support programme, this is mandated focused and integrated support for trusts and systems in segment 4. The trust was receiving intensive support for elective care and cancer, as well as a wider improvement support given to the Devon integrated care board and Devon providers. At the time of our inspection the trust had exited all tier levels for cancel performance and were

improving delivery against key targets sustainably, there were no patients waiting over 104 weeks and the trust was aiming to eradicate 65 week referral to treatment waits by March 2024. As of 11 June 2023, the number of open pathways against the 62 day cancer standard waiting over 62 days was 104 and represented 6.6% of the total urgent cancer referral to treatment patient tracking list.

The financial position for the trust and for the Devon system was challenged. There was an ambitious financial plan but the chief finance officer was clear where the risks were and there was a clear programme of work. There was a £46.6 million cost improvement plan and a £35 million agreed deficit risk for the trust at the end of the financial year. The trust had a 6-point financial plan covering workforce, agency, budget transfers, activity, business cases, and tender waiver. Leaders were confident the cost improvement programme would deliver the financial position.

There was a clear process to review cost improvement plans with care groups (previously integrated service units) and good quality impact assessment processes, these were signed off by medical director and chief nurse. Leaders were satisfied cost improvements and finance were not having an impact on quality. However, staff felt sometimes finance impacted on the provision of quality services. One budget holder told us they were not clear on their finances because information was not being shared about how much the department spends and how this compared.

The estate infrastructure was fragile and underpinned some of the challenges the trust faced, this was recognised on the risk register both a fit for purpose estate and space. The trust had secured investment from the new hospital programme to build by 2030. They had also secured additional day surgery theatres and endoscopy facilities. In 2022 a new acute medical unit had been delivered to help improve pathways for urgent and emergency care and a new health and wellbeing centre had opened in Dartmouth. Estates had a £58 million maintenance backlog, which had been reduced by £1 million this year. There was a concern about how much there was available to invest in estates. We were told the estates spend was prioritised involving nurses, clinicians, and the board.

There were processes for identifying, understanding, monitoring, and addressing current and future risk. There was a high-risk tolerance in the organisation. The corporate risk register and board assurance framework were evolving, they were reviewed every month at board at a high level and risks were aligned to the strategy. Every subcommittee reviewed their areas of the board assurance framework and corporate risk register. An internal audit was completed in May 2023 to review the board assurance framework and risk management with recommendations identified.

The board assurance framework had recently been reviewed and improved to include a gap analysis. There were 10 objectives on the board assurance framework each with an executive lead, current risk score and target risk score. These objectives were consistent with the risks and issues discussed across the course of our inspection. The objectives were assigned to board sub committees who focused on giving the board assurances on these areas.

We reviewed the corporate risk register, dated May 2023, and there were 31 risks on the register. There were 5 risks rated 25 to include estates, finance sustainability and delivery of cost improvement plans and IT systems and infrastructure. Most risks had been on the risk register for some time with no new risks in 2023. All risks had recorded controls and gaps in control with progress notes for managing the risk. Staffing was a risk across the organisation, there were medical fragile services and this was being supported by the acute sustainability programme. There were also several vacancies across the trust. However, there was no long-term workforce plan.

Risks were discussed and managed at the relevant subcommittees and at the risk group meeting. Each care group (previously integrated service units) and service areas/departments held a risk register. Risks were now being reviewed monthly by care groups, previously this was reviewed 6 monthly. Risks under 12 were managed by the care group, 12 and above underwent a validation process, and 15 and above were identified for potential corporate risk validation.

Our findings

There was a new accountability framework to ensure accountabilities were assigned to roles and ensure proper assurance and internal controls. It set out roles and responsibilities and autonomy framework and local escalation criteria and metrics.

The trust had a rolling programme of internal and external audit to manage risk, issues, and performance, and monitor quality, operational and financial processes.

Complaints were reviewed and investigated and complaint responses signed by the chief executive. Following receipt of a complaint the trust aimed to send an acknowledgement within 3 working days, the trust's compliance with this was 95%, and a response to the complaint within 6 weeks, the trust's compliance with this was 74% in 2022/23. The 6 weeks target was dependent on the complexity of the complaint and clinical capacity, an idea of timescales was provided in the acknowledgement letter to the complainant. The national standard was for complaints to be responded to within 6 months and the trust met this for 90% of complaints in 2022/23. Complaint themes included delays and discharges, and social care benefits. We reviewed examples of complaints and these were managed and responded to appropriately with examples of learning identified. There was no non-executive director for complaints or patient experience to advocate the patient voice, there had previously been a non-executive director with this responsibility, although this was not a statutory requirement.

The trust had an incident reporting system, where harm identified as moderate and above would be flagged to the central team. Weekly incident meetings were held with the patient safety team to look at incidents with a harm level of moderate or above. A monthly serious and adverse incident review group was held to check and challenge investigation reports before sign off was completed by an executive before being shared with the Devon integrated care board and the patient or their family. It was reported the time taken for 72-hour reports to be completed had improved, but some took longer due to the level of complexity. The time taken for the final investigation reports was variable.

The learning from deaths executive lead was the chief medical officer and there was a non-executive lead. It is mandated to report to board on a quarterly basis but this was done every 2 months. The mortality surveillance group met monthly to analyse mortality figures and there were deep dives commissioned as required. Medical examiners were scrutinising 100% of inpatient deaths and were starting to build up a community portfolio. Medical examiners would then pass on to coroner if there were concerns with the death or raise via the incident reporting system to be reviewed by the trust's patient safety team. The mortality review policy was dated December 2017 and was pending a full review.

Junior doctors knew who their guardian of safe working hours was and how they reported, although found the process laborious. There had been a vacancy in the guardian of safe working hours for 6 months. The current guardian of safe working hours had 1 programmed activity for the role but this was under the recommendation in line with the numbers of junior doctors. Since inheriting the role the guardian of safe working hours has been addressing the backlog from the vacancy. On average the trust received 250-350 exception reports per year. There was a guardian oversight group to discuss any issues and the departments that needed support. Guardian newsletters were available twice a year and information was available on intranet page and at induction. The guardian of safe working hours reported to board quarterly, the report presented in May 2023 identified 139 exception reports between 10 December 2022 and 10 April 2023, the large majority related to additional hours. The highest proportion came from general medicine and general surgery.

The health and safety lead had energised the health and safety agenda and could describe the oversight structure and how they engaged with the divisions. The reporting and accountability structure was confusing as they reported to the chief finance officer but met with the chief operating officer.

Our findings

The safeguarding leads were knowledgeable and passionate about safeguarding and felt supported by the board and their line managers. There were strong links with safeguarding boards and key partners. There was a good awareness of the needs of local people and examples of practices implemented. The domestic abuse officer was available to support both staff and patients. There was an acknowledgement that mental capacity act and deprivation of liberty safeguards could be better and they were working on bitesize accessible learning for staff.

The board oversight and risk register for mental health was not clear. There was no strategy in the trust for mental health and there was no legal assurance for the mental health act, the trust was reliant on a local mental health trust. There was not consistent training for acute mental health patients, either variance in training or no training at all.

Infection prevention and control team were clear on priorities and used data for benchmarking. They were clear of their responsibilities across the acute, community and social care. A quarterly infection prevention control group fed into the quality assurance committee, and an annual report was presented to board, last presented July 2023.

Information Management

Integrated reporting covered quality, operational and financial information. The information was used for both assurance and improvement. The IT infrastructure was outdated and provided barriers to sharing information and impacted on the confidence in the quality of data when pulling from lots of sources. There were arrangements to ensure data or notifications were submitted to external bodies as required.

Integrated reporting covered quality, operational and financial information. The information was used for both assurance and improvement. The trust board papers included integrated performance reports which presented performance against targets and provided summary information. The integrated performance report was being developed to provide clearer exception reporting, we were told this would make it clearer where finance and quality are balanced. Community and social care were not always well represented within board papers due to the data available. However, during the June 2023 board meeting there was discussion about how to ensure community and its performance was well represented in board papers and one non-executive director raised the “importance of incorporating soft measures in our review of quality and efficiencies” with another adding “would benefit in looking at the social care metrics too”.

The IT infrastructure was outdated and required modernising. There were multiple IT systems across the organisation, which did not link, and this took additional time for staff to use the different systems, provided barriers to sharing information and impacted on the confidence in the quality of data when pulling from lots of sources. People shared their frustrations about the systems they were working with and how they were reliant on interpersonal relationships to help share information. It was commented how IT was failing the workforce and indirectly patients, with the multiple systems and time taken. There were struggles with the clinical systems used, with challenges with age of systems to be able to keep them updated and maintained, for example in line with new reporting standards for national mandated data and work arounds were required to achieve this.

There had been challenges with developing the portal for clinical specialties, approximately 25-30% of clinical teams had specialist access to the portal, however the rest of the clinical teams just had basic access. Portal 2 was accessible to all clinicians and current usage highlighted 70% of all inpatient services were using portal 2 to access patient information at basic access.

Our findings

The trust recognised there was lots of work to do around data management, further plans were being developed and the new operational structure would enable more data to be cascaded and improve the ability to drill down to analyse and interpret data.

The trust was in the process of procuring an electronic patient record system which would help resolve and address the IT infrastructure risks. The procurement process was expected to progress to a preferred bidder in the Autumn of 2023. The electronic patient record system will help provide real time data and information.

The director of transformation and partnerships was the senior information risk officer, who is accountable and responsible for information risk across the trust and ensure everyone is aware of their personal responsibility to exercise good judgement and to safeguarding and share information appropriately. There were arrangements to ensure the confidentiality of identifiable data, records and data management systems and information governance breaches were reported. We were told there had been 162 incidents of breaches of confidentiality reported through the trust's incident reporting system between 1 July 2022 and 1 July 2023. Of these, only 2 were reportable to the information commissioner as information governance breaches.

The trust had a Caldicott guardian, whose role was to be responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. There was not a clear work plan for the Caldicott guardian but they discussed areas they intended to focus on. Recent training undertaken by the Caldicott guardian had identified areas where the role and process could be improved. Comparatively to other trusts' Caldicott guardians there were not many requests and this was going to be explored.

There were arrangements to ensure data or notifications were submitted to external bodies as required.

Engagement

The trust engaged with relevant stakeholders to build a shared understanding of challenges to the system and understood the needs of the population and engaged with patients, families and service users to gather feedback. Staff views and concerns were encouraged, but they were not always heard and acted on, and staff were not consistently told about action taken to improve processes.

The trust was transparent, collaborative, and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvement to meet them.

As an integrated care organisation the trust had a breadth of engagement within the system and felt their partnership was mature. They worked closely with mental health, council colleagues, voluntary sector, independent sector, and primary care. The trust held conversations and workshops with local care partnerships.

Staff views and concerns were encouraged but they were not always heard and acted on, and feedback was not always reported or acted on in a timely way. There was a theme across the staff groups and specialties we spoke with that although people initially felt listened to, they did not see actions or solutions. People said there was no feedback loop on decisions, no reflection or internal learning on management decisions. We were also told when solutions were given people were told no. There were concerns things were not followed up appropriately or there was inaction from leaders. Some people found there was not a clear route to take ideas and understand where a decision was finally made. There were also comments relating to how staff felt listened to, but it took time for change to happen.

Our findings

Concerns were raised about the amount of operational work without enough clinical input. Engagement of clinical leaders was said by some to be difficult because they are exhausted and have had to spend too much time on management due to gaps in operational management teams. Clinicians raised they were not allowed to go to meetings which they felt they should participate in.

There was an awareness by leaders that clinicians were frustrated around the pace of change and the legacy of the organisation. They knew it was a critical point engaging with those individuals as they were a positive group of clinicians who wanted to drive change and improvements, and they needed to create space for innovative pathways led by consultants. Conversations had been held about what a new engaged workforce looks like.

The trust's engagement in their improvement plan was through 'regain and renew', leaders told us meaningful conversations were held to ensure all teams felt empowered to own their improvements, aligned with a common purpose. The trust was at the start of their regain and renew plan and had held more than 94 conversations with teams. The trust received feedback that teams appreciated senior leader visibility and the opportunity to enter direct discussion.

Trust talks were held monthly where the chief executive, supported by a director, provided feedback on what has happened at board, this was held both face to face and online, with recordings available on the trust intranet.

The trust participated in surveys to gain feedback from their staff. This included the national NHS staff survey, quarterly pulse surveys and a recent just culture survey.

The trust engaged with patients and had a patient experience and engagement group. The patient experience and engagement strategy in 2022 was co-designed with patients. Engagement was held with local people in the development off the health and wellbeing centres. Building brighter future roadshows were completed in communities with local councils and community groups. Co-production of services was done with patients, users and services, for example a long-term conditions group led the design of apps and programmes.

The trust used different approaches to capture the patient voice. The trust worked closely with Healthwatch to help understand the voice of the patients and make improvements. Friends and family test was used to gather feedback from patients, in June 2023 the trust saw an increase with a 50% response rate. Patients and carers were invited to board to share their experiences of care. Patient groups were held and the trust had a service user and carer involved for dementia. There was a working with us panel of volunteers who could talk to people.

Seminars had been held with ward managers, matrons and therapists, where staff were provided with briefings and updates and picked five patients on a ward to tell them today what has happened. This was fed back into the trust's fantastic fundamentals. The trust had also started a live questionnaire randomly picking 10 patients a month to call and ask their experience of discharge, to provide live feedback and a sense check and identify themes for sharing.

It was acknowledged there was not a robust way of measuring or capturing people's mental health experience.

Learning, continuous improvement and innovation

There was a focus on continuous learning and improvement, including appropriate use of external accreditation and participation in research. There had been significant investment in quality improvement, but this was not yet fully embedded across the organisation and staff found it difficult to have time to engage in quality improvement work. Internal and external reviews were used to identify learning and make improvements.

Our findings

There had been significant investment in quality improvement, with a business case signed off in July 2022, to include financial input and extra resource, and the board was committed to quality improvement. An improvement and innovation building capability framework was set out to support creating a culture of continuous learning and improvement. The quality improvement team worked alongside executives to deliver workload priorities. Quality improvement was not yet fully embedded in the organisation and was still working to deliver meaningful and sustainable change. However, there was no real policy and process embedded in the organisation and no repository of work which was being done.

Staff told us although they could have support from the quality improvement team, they struggled to find time to be able to complete quality improvement. We were provided with examples where quality improvement had supported individuals or teams to complete work and projects to make improvements to the care provided. Some staff spoke of quality improvement boards focusing on what they can achieve locally and the goals they have.

The trust participated in research. However, there was a lack of investment in research for clinicians. Research had not been well invested with clinicians currently only offered, on a competitive basis, 5 programmed activities for research. This was part of a pilot to understand the extent of financial return and for patients and quality of their care. The ability to offer research and clinical trials would help to attract and retain medical staff.

Internal and external reviews were used to identify learning and make improvements. However, some staff commented how they didn't feel the learning from reviews and investigations was always embedded or action plans followed up and completed.

The trust worked with national leaders to help make improvements, to include getting it right first time and the emergency care improvement support team. The trust continued to learn from industrial action days and this learning was being brought into business as usual.

The trust celebrated success and their people, to include the people awards based on the 7 strands people promise, daisy award for nurses, primrose award for healthcare workers, junior doctor award under training, and long service award. As well as regional and national award ceremonies.

The trust provided examples where they have been innovative, this included:

- Health connect coaching, a volunteer, peer led, health and wellbeing coaching programme designed and developed with people who have lived experience of long term health conditions. The programme aims to support and empower individuals who are struggling to manage their condition, to build their knowledge, skills and confidence for self-management of their health and wellbeing. This programme grew out of a large co-design event held in September 2019.
- Digital futures transforming healthcare through digital innovation, uses the innovative application of virtual reality, extended reality, and emerging technologies within the NHS. Examples included the adolescent mental health app, virtual reality sexual harassment training, extended reality community simulation van and augmented reality multiple sclerosis clinic.
- NHS clinical entrepreneur programme innovation sites pilot programme, the trust applied and was successful in its bid to become a pilot site to introduce new treatments and diagnostics which can transform care. The programmes for the trust revolve around the continued need to release capacity within acute services and standardise pathways.

Our findings

- Torbay charts patient decision aids platform, co-created with input from clinicians, subject matter experts, patient groups, and expert patient panels. It provides a disease continuum with all treatment options populated at relevant stages allowing users to navigate the information and make choices. Currently this has been fully developed for the hip and knee arthritis pathways.
- Assessment and accreditation, the ward accreditation programme commenced in July 2020 and has evolved over time. The framework is designed around fundamental standards divided into sections relating to environment, care, and leadership. Assessment includes observation of practice and the environment, direct feedback from patients, questions to staff and examination of records and audits to provide a cumulative overall score. Clinical areas and services can progress through white, bronze, silver and gold awards, aiming for improvement where identified, and the maintenance of consistent practice and performance.
- Chief nurse research fellow, the fellowship offers protected clinical time, links with other research centres and mentorship from the chief nurse.
- Stay and thrive international recruitment and pastoral care award. Since 2021 the trust has recruited 220 internationally educated nurses and initiatives were introduced to support these nurses when joining the organisation. The trust was awarded the NHS pastoral care quality award in May 2022.
- Quality boards were used to aid local ward based quality improvement, displaying the quality journey and its data to evidence to staff, patients and visitors what the teams were doing to improve quality.

There were several research projects completed by the trust, some examples include:

- In the 2022/23 financial year there was recruitment of 2476 patients into 57 studies across 20 clinical specialties.
- In July 2023 the trust was ranked number 2 in the country for recruitment into commercial cancer trials.
- In July 2023 the trust was the first site in the UK to open a trial of oral medication for patients with lung cancer with a specific gene mutation and were the first site or a patient to be on the trial in the UK.
- The trust was the first recruiting site in the South West to an ophthalmology study.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Nov 2023	Requires Improvement ↓ Nov 2023	Outstanding ➔➔ Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement ↓ Nov 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Adult social	Good	Good	Good	Good	Good	Good
Community	Good	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Outstanding ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Torbay Hospital	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023
St Edmunds	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Overall trust	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Outstanding ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Torbay Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023	Good Jul 2020	Good → ← Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023
Services for children & young people	Good Jul 2020	Good Jul 2020	Good Jul 2020	Good Jul 2020	Good Jul 2020	Good Jul 2020
Critical care	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
End of life care	Requires improvement May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Surgery	Requires improvement Jul 2020	Good Jul 2020	Good Jul 2020	Requires improvement Jul 2020	Requires improvement Jul 2020	Requires improvement Jul 2020
Patient transport services	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Urgent and emergency services	Requires Improvement ↑ Nov 2023	Requires Improvement → ← Nov 2023	Good → ← Nov 2023	Requires Improvement → ← Nov 2023	Good ↑ Nov 2023	Requires Improvement → ← Nov 2023
Maternity	Requires improvement Jul 2020	Good Jul 2020	Good Jul 2020	Good Jul 2020	Requires improvement Jul 2020	Requires improvement Jul 2020
Outpatients	Inadequate ↓ Nov 2023	Not rated	Good → ← Nov 2023	Requires Improvement ↓ Nov 2023	Good → ← Nov 2023	Requires Improvement ↓ Nov 2023
Diagnostic imaging	Requires Improvement Nov 2023	Not rated	Good Nov 2023	Good Nov 2023	Requires Improvement Nov 2023	Requires Improvement Nov 2023
Overall	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023	Good → ← Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023

Rating for St Edmunds

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Jul 2020	Good Jul 2020	Good Jul 2020	Good Jul 2020	Good Jul 2020	Good Jul 2020
Community health services for children and young people	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Community end of life care	Requires improvement May 2018	Requires improvement May 2018	Good May 2018	Good May 2018	Requires improvement May 2018	Requires improvement May 2018
Community urgent care service	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community dental services	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016
Community health services for adults	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Overall	Good	Good	Outstanding	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Torbay Hospital

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Description of this hospital

Torbay hospital is an acute general hospital delivering a wide range of emergency, specialist, and general medical services.

We inspected 4 core services to include diagnostic imaging, medical care, urgent and emergency care and outpatients.

Diagnostic Imaging

The diagnostic imaging department currently includes general X-rays, fluoroscopy and interventional radiology, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, ultrasound imaging, mammography, and dual energy X-ray absorptiometry (DXA) scans. For the purposes of this report, the different types of examinations taken will be referred to as modalities.

In the 12 months up until the inspection, the service had performed a total of 179,542 examinations across all modalities. This included 31,585 CT scans, 13,674 MRI scans, 91,854 plain film x-rays and 22,716 non obstetric ultrasound scans.

The inspection team comprised of a CQC inspector and a specialist advisor with expertise in diagnostic imaging. We spoke with 20 members of staff and 6 patients and observed interactions with patients throughout the day.

Medical Care

At Torbay Hospital, medical services include (but are not limited to) general medicine, respiratory medicine, cardiology, renal services, gastroenterology, elderly care, dementia services, dermatology services, stroke services and specialist cancer services.

The trust provides inpatient facilities and outpatient clinics, with clinics at the main hospital sites and as part of wider services based in the community. During this inspection we only visited medical services at Torbay Hospital.

During inspection we visited the George Earl Ward, Simpson Ward, Cheetham Hill Ward, Turner Ward, Medical receiving Unit (MRU), Midgley Ward and New Forrest Ward. These wards were part of the medical care directorate.

Our findings

The inspection team comprised of 3 CQC inspectors, 1 member of the CQC medicines team and 1 specialist nurse advisor.

We spoke with members of staff, including members of the senior leadership team, nurses, doctors, speech and language therapists, healthcare assistants, domestic and housekeeping staff and patients. We reviewed 14 sets of patient records focusing on the Mental Capacity Act and 9 patient records, which included medical, nursing and observation records.

Urgent and Emergency Care

Urgent and emergency care services are provided at Torbay Hospital, they are delivered as part of the Newton Abbot Integrated Service Unit (ISU) which is the system providing urgent and emergency care. The emergency department operates 24 hours a day, seven days a week.

Adult patients receive care and treatment in two main areas: minors and majors. Patients with serious injury or illness, who usually arrive by ambulance, are seen and treated in the majors' area. This includes a resuscitation area with four cubicles, and 16 cubicles and side rooms, additionally there are four allocated areas which are used, when needed, on a stretch of corridor. The majors' area is accessed by a dedicated ambulance entrance.

Self-presenting patients with minor injury are assessed and treated in the minors area. There is a dedicated children's unit within the main emergency department with a small separate waiting area. A further waiting area for children is designated in the main waiting room.

The emergency department is a designated trauma unit and provides care for all but the most severely injured trauma patients, who would usually be taken by ambulance to the nearest major trauma centre. If the patient is not suitable to travel immediately, they may be stabilised at Torbay Hospital and transferred as their condition dictates.

The department is served by a helipad.

From March 2021 to March 2022 there were 101,210 attendances at the trust's urgent and emergency care. (Source: Hospital Episode Statistics)

The inspection team comprised of 1 CQC inspector, 1 CQC senior specialist in secondary and specialist care, 1 member of the CQC medicines team, and 2 specialist advisors to include a consultant and nurse.

As part of the inspection we spoke with 6 patients. We spoke with 21 staff, including nurses, doctors, managers, support staff and ambulance staff. We observed care and treatment and reviewed 10 care records.

Outpatients

Torbay and South Devon NHS Foundation Trust provides outpatient services at Torbay Hospital and 4 community hospitals throughout the region. These are Newton Abbot Community Hospital, Paignton Hospital, Teignmouth Hospital and Totnes Hospital.

We inspected outpatient services at the Torbay Hospital site. We did not visit outpatient services at Newton Abbot Community Hospital, Paignton Hospital, Teignmouth Hospital or Totnes Hospital. However, after the inspection we spoke to some staff based at the community hospitals.

Our findings

At Torbay Hospital, there is a dedicated outpatient department. In addition to this there is a dedicated oncology outpatient department, breast care department, and several specialist dedicated outpatient clinics. These include dermatology, ophthalmology, and cardiology. Throughout the report we will refer to the different outpatient departments as OPDs.

Throughout the report the outpatient department has been shortened to OPD.

The inspection team comprised of 2 CQC inspectors and 1 specialist advisor nurse.

The team visited the main OPD unit, the Crow Thorne Unit, ophthalmology, dermatology and the fracture clinic. We spoke with 21 members of staff (including managers, nurses, healthcare assistants, healthcare professionals, medical secretaries, receptionists and administrative staff). We spoke with 12 patients and 2 relatives and carers. We observed 2 patients undergoing minor procedures.

Diagnostic imaging

Requires Improvement

Is the service safe?

Requires Improvement

We have not inspected safe before. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to staff, but not everyone completed it.

Staff received and kept up to date with their mandatory training. Data submitted showed in May 2023, 87.5% of staff had completed all their required mandatory training against a trust wide target of 85%. However, only 67.5 % of staff had completed manual handling training and 78.5% had completed information governance training. This was below the trust's target, however, managers explained reminder emails had been sent to all staff whose training had lapsed.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. Staff had access to mandatory update training in learning disability and autism awareness. However, data submitted showed 54% of staff had competed this training at the time of the inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training.

There was evidence all staff working with radiation had relevant training in the regulations, radiation risks, and the use of radiation and we saw from training records, modules covering Ionising Radiation (Medical Exposures) Regulations (IR(ME)R).

Safeguarding

Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Training compliance rates for level 1 safeguarding adults and children in May 2023 was 92.9% and 88.31% respectively. In line with legal requirement, staff also completed Level 2 training. Data submitted showed 94.5% compliance for adults and 84.3% for children. Four radiographers were trained to level 3.

Safeguarding training was included and monitored through mandatory training records.

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

Diagnostic imaging

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, in the breast care team, staff contacted the safeguarding team when a patient raised concerns about one of their carers.

Staff knew how to make a safeguarding referral, and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department. However, there were few dedicated children's waiting areas.

Staff were aware of their responsibilities surrounding female genital mutilation which was included in safeguarding training modules.

Information regarding safeguarding from abuse was displayed where service users could see it including domestic violence advice in toilets.

Staff were able to always access a named or designated professional for advice 24 hours a day.

The department had developed dedicated training resources for staff involved in non-accidental imaging of children and had worked with a university to offer this training nationally.

There was a chaperoning policy for children and young people which staff were aware of and understood. However, information about chaperone availability was not on display in some areas.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean. However, in some modalities there were few records to support this.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

In some areas we visited there were no cleaning records to demonstrate all areas were cleaned regularly. Following our inspection and a review of existing cleaning oversight documents, the service had introduced a new daily cleaning record for staff in all areas to fill in and submit.

Staff followed infection prevention and control (IPC) principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff undertook mandatory IPC training. Data supplied showed in May 2023, 83.7% of staff had completed this training against an 85% trust target.

The service used infection control measures when carrying out x-rays or scans where people had or were suspected of having infectious or communicable diseases. Deep cleans of scan rooms were available from the onsite cleaning team on request. These patients were also scanned at the end of the procedure lists to allow for deep cleaning and to minimise contact with others.

Diagnostic imaging

Local hand hygiene audits were performed monthly, and data showed that in June 2023 the service achieved 100% compliance. However, in the 12 months prior, audits had not been performed in 6 out of 12 months.

The service carried out a standard review once a month which sampled 16 points of IPC compliance. Data submitted showed the service achieved between 88% and 100% compliance with clear actions recorded where necessary.

Ultrasound probes were cleaned using a 3-step disinfecting system following intimate examinations.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, some MRI equipment was not labelled as safe.

Patients could reach call bells and staff responded quickly when called. Each sub waiting area in the main department had a call bell which was in reach of patients.

Staff carried out daily safety checks of specialist equipment including CT scanners and X-ray equipment.

The service had suitable facilities to meet the needs of patients' families. There was plenty of seating and waiting areas were spread out.

Adults and paediatric patients attending for CT scans often had to use a disabled toilet to change into a gown for their examination as there were no dedicated changing facilities close to the scanner.

The service had enough suitable equipment to help them safely care for patients including manual handling equipment such as standing aids in breast care.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and dated. They were disposed of in line with trust policy.

Resuscitation equipment was readily available, adequately stocked and there was evidence of regular review. Resuscitation equipment seen was clean and in good condition.

The imaging service had risk assessments for all new or modified use of radiation. However, these had not been reviewed or updated for several years, in line with the previous radiation protection advisor (RPA) recommendations. A new RPA had started employment around the time of our inspection and had picked this up as an area to address. Risk assessments we viewed addressed occupational safety as well as considering risks to people who used services.

Not all relevant MRI equipment was labelled in line with the Medicines and Healthcare Products Regulatory Agency Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use (February 2021). This meant it was not always clear if equipment was safe to enter the MRI scanner or the MRI scanner room. Following our inspection, the team reviewed all equipment and provided evidence to show all equipment was now clearly marked.

The imaging service ensured areas where ionising radiation was used were controlled and access was restricted. Warning signs were present on all rooms using ionising radiation and the MRI scanner door had a key code lock which prevented any unauthorised or accidental access.

Diagnostic imaging

There was clear signage where ionising radiation exposures occurred.

Specialised PPE was available and used by staff and carers when needed.

Lead aprons, lead screens and syringe shields in nuclear medicine were checked annually to ensure their integrity.

The service had an equipment quality assurance programme for all equipment which was carried out as recommended by the medical physics expert and manufacturers guidance.

Service contracts were in place for all equipment and there was a clear process for maintenance and for reporting of any faults.

There was documented process for the safe handover of equipment to engineers before and after planned or emergency maintenance.

The service managed aging equipment and equipment failures through a capital replacement programme and servicing contracts.

The service monitored staff for radiation exposure using thermo luminescent devices which monitored each radiographer's personal radiation exposure. These were changed quarterly, and any out-of-range readings were flagged with the individuals affected and investigated.

Where radioactive substances were used in nuclear medicine, there were effective arrangements to contain any incidents such as radioactive spillage and staff undertook specialist training to respond to such an incident.

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, checks to ensure the correct patient received the correct scan were not always effective.

Staff responded promptly to any sudden deterioration in a patient's health. Staff undertook level 1 resuscitation training which included basic lifesaving skills for both adults and paediatric patients. Data submitted for May 2023 showed 98% of staff had completed this training.

There were clear pathways and processes for the management of people who were, or became, clinically unwell.

There were procedures in the event a patient collapsed in MRI and nuclear medicine, and these were practiced.

Staff shared key information to keep patients safe when handing over their care to others and handovers included all necessary key information.

There was a policy for sepsis management and staff were aware of it.

The service had access to mental health support for both staff and patients and had several trained mental health first aiders.

Diagnostic imaging

There was a clear pathway and transfer policy for the management of patients using services within the radiology departments who were clinically unwell and required hospital admission.

The service followed the Royal College of Radiologists standards for the communication of radiological reports which included fail-safe alert notifications to flag any urgent or unexpected findings. Reports were run twice a day to make sure all flagged reports were acted on.

The service did not always ensure the right person got the right scan, at the right time. The service reported 7 incidents in the 2 years prior to our inspection where scans or x-rays had been requested and performed on the wrong patient or duplicate scans had been performed. Staff explained referring doctors had selected the wrong patient at the point of requesting, which had not been picked up by the vetting process. We saw staff in the emergency department had acted as a result including taking regular breaks and monitoring of workloads whilst on duty.

The service held a list of approved referrers and any requests received from persons not on the list were immediately escalated for clarification.

The service ensured that the radiation protection advisor and the medical physics expert were easily accessible for providing radiation advice.

The service appointed radiation protection supervisors (RPS) in departments which used ionising radiation. Staff told us they had attended specialist training to undertake the RPS role and felt supported by senior management and the training was of good quality.

The service ensured the 'requesting' of an X-ray, nuclear medicine or other radiation diagnostic test by GP's or other approved referrers was only made by staff in accordance with IR(ME)R. The service adopted referral criteria and held a database which clearly showed the scope of requesting each referrer both medical and non-medical.

Staff were able to attend debriefs and had access to support following incidents of aggression or violence. Staff were supported by a dedicated security team.

The service ensured staff were aware of patients who were or may be pregnant, in accordance with IR(ME)R, and Ionising Radiation Regulations (IRR) 2017. We saw posters displayed in patient areas asking patients to speak to a member of staff before they were scanned if they were, or maybe pregnant.

There was a pregnancy procedure which took account of both cisgender women and transgender men in line with the Inclusive pregnancy status guidelines (Society of Radiographers, 2021). The department had developed an inclusive pregnancy check form and consulted the trust LGBTQIA+ network for feedback.

Not all eligible patients had their pregnancy status determined in line with legal requirements. A recent audit from 2022 showed in CT, 82.5% of eligible patients had their pregnancy status checked and documented. In plain film, 90.8% of eligible patients were checked and documented. This was below the trust target of 95%. We saw the service had clarified the pregnancy policy to state patients over 55 did not need to be checked as this was the biggest area of discrepancy which accounted for most of the undocumented checks.

Staff followed the Society of Radiographers "pause and check" guidance when checking patient's identity before administering injections or scanning/imaging patients.

Diagnostic imaging

Staff in MRI received training on identifying specific risks such as pacemakers or metal implants.

The service followed the Royal College of Radiologists standards for intravascular contrast agent administration and National Institute for Health and Care Excellence Acute kidney injury guidelines when administering iodine-based contrast agents. The local policy and risk assessment showed the steps taken to help prevent contrast-induced nephropathy.

The service had a dedicated cannulation room for CT. All cannulations were completed by a trained assistant practitioner. Extravasations were reported through the National Reporting and Learning System.

There were local policies to document, investigate, and make a referral to a specialist allergy service should a patient experience an allergic reaction to contrast.

There were clear processes to escalate unexpected or significant findings both at examinations and upon reporting.

Managers ensured Local Safety Standards for Invasive Procedures using the National Safety Standards for Invasive Procedures. Data submitted showed in May 2023, the service achieved 100% compliance against the World Health Organisation safer surgery checklist modified for use in radiological settings.

There were processes and information leaflets to direct patients as to what to do if they had a complication post procedure in various formats and languages.

The service utilised dedicated pre assessment clinics for patients attending for interventional procedures which included starting the consent process in advance of the procedure.

The service had a set of local rules (IRR) and employer's procedures (IR(ME)R) which protected staff and patients from ionising radiation.

When children were seen, the service had access to a paediatric crash team in the event of a medical emergency or deteriorating child. Staff told us they needed to state the emergency was paediatric when making the crash call.

Staffing

The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe however, recruitment and retention was a challenge due to general staffing shortages.

The senior management team included a radiology manager, a deputy radiology manager, a quality assurance manager and a clinical lead radiologist. Each modality had a lead superintendent radiographer.

Diagnostic imaging

At the time of our inspection, the service employed 73 radiographers (both full and part time). Most areas were fully staffed at the time of our inspection, except for CT which was operating at 70% of establishment and plain film which was operating at 76% of establishment. Overall, across all staff groups, the service had a 15.33% vacancy rate. Six radiographers had been recruited from local universities and were due to start later in the summer. Two further radiographers had been recruited from overseas and had begun working in the department.

Senior leaders were also promoting radiographer apprenticeships which would give the apprentices access to university training to become radiographers. This opportunity would fit around their lives and commitments where otherwise they would not have been able to access the training.

The service had 19 radiologists with a further 2 radiologists starting in October 2023. Vacancies had been filled by locum radiologists in the interim. There was currently only 1 interventional radiologist onsite however, the department was using locums to support the service.

Managers accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance. The manager adjusted staffing levels daily according to the needs of patients. The service generally had a low rate of staff sickness across all modalities. In May 2023 overall sickness across the service was 1.9%.

The service tried to limit their use of bank and agency staff and requested staff familiar with the service. However, due to staff long term absences, managers explained they needed to use up to 50% agency staff to support the CT service at present.

All bank and agency staff had a full induction, and the modality/clinical lead assessed staff before they were signed off to start work.

The service carried out lone working risk assessments to minimise risks associated with lone working, and as a result the department was being fitted with a new CCTV system in communal areas.

The service ensured it had adequate diagnostic staffing to support cancer services. The service utilised overseas recruitment and actively reached out to local universities. It also utilised nearby community diagnostic centres to keep up with demand.

Managers could access locums when they needed additional medical staff and made sure they had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends through a combination of consultant on call rota cover from a local radiology training academy.

Radiographers could always contact a radiologist for advice even if the radiologist was not onsite. Staff used telephone calls and online messages to communicate with the radiologist.

The service used teleradiology services for out of hours work and normal reporting. Staff had access to these radiologists for queries and advice.

Staff had access to a trained clinician when contrast was administered.

Records

Diagnostic imaging

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, previous images were not always reviewed when vetting imaging requests.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely.

All requests were entered onto the radiology information system. The service ensured imaging requests were appropriate and included the relevant information to allow for requests to be justified in accordance with Ionising Radiation (Medical Exposures) Regulations (IR(ME)R). Patient request forms we reviewed included all the required information, medical history, and clinical indication for the scan.

The service provided electronic access to diagnostic results within the hospital and to GPs.

Information was transported with patients when attending for scans or procedures. Staff were aware of relevant clinical and care requirements such as fall assessments, do not attempt cardiopulmonary resuscitation, and renal function if contrast was needed.

As part of the justification process to carry out exposure to radiation, the service attempted to make use of previous images of the same persons requiring the test, even if they had been taken elsewhere. However, we saw 5 incidents reported to Care Quality Commission where images or information had not been reviewed when vetting scan imaging requests which resulted in a scan being performed on the wrong patient. Additionally, we saw a further 4 incidents reported where booking information had not been reviewed which resulted in patients receiving a duplicate scan or a scan before they were due.

There was a secure transfer of data to and from teleradiology companies. All transferred data and images were deleted 30 days after transfer to comply with trust information governance policy and legislation.

Reporting was undertaken by a mix of in-house radiologist/radiographers and external teleradiology services. The service stored images on a Picture Archive Communication system. Internal reports were available electronically, but some external reports were paper based. The administration and clerical team managed this with an agreed process for sending urgent results back to referrers.

Medicines

The service used systems and processes to safely prescribe, administer, and record medicines. However, there was no patient group direction to support radiographers administering saline and not all medicines were stored appropriately.

Staff followed systems and processes to prescribe and administer medicines such as saline. The service used Patient Group Directions (PGDs) to administer medicines including contrast when conducting scans. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presenting for treatment. However, at the time of our inspection the trust did not have a PGD which covered all areas using vials of saline. In response to our inspection, the service introduced both an updated nuclear medicine request form and an overarching PGD for the use of saline across all modalities.

Staff stored contrast safely in a lockable cupboard. Contrast was in date, but staff did not monitor temperatures the contrast was stored at. No contrast had been stored in direct sunlight.

Diagnostic imaging

Staff completed medicines records accurately and kept them up to date. They recorded contrast batch numbers clearly in patient records after administration. Staff kept records of all doses administered in nuclear medicine using dedicated specialist software.

Staff checked for allergies and some pre-existing conditions such as diabetes prior to giving patients iodine-based contrast.

Staff in nuclear medicine ensured that the right radiopharmaceutical and activity was sourced, prepared, and injected. All doses were double checked at the point of drawing up and at the point of administration

In nuclear medicine both the trust and the practitioner (radiologist) held in date IR(ME)R licenses (formerly ARSAC certificates) for the administration of each radioactive medicinal product.

There was a clear scheme of delegation for injecting radiopharmaceuticals which was clearly documented and in date.

Staff in nuclear medicine, as part of imaging protocols, sometimes gave patients medicines such as furosemide (a diuretic used in some CT and nuclear medicine scans). Medicines were risk assessed and covered under the radiopharmaceutical scheme of delegation (a document which gave each staff member permission to give radiopharmaceuticals and medicines for specific purposes). However, radiologists did not specify what medicines were to be given to which patient. Following our inspection, the service introduced a policy to ensure radiologists included this information when vetting each scan and request forms were updated to reflect this.

Incidents

The service generally 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 and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts and incidents were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff reported serious incidents clearly and in line with the service's policy.

The service had no never events. Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The provider’s incident management policy established the threshold to guide staff in line with The Royal College of Radiologists position statement in relation to duty of candour in diagnostic imaging (October 2015).

Staff received feedback from investigation of incidents, both internal and external to the service. Managers ran monthly reports to look for trends and themes and disseminated this down through specialty meetings to staff.

Diagnostic imaging

Staff met to discuss the feedback and look at improvements to patient care and there was evidence that changes had been made because of feedback. For example, the service identified a cluster of allergic reaction to contrast, so used the Medicines and Healthcare products Regulatory Agency yellow card scheme to report the reactions and immediately removed the batch of contrast from use.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. All staff were included in emergency department debriefs following difficult or traumatic incidents.

The service ensured radiation incidents were fed into risk management and for accidental and unintended exposures, notified to the Care Quality Commission under IR(ME)R or to the health and safety executive under IRR requirements.

Between October 2020 and April 2023, the service reported 12 IR(ME)R incidents where a significant accidental or unintended exposure had occurred. There was evidence of cross departmental working following these incidents for the service to be assured emergency doctors had understood the incidents and instigated changes as a result, which included delegation of work and taking regular breaks. All incidents relating to the dose of radiation received were reviewed by a Medical Physics Expert and recorded in investigation reports.

Is the service effective?

Inspected but not rated

We inspect but do not rate effective in line with CQC current methodology.

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 protected the rights of patients subject to the Mental Health Act 1983. However, there was limited evidence of audit to ensure procedures and protocols were up to date in some modalities.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance such as Ionising Radiation (Medical Exposure) Regulations 2017, the Royal College of Radiologists and the National Institute of Health and Care Excellence (NICE). However, the service did not always regularly review policies and standard operating procedures and some modalities did not have any imaging protocols written down. The service ran monthly clinical imaging and reporting audits but there was no evidence of any reject analysis audits.

The service ensured radiation doses were kept as low as reasonably practicable. The service had a clinical audit and effectiveness programme which included auditing radiation dose reference levels (DRLs) for comparison to national levels. Audit data showed the service highlighted changing or increasing DRLs (such as for head CT scans) and recorded actions such as emphasising the importance of recording patient weights to better improve dose analysis in the future.

Diagnostic imaging

Staff audited practice against the Society of Radiographers and 'pause and check' standards. Data submitted showed between February 2023 and April 2023 plain film ID check compliance increased from 87% in the previous audit to 91%. Over the same time frame in CT compliance improved from 41% to 74.8%. However, both departments did not meet the trust target of 95% and we saw actions recorded to improve this.

The ultrasound service authorised and consented procedures in line with British Medical Ultrasound Society policies.

The service ensured it identified and implemented relevant best practice and guidance, such as NICE guidance. A clinical audit team monitored publication and new guidance and disseminated it to service leads for consideration and implementation if relevant.

Nutrition and hydration

Staff gave patients food and drink when needed. Patients could access specialist dietary advice and support.

Patients were provided with specific instructions relating to eating and drinking prior to their scan within the appointment/booking information if required.

Staff made sure patients had enough to eat and drink. There were facilities for hot and cold drinks available.

There were processes for vulnerable patients such as diabetic people. The bookings team identified these patients who were placed at the beginning of lists to minimise fasting time for procedures where these were required.

Where an investigation required food or drink consumption, staff were able to manage patients with special requirements, such as using gluten free produce for Fluoroscopy or Nuclear Medicine procedures.

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 used appropriate tools to help assess the level of pain in patients who were non-verbal. For example, Disability Distress Assessment Tool was used to help to identify the source of pain. Abbey Pain Scales were used for people with dementia, and the learning disabilities team had developed a toolbox including face pain scales.

Patient outcomes

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

The service participated in relevant national clinical audits. The service reviewed the effectiveness of care and treatment through local audit and national audit with a structured audit programme. Managers and staff used results to produce action plans and improve patient outcomes.

Diagnostic imaging

The service did not currently have Quality Standards for Imaging (QSI) accreditation from the United Kingdom Accreditation Service (UKAS). The QSI were developed by The Royal College of Radiologists and the College of Radiographers. It sets out criteria that defined a quality imaging service. UKAS accreditation is a patient-focused assessment designed to give patients and their carers confidence in their diagnosis and all aspects of their care. However, the service was working towards trust accreditation in the future.

The service used onsite and teleradiology remote reporting. The company produced a monthly report which showed report turnaround times across all specialities was between 2-3 days.

Quality assurance and audit standards for ultrasound reflected national best practice and staff reported scans immediately.

There was evidence the service had changed processes in response to their audits. For example, the service had changed the coding of some CT scans to non-contrast scans if an abnormality was seen on a chest x-ray.

The service undertook regular Radiology Events and Learning Meetings in line with Royal College of Radiologists guidance and monitored these meetings with evidence of historic case discussion and learning.

The service regularly reviewed the effectiveness of care and treatment through national audit.

CT scan timeliness data fed into the overall hospital stroke performance and data submitted to the most recent Sentinel Stroke National Audit programme showed 65.5% of patients received a scan within one hour and 98.2% of patients received a scan within 12 hours, which was an improvement on previous months.

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. However, not all staff had received an appraisal.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers identified any training needs and made sure staff received any specialist training for their role and gave them the time and opportunity to develop their skills and knowledge.

Managers gave all new staff a full induction tailored to their role before they started work. This included a preceptorship programme to enhance the competence and confidence of newly registered practitioners as autonomous professionals in line with Department of Health (2009) Preceptorship Framework.

Managers supported staff to develop through yearly, constructive appraisals of their work. As part of their annual appraisals, staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. However, data submitted showed in May 2023, 73.6% of staff had received an appraisal against a trust target of 85%.

Staff maintained up to date training on the safe use of equipment in line with their professional registration and manufacturer's guidance. Managers made sure staff received any specialist training for their role. Nursing staff and radiographers were supported to maintain registration with relevant professional bodies.

Diagnostic imaging

Results from the 2022 staff survey showed some staff felt they had opportunities to improve their knowledge and skills and there were opportunities for them to develop their career. However, burnout, work pressures and appraisals had the poorest scores.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve. Performance of clinical staff was monitored through peer review and quality audit. Any issues were discussed in a supportive environment to enhance learning or highlight areas of improvement.

Managers completed an induction process for bank/agency staff. General induction included an introduction to the team, department and facilities, equipment training, policies and procedures including IR(ME)R and local rules. Specific requirements were completed for entry into radiation-controlled areas.

Equipment training records were available for any staff who operated imaging equipment, including, radiologists, radiographers, surgeons, and cardiologists. We also saw discussion of this recorded in radiation protection committee meeting minutes.

The imaging service provided referral guidance and training on the electronic requesting system, as part of the induction for doctors and other referrers. Videos were available and formed mandatory training for all non-medical referrers.

Where images were reported outside of radiology, there was evidence that these members of staff were trained and followed the Royal College of Radiologists guidance.

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 team (MDT) meetings to discuss patients and improve their care. Each radiologist led for a different MDT specialty. Preparation time for meeting was factored into job plans and administrative support was available.

Radiography staff had also established a non-medical MDT programme which involved other specialities such as physiotherapy. Meeting minutes showed these were well attended and key issues, such as the use of 2 week wait requests being used to expedite non cancer related plain film requests, were discussed.

Patients could see all the health professionals involved in their care at one-stop clinics. This included the breast clinic where patients saw a consultant, nurse specialist, and imaging staff in the same appointment.

The service supported some extended roles for radiographers and other healthcare professionals, such as plain film reporting with support by radiologists.

The service incorporated NHS England's rapid cancer diagnostic and assessment pathways, as well as local diagnostic protocols where applicable, to support the Faster Diagnosis Standard. In March 2023, 77% of patients who had been referred by their GP for suspected cancer were either diagnosed or had cancer ruled out within 28 days against a national 75% target.

Diagnostic imaging

Seven-day services

Key services were available to support timely patient care.

The service provided access for plain film 24 hours a day 7 days a week.

There was an on-call system for CT during evenings and weekends. Out of hours advice was provided as part of the Peninsula Registrar on call system.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needing to live a healthier lifestyle.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If staff felt a patient lacked the capacity to consent to the procedure, they would seek further advice from the referrer. Patients were provided with written and verbal information prior to their appointment to enable them to understand the planned diagnostic test.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Where written consent was required, staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Is the service caring?

Good

We have not rated caring before. We rated it as good.

Diagnostic imaging

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 saw staff were extremely polite and courteous when speaking with patients and their families and carers.

All patients we spoke with said staff treated them with kindness and showed compassion. The service was reviewing the way in which it utilised the friends and family test due to low response rates. A new questionnaire was under development at the time of our inspection.

The service held a compliments tracker and shared feedback with staff. We saw from comments that patients felt staff treated them with the level of care they expected.

Staff followed policy to keep patient care and treatment confidential. The main x-ray department was surrounded by a long, square corridor which formed the waiting area. There were plenty of spaces where patients could speak in confidence with staff if requested.

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.

When intimate examinations were performed by a member of staff of the opposite sex, patients were always offered the option of a chaperone, especially in ultrasound, although this was not publicly advertised outside of this department.

Staff tried to ensure, where possible, chaperones were the same gender as the patient.

Staff displayed understanding and an inclusive attitude towards patients who had mental health, learning disability, autism or dementia diagnoses. Staff described recent mandatory training they had undertaken and how it had sparked conversation about how disabilities manifest in different behaviours.

Staff supported patients who might be frightened or confused about their scans or equipment used, and often invited them into the department to familiarise themselves with the equipment before their scans.

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 in CT, MRI and Nuclear Medicine checked patients understanding of their procedure and gave them time to discuss their concerns at length if needed.

Diagnostic imaging

Staff in MRI provided patients with choices to listen to music, wear headphones and provided ear protection to reduce stress during scans. Patients in MRI also had access to changing areas and lockers were available to safely store personal belongings during their appointment.

Staff supported patients who became distressed in an open environment such as a waiting room, staff helped them maintain their privacy and dignity.

Staff in obstetric ultrasound undertook training on breaking bad news and demonstrated genuine empathy when having difficult conversations.

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. The ultrasound team were observed to be particularly responsive, kind and caring when scanning patients.

Staff in the bookings team provided people who used services with information leaflets and written information to explain their appointment or scan.

Imaging options were discussed with people, and they were encouraged to be part of the decision-making process. Staff worked together to achieve the best outcomes for patients by producing good quality, diagnostic images.

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. Information sheets were available for patients as well as information about each modality was available on the hospital's website. We saw posters in the reception area and in various waiting rooms. These gave information about x-rays in general, radiation doses, staff uniforms, pregnancy status and updates about the department. Staff and patient information were kept separate.

Staff spoke with patients, families and carers in a way they could understand. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service. We spoke with 6 patients, and all were consistently positive about the services offered. Patients told us 'Staff have been so lovely' and 'they really helped me stay calm for my scan'.

Staff supported patients to make informed decisions about their care. We saw staff gain consent, either verbal or written depending on the modality. This included checklists with details of contra-indications and any contrast medium to be used. We saw patients having CT scans being informed about associated dangers of radiation in an open, calm, professional manner and in a way patients could understand.

Following their tests, patients told us they understood how and when they would receive their test results. Patients told us their GPs received copies of letters and reports.

Safeguarding from abuse information was not openly displayed, but some information about domestic violence was discretely displayed in toilet areas.

Diagnostic imaging

Staff had access to communication aids and used the patient's own preferred methods of communication where possible.

Staff communicated appropriately with children and young people and their relatives and had access to play therapists to help support children.

Older children could talk to a clinician without a parent present and staff were discreet when asking children under 16 about pregnancy status.

Is the service responsive?

Good

We have not rated responsive before. We rated it as good.

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. The service had undergone a significant equipment replacement programme in 2019 which had resulted in improvements in capacity for some modalities.

The service minimised the number of times breast care patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered. The environment was appropriate, and patient centred. The main waiting room was spread out, but a good size and seating was available for the number of patients and allowed for social distancing. However, there were no dedicated children's spaces and no changing rooms for one CT scanner.

There was enough car parking, including disabled parking, available onsite for a charge. The department was signposted with lifts and wheelchair access throughout. Volunteers were readily available to show patients where to go.

The service had systems to help care for patients in need of additional support or specialist intervention. For those patients coming from the inpatient wards, timing was considered to support their other medical needs. Staff escorted inpatients to maintain patient safety and dignity.

Managers monitored and took action to minimise missed appointments. Staff were also available by telephone to discuss any concerns. When booking appointments, staff considered the time and location of each patient. Community sites were offered where available, to increase capacity in some modalities such as ultrasound and options to attend other trust facilities were given.

Diagnostic imaging

If a patient did not attend their appointment, the referral was cancelled and returned to the referrer with a notification of the non-attendance. The referrer was responsible for following up with the patient and contacting the department if the appointment needed to be rescheduled.

Senior leaders were aware of service pressures on other departments. They monitored inpatient referrals to facilitate timely discharge, provided support to urgent and emergency care and inpatients by providing mobile imaging services and ultrasound.

Information was provided to patients in accessible formats before appointments, which included contact details, hospital map and directions, consultant name, and any information about the test such as if fasting was required.

Public transport availability was considered when booking appointments and if a patient rang up to change or cancel an appointment, transport needs were discussed before rebooking the appointment to better suit the patient.

The service offered a rapid access chest clinic which aimed to give all patients referred an appointment within 7 days.

There were systems to aid the delivery of care to patients in need of additional support. For example, the bookings team regularly contacted the Learning Disability link nurses to support patients coming into the hospital for imaging.

The design of the department meant there were multiple quiet areas where patients could wait if they found busy environments distressing.

Children and young people were seen in a predominantly adult based area. However, the design of the waiting areas was such that quiet spaces could be designated as just for children. Some x-ray rooms had whole paediatric lists booked out, so only children and their families would be present in those waiting areas

Reasonable adjustments were made for children and young people who struggled with the hospital environment. Familiarisation visits were always offered in advance of the child's appointment and play therapists were available on the day of the appointment and beforehand if needed.

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 understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports which accompanied the patient when they came for their imaging.

The service did not routinely have information leaflets in other languages. Instead, interpreters were booked to contact the patient once their appointment was booked and to attend the appointment with the patient. One radiographer had completed a British sign language course to be able to greet and provide basic information to patients with hearing loss.

Managers made sure staff, and patients loved ones and carers could get help from interpreters or signers when needed.

Diagnostic imaging

Staff had access to communication aids to help patients become partners in their care and treatment.

Support with transport was available to patients with mobility issues and was booked by the bookings team when sending out appointments. The booking system had a flagging system to alert the bookings team of patients' additional communication, disability, or mobility needs.

Where the service saw bariatric patients, they had access to specialist equipment if needed. Most scanners' tables had weight limits of more than 180 Kg. Patients were discreetly weighed prior to scans if needed.

The service did not yet utilise online bookings and instead had a dedicated team overseeing complex and specialist procedure bookings. Routine bookings were undertaken by the general outpatient call centre. There was a dedicated phone line for patients to call if they needed to cancel or rearrange an appointment.

The service scheduled multiple investigations or appointments together wherever possible.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were generally in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. In June 2023 waiting times for tests reported under diagnostic waiting times showed the longest waits were for non-obstetric ultrasound, where 26% of patients waited over 6 weeks for their ultrasound scan, and MRI, where 41% of patients waited over 6 weeks for their MRI scan. Staff explained most patients on the MRI list were waiting for specialist MRI cardiac scans, of which the trust had limited capacity to perform. This was recorded on the risk register, including actions the service was taking to reduce the waiting times.

Managers worked to keep the number of cancelled appointments to a minimum. Data submitted showed over the past 12 months, the highest did not attend rates were in MRI (7.1%) and non-obstetric ultrasound (6.7%).

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Data submitted showed in the 12 months before our inspection, the service cancelled 4.1% of appointments across all modalities.

The provider was not meeting the six-week diagnostic test national standard overall. Data submitted for June 2023 showed 27.7% of patients waited longer than 6 weeks compared to a 25% target. This had declined from May 2023 where 23.9% of patients had waited longer than 6 weeks.

The service managed inpatient diagnostic demand, particularly when bed pressures were at their highest. The deputy radiology manager attended daily hospital briefings to help with the flow for inpatient examinations.

Diagnostic imaging

The service managed urgent cancer appointments using a 2 week wait model. In breast screening, data submitted showed patients waited an average of 12 days for their appointment. Report times for all 2 week wait referrals showed an average turnaround of 2.5 days.

The service ensured it met local targets for report turnaround times. Routine images and scans were reported in an average of 1.1 days and urgent scans and images were reported in an average of 2.5 days.

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. Staff understood the policy on managing complaints and concerns stating the roles, responsibilities, and processes for managing complaints. Written complaints were acknowledged within 3 working days by telephone or email depending on patients' preference. Details of the complaint were entered onto the management software programme. Trust policy stated all formal complaints must have a written response from the chief executive or a deputy within 6 months.

Managers investigated complaints and identified themes. Between July 2022 and June 2023, the service received 54 complaints and concerns. The most complained about areas were communication and appointment delays.

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.

One complaint had been referred to the Parliamentary and Health Service Ombudsman, where radiology featured as part of the overall complaint.

Is the service well-led?

Requires Improvement

We have not inspected well led before. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were approachable for patients and staff. They supported staff to develop their skills and take on more senior roles.

Diagnostic imaging

Leaders had the skills, knowledge and experience they needed. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges the service faced and were addressing them.

Some staff felt leaders were not as visible as they could be, but said leaders were approachable.

There were priorities for ensuring sustainable, compassionate, inclusive, and effective leadership. The service had appointed a quality assurance manager. However, not all governance processes had been effectively reviewed. For example, in CT there were no cleaning records, contrast temperature checks or consistent pregnancy or ID checking of patients.

There was a leadership strategy which included succession planning. The service had recently established a leadership triumvirate to work together to give effective overall leadership.

Staff were aware of the whistleblowing policy and knew how to access freedom to speak up guardians.

There were appropriate leadership arrangements to support improvement of services. The trust recently approved a lead healthcare scientist role which would oversee some aspects of diagnostic imaging and have board presence.

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 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 the top priorities.

There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. The trust had a strategy focused on better health care for all.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners.

Staff we spoke with knew about and understood what the vision, values and strategy were, and what their role was in achieving them.

The strategy was aligned to local plans in the wider health and social care economy, and the service had facilitated several research projects into exploring barriers in socially deprived areas to accessing imaging. Staff were working with minority communities to promote access to services.

The service planned their staffing ahead and actively engaged in extended roles, apprenticeship and was linked with a local university.

The radiology department had sufficient plans for the replacement of most high-cost equipment. However, some equipment replacement in nuclear medicine had been halted whilst it was decided if there would be a regional approach to radio pharmaceutical production.

Diagnostic imaging

Equipment was managed through services, lease, or capital replacement programmes. The diagnostic imaging service had managed an extensive procurement programme which had seen several scanners replaced in the last 4 years.

The service was working effectively with other providers in its Cancer Alliance towards achieving local priorities on earlier and faster diagnosis. This also included the development of a Rapid Diagnostic Centre which was under construction at the time of our inspection.

Culture

Staff felt respected, supported, and valued. 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.

Staff felt supported, respected, and valued. There were multiple systems to give formal and informal awards to peers. The was a strong emphasis on well-being.

Staff recognised and valued the work of their colleagues. The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vision and values, regardless of seniority.

The service demonstrated openness, honesty and transparency when responding to incidents and complaints and had systems to ensure compliance with the requirements of the duty of candour.

There were processes and procedures to ensure the service met the duty of candour requirements. We saw multiple letters written to patients following incidents where they had received an accidental or unintended dose of radiation. All staff undertook training in duty of candour awareness.

Staff felt positive and proud to work in the organisation. The latest staff survey results showed 89.8% of respondents felt their role made a difference to patients.

Staff had access to a range of support in the event they needed to escalate a concern. We saw posters in staff areas giving details about how they could contact their local Freedom to Speak Up Guardian.

The culture encouraged openness and honesty at all levels within the organisation, including with people who use services and in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. For example, staff documented where patient jewellery was stored, if it was removed for an x-ray or scan, as nurses in the emergency department had raised concerns about jewellery going missing.

Modality leads demonstrated a strong emphasis on the safety and well-being of staff.

Equality and diversity were promoted within and beyond the organisation and staff, including those with protected characteristics under the Equality Act, felt they were treated equitably.

All staff were treated with respect and were supported to carry out their day-to-day jobs.

Diagnostic imaging

The service could provide support for staff who had contact with patients with life-changing or limiting conditions. Schwarz Rounds were held before the Covid-19 pandemic but had not yet been re-established.

Governance

Leaders did not always operate 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.

There were not always effective structures, processes and systems of accountability to support the delivery of the strategy, quality and sustainability. For example, vetting processes and scanning protocols had not been written down and captured in MRI and CT.

The senior leadership team held monthly meetings covering most aspects of performance and safety monitoring. Records showed these meetings were well attended with actions recorded, shared and monitored. However, we saw hand hygiene and cleaning audits were not consistently being carried out or had no records at all.

Not all governance and management processes within the department functioned effectively. There had been a high number of patients receiving a significant accidental or unintended dose of radiation because of an incorrect scan request. Staff were unaware of actions taken by the emergency department to stop this from happening again.

Managers acted quickly to resolve issues we raised during the inspection. We saw no evidence of cleaning records in some modalities and managers responded by immediately introducing daily and weekly cleaning checklists. All other modalities had appropriate daily/weekly cleaning and quality assurances processes in place however, some were overdue medical physics quality assurance checks.

Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom.

There were effective governance procedures for managing and monitoring any service level agreements the service had with third parties. All agreements we saw were routinely reviewed halfway through the contract or whenever a change was required.

Medical physics support was now onsite following successful recruitment of a new radiation protection advisor. This ensured open contact and access to advice.

When using teleradiology companies, the service ensured the quality of the reports was maintained. Where discrepancies were identified, these were included in radiology events and learning meetings and the radiologist involved were invited to attend for continuous professional development.

The provider ensured all staff underwent appropriate checks as required by Schedule 3 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

There were regular radiation protection committee meetings which fed up to the cancer and clinical support care group. Issues could further be escalated upwards to the planned care board and trust management board if necessary.

Management of risk, issues, and performance

Diagnostic imaging

Processes to monitor and evaluate risk and information were not always effective. Leaders and teams used systems to manage performance. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Processes to monitor and evaluate risk and information were not always effective. There are several examples within this report where the service, in particular CT, were not utilising all the information, and examples of a lack of monitoring of information. For example, CT had no records of daily cleaning and there was poor compliance with ID and pregnancy checking. There was no programme of reject analysis despite there being a high number of errors reported by staff. Staff were unaware of actions taken by the emergency department in response to the incorrect patient requests resulting in IR(ME)R notifications. Standard operating procedures and protocols in CT, MRI and interventional radiology were mostly out of date or absent completely.

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit.

Managers monitored risks within the provider's overarching risk register and management process. Each record had undergone a full risk assessment which included detail about mitigation and actions. Risk registers were reviewed by the service and divisional governance groups.

There were comprehensive assurance systems, and most performance issues were escalated appropriately. Risk reports were regularly reviewed and improved, and we saw ongoing actions, plans and mitigation recorded.

There were arrangements for identifying, recording, and managing risks, issues and reports contained mitigating actions. There was alignment between the recorded risks and what staff said worried them, including the services capacity to carry out cardiac stress MRI scans.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand. For example, the breast care team had foreseen a peak in demand after a celebrity promoted the breast care centre on social media following their visit.

When considering developments to services or efficiency changes, the impact on quality and sustainability was considered, assessed, and monitored. Managers explained recruitment processes could sometimes introduce barriers as all job descriptions had to go for approval through the agenda for change committee, which could delay processes by up to 6 weeks.

The trust had a comprehensive and clear business continuity plan and the service had completed a business impact analysis.

There was 24/7 Picture Archiving and Communication System support and specific IT systems service continuity plan in the event of IT failure, which fed into a wider overall trust plan.

Information Management

The service collected reliable data but did not always analyse 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.

All staff were required to complete information governance training but only 78.5% of staff were up to date with this. Staff used their training to work within the trust's data protection policies and ensure they avoided risks associated with data breaches. This ensured they protected patient identifiable data and acted with integrity when handling personal information.

We reviewed meeting minutes and found quality and sustainability both received sufficient coverage in relevant meetings at all levels.

Not all arrangements to ensure the information used to monitor, manage, and report on quality and performance is accurate, valid, reliable, timely and relevant were effective. Information technology systems were used effectively to monitor and improve the quality of care. In addition to the standard examinations covered in the DM01 submission, the service monitored all specialties in the same way, so data was live, relevant, and reproducible. However, the service had no programme of reject analysis to review and identify persisting issues in plain film radiography, such as the selection of incorrect detectors, and relied on staff to report issues through the incident reporting system.

There were effective arrangements to ensure data or notifications were submitted to external bodies as required. The service was aware of its responsibilities around IR(ME)R reportable incidents. Incidents were investigated appropriately, with oversight from the radiation protection advisor and the medical physics expert.

There were arrangements to ensure the availability, integrity and confidentiality of identifiable data, records, and data management systems, in line with data security standards. Lessons were learned when there were data security breaches.

The service proactively monitored demand, activity and capacity across their modalities and how it utilised IT systems to support this. The service linked in with other specialties, such as endoscopy, to understand where additional lists were being undertaken and plan for additional requests for follow up examinations, which may arise as result of the additional lists.

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.

Leaders engaged with staff using a variety of methods, including annual staff surveys, team meetings, electronic communication, appraisals, monthly supervision, and informal discussions.

People's views and experiences were gathered and acted on to shape and improve services and culture. Staff encouraged patients to complete a friends and family survey following their appointment.

Staff survey results showed that in the top 3 best scores, staff felt the organisation was inclusive, promoted equality and diversity and handled negative incidents well.

People who used services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. This included people in a range of equality groups. For example, the breast care team was attempting to raise awareness of breast screening availability for transgender men.

Diagnostic imaging

Staff were actively engaged so their views were reflected in the planning and delivery of services and in shaping the culture. Staff completed the 'just culture' and global staff survey to share their views on services.

There was transparency and openness with all stakeholders about performance. The service worked with local partners and had attended national meetings around the development of the community diagnostic centres. Managers told us it had been refreshing and useful to have more of a focus on processes used in radiology department rather than just on waiting times.

Patient surveys were in use and questions were sufficiently open ended to allow people to express themselves.

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.

Leaders and staff strived for continuous learning, improvement, and innovation. Staff had helped develop and promote radiographer apprenticeships to help staff develop who would otherwise not have been able to access traditional forms of higher learning.

The service participated in research projects and recognised accreditation schemes, with a focus on social inequalities and deprivation in the local populations.

The service had developed training materials and posters to promote and clarify the use of inclusive language throughout the department and across all modalities, which was being considered by a professional body for roll out nationally.

The service used standardised improvement tools and methods, and staff had the skills to use them. This included a model for improvement using the NHS England plan, do, study and act cycle to assess what was being measured and how.

All staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes, and performance. All teams met on either monthly or two monthly to discuss improvement and challenges and to seek solutions. Actions were clearly documented in all minutes we reviewed.

The service had an extensive audit and research plan in progress in relation to learning and all staff were encouraged to push to publish any projects and research.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, however not all staff had completed it.

Staff received mandatory training but did not keep up to date with it. Mandatory training compliance did not always meet the service's target of 85% compliance. At our last inspection, the trust did not achieve compliance in 4 subjects, compared to this inspection where they were not compliant in 2 out of the 11 mandatory training subjects. Moving and handling training was at 56% and information governance at 84% compliance. Wards such as the stroke ward and acute medical elderly ward where the requirement to support patients with moving and handling may be higher had low compliance levels in moving and handling training, the stroke ward compliance was 59.09% and the acute elderly medical elderly ward 59.57%. The trust had highlighted themselves falls were an area of concern, trust data showed this training had been non-compliant for the past year. During the inspection we witnessed a patient being supported from the bed by one health care assistant, however the patient notes stated they required two staff to support with mobilising. Information Governance was also non-compliant, during the inspection we witnessed an unlocked patient records cabinet.

Since 1 July 2022, all registered health and social care providers were required to provide training for staff in learning disability and autism, including how to interact with autistic people and people who have a learning disability. This should be at a level appropriate to their role. This new legal requirement was introduced by the Health and Care Act 2022. Senior leaders told us clinical staff were given the opportunity to undertake training on recognising and responding to patients with learning disabilities and autism, but this did not form part of their mandatory training requirements. Most of the staff we spoke with told us they were not provided with training on recognising and supporting people with autism. Senior management told us staff were not yet compliant with this training. The trust was part of the One Devon pilot for this training. Part 1 of this pilot has been available since 2022, and there were plans for part 2 to be available by October 2023 with an aim for the full roll-out to start in March 2024.

Managers monitored mandatory training and alerted staff when they needed to update their training, however this was not always effective. The trust used an electronic system for training and monitoring compliance for mandatory training and face to face training was provided for some topics.

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.

Staff received training specific for their role on how to recognise and report abuse. Staff were trained to level 2 in adult and children safeguarding.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We were given an example by a nurse who reported a safeguarding issue where this was investigated and learning from the incident was shared amongst the wider staffing group.

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 we spoke with were able to clearly explain the referral process.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. However, compliance with hand hygiene could be improved and there were examples where equipment was not clean, or cleaning records were not up to date.

The trust managed Covid-19 and other infectious diseases outbreaks by cohorting patients to 1 area and closing admission to those areas. The trust continued to follow infection prevention control guidelines and Public Health England guidance in relation to the management of infectious disease outbreaks.

Hand hygiene audit data provided by the service following our inspection showed medical ward staff did not always achieve compliance with hand hygiene. The trust's Quality and Safety report for May 2023 showed Simpson ward had scored 64% in their handwashing compliance and Cheetham Hill ward 71%. Simpson ward had an infection control outbreak during this time.

Most cleaning records were up-to-date and demonstrated all areas were cleaned regularly. However, we found some cleaning records had not been completed. For example, we looked at a month's records for toilet cleaning on 3 wards and found incomplete records on George Earl and New Forest wards.

Staff followed infection control principles including the use of personal protective equipment. The trust was better than the NHS England threshold rate in terms of Clostridium Difficile and we observed a patient who was isolated in a side room with Clostridium Difficile.

Staff mostly cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We visited 9 wards and the discharge lounge and found a commode that had faeces on yet carried a label stating it was clean. However, most ward areas were clean and had suitable furnishings which were clean and well-maintained.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment. We checked 15 pieces of equipment which had been tested in line with guidelines. Checks were also completed of emergency resuscitation equipment, and these were well maintained.

The service had enough suitable equipment to help them to safely care for patients and were trained in its use. We confirmed this when visiting 9 wards and the discharge lounge.

Medical care (including older people's care)

Patients could reach call bells and staff mostly responded quickly when called. We observed call bells were available and in reach of patients. Patients told us call bells were answered but not always quickly.

Clinical waste was well managed.

Day rooms which were open and accessible for use by patients and their visitors were being used for storage. This included mattresses and beds. We visited 3 day rooms and these rooms did not provide a comfortable area to complete activities or relax. Patients would be seated here if they were fit to be discharged. We were told day rooms could be used for escalation, although leaders confirmed they were no longer used as escalation areas. We spoke to a ward manager who was aware of the poor environment the current day room provided however, they spoke of how they planned to use charitable donations to decorate the room and develop activities for patients. The staff team were working together with patients to create a better environment and hoped to have this completed within the next 3 months.

Facilities did not always meet the needs of patients. One ward had 1 accessible shower to 15 patients. There were 2 other shower facilities, but these could only be used by patients who were mobile. Patients who needed help with mobility were not able to access this shower.

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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Adult patients were assessed using the National Early Warning Score (NEWS2) as recommended in guidance from the National Institute of Health and Care Excellence. We reviewed 6 patient records and found they had NEWS2 scores, and most had falls assessments completed where appropriate and within national timescales. Patient records showed deteriorating patients had been escalated appropriately.

Staff mostly completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. In the 6 patient records we reviewed, we saw falls assessments, pressure ulcer assessments and venous thromboembolism (VTE) assessments. We found 1 out of the 6 records did not have a falls assessment completed. VTE assessment completion had improved from the last inspection and at the time of inspection data showed 94.9% were completed within 24hrs and 97.1% in overall completion.

Staff knew about and dealt with any specific risk issues. Staff explained the assessment for sepsis and how to escalate concerns. Falls and bed rails assessments were being completed. We received evidence for the 6 months from November 2022 to April 2023 which showed staff completed at least 97.9% of assessments, however, falls remained one of the highest categories of incidents across some medical wards. The service had dedicated falls leads and an up-to-date action plan to improve the management of falls across the service as part of their falls strategy.

The service had 24-hour access to mental health liaison and specialist mental health support. The mental health team was accessible 24 hours a day, 7 days a week. Staff described the referral process, however, there were sometimes delays in patients being seen. The local mental health trust aimed to review these patients within 1 hour and achieved this in 75% of patients.

Shift changes and handovers included all necessary key information to keep patients safe. We observed safety briefing and morning briefing meetings where key information was shared and plans to ensure patient safety were discussed.

Medical care (including older people's care)

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience. Staffing numbers did not always meet planned levels and there was not always consultant cover available out of hours. However, managers regularly reviewed and adjusted staffing levels and skill mix to ensure safe staffing levels were maintained and used bank, agency or locums to fill gaps. We were not assured all agency staff received a full induction.

At our previous inspection in December 2021, we identified a high usage of agency staff and they had not all received an induction. During this inspection, we found similar concerns regarding high use of agency staff and a lack of induction. Data provided by the trust showed there had been a steady increase in the use of agency staff since December 2022. The medical receiving unit did not have an induction process for agency staff but were aware this needed to be developed. Staff said there was an agency induction file, however they were not given time to read it. The risk of agency staff not receiving an induction was partly mitigated by ensuring only agency staff who had worked for the trust in the previous 3 months were engaged on the ward.

Staff sickness had decreased from 5.26% in January to 4.59% in February 2023.

Allied Health Care Professionals and Specialist Teams

The service identified during a risk group meeting in February 2023, the lack of available therapy staff was an emerging risk**.** It showed there were significant vacancies within inpatient therapies (50% at Band 5 level) affecting ward cover and in community physiotherapy affecting Totnes' Dart ward cover. Occupational therapists in Torbay Hospital were operating a prioritisation system whereby they were only seeing medically optimised patients.

The trust had an alcohol liaison team who supported patients with alcohol withdrawal. There was also a mental health team who were accessible 24/7 for referrals to psychiatric liaison. However, there were sometimes delays to the team responding to referrals. The expectation was for referrals to be picked up within 1 hour, 80% of the time. At the time of inspection this response was a little lower than expected at 75% of the time.

Nurse Staffing

The service did not always have enough nursing and support staff. The trust improved their staffing levels by employing agency staff to fill vacancies, however, despite this, there had been some shortfalls in staffing levels at times. Some staff we spoke with did not feel staffing levels were always adequate and supporting patients needing one to one care was difficult or not always offered to patients requiring this. The use of agency staffing had improved this.

Senior nursing staff held meetings twice daily to ensure risks were assessed and addressed. Mitigations were implemented to ensure safe staffing levels were maintained. 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. Staffing levels were reviewed daily by managers and staff moved to cover other wards if needed. The trust had an escalation procedure for managers to follow if staffing levels became unsafe.

The ward manager adjusted staffing levels daily according to the needs of patients. Escalation policies provided a source of clarity for staff at times of increased pressure and risk around staffing levels.

Medical care (including older people's care)

The number of registered nurses (RGN) and healthcare assistants (HCA) did not always match the planned numbers. Data we reviewed for April 2023 showed during the day, the fill rate for RGNs was 93.2% and for HCAs 103.8%, During the night, fill rate for RGNs was 91% and HCA was 115.4%. To mitigate risks associated with the nurse fill rate, additional HCA staffing had been arranged.

The workforce vacancy figures showed an increase in RGN vacancies and a reduction in HCA vacancies, with vacancies remaining the main agency/bank requesting reason. There was ongoing recruitment work including hosting students from several local universities, there had also been a large international recruitment drive. The RGN fill rate for days during March 2023 was reported as 93.1% which was a slight increase on February 2023 fill rate of 91.3%. The RGN night duty fill rate had also improved from 87% in February 2023 to 88.4% in March 2023. The fill rate for HCAs had reduced slightly to 97.9% from 99.5% for days and reported at 114.6% overnight.

The service had low turnover rates. Turnover rate for nursing staff had reduced to 0.27% and for HCAs was 2.29% in March 2023.

The service had reducing sickness rates. HCA sickness rates were at 7.72% in April 2023 and nursing sickness rates were 4.61% in April 2023.

Medical Staffing

Medical staffing rates mostly met the planned numbers. However, at times short notice sickness made it difficult to meet planned numbers. During May 2023, there were 4 occasions when the actual numbers of medical staff did not match the planned numbers and 3 occasions in June 2023. Managers could access locums when they needed additional medical staff.

Staff told us consultants did not always lead daily ward rounds on all wards. We were told on the oncology / haematology ward, the consultant reviewed patients once or twice a week. The service did not always have a consultant on call during evenings and weekends. Some areas did not have dedicated consultant cover at weekends. Stroke consultant cover was not provided 24 hours a day, 7 days a week, however the trust was working with local providers to resolve this.

Between April and June 2023 there were between 8 and 8.5 whole time equivalent vacancies across the medical division. The area most effected was dermatology.

The service had low turnover rates for medical staff. We reviewed data that showed there had been no staff turnover in 15 of 17 medical staffing areas between April 2023 and June 2023 and 5.39% in radiology and 5.78% in cardiology departments during this time.

Sickness rates for some medical staff were reducing. Data provided by the trust showed sickness rates for junior doctors was at 1.25% in April 2023. Senior medical staff were at 1.70% in April 2023.

Records

Staff mostly kept detailed records of patients' care and treatment. Records were clear, up-to-date, mostly stored securely and easily available to all staff providing care.

Medical care (including older people's care)

Staff mostly kept detailed records of patients' care and treatment. At the previous inspection in December 2021, this was highlighted as an issue and the trust had completed training and carried out 5 audits of patient records each day on the medical wards to improve this.

We observed an overall improvement, however, we identified gaps in risk assessments and nursing records. Completion of patient Malnutrition Universal Screening Tool risk assessments, a 5-step screening tool used to identify adults who are malnourished or at risk of malnutrition, were greatly improved. However, despite staff completing mental capacity assessments, there were areas of improvement required in documentation of capacity decisions. We found incomplete information in 4 out of 6 patient notes we reviewed, along with conflicted patient diagnosis. In 1 patient notes we reviewed it stated the patient had a learning disability in a section of their notes, in another it stated autism and another Aspergers.

Staff were eager to use a new electronic system as this would result in improved information sharing between departments and better patient outcomes.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. They completed medicines records accurately and kept them up to date.

Staff did not always store and manage all medicines and prescribing documents safely. On one ward, we found valuables were being stored in a medicines cupboard which was not in accordance with their policy. Managers said this was because it was difficult to access site managers out of hours to store these valuables in the safe. Following inspection, the trust circulated a security alert to remind all staff of the legal obligation to store controlled drugs securely in the controlled drug cupboard which should not be used for any other purpose.

There was inconsistent storage of prescription forms on the different MAU areas. In the ambulatory area there was a clear system to record forms received and when issued. However, on the non-ambulatory area the system was to record the use of prescription forms in a book but there was no tracking of the numbers received. During the inspection this was addressed and rectified to take forward a consistent system which was monitored through routine audit.

All wards visited carried hypoboxes, a patient treatment kit with a range of glucose products for use in cases of low blood sugar. We found they were not stored in accordance with their own policy, the trust policy stated the medicines should be stored somewhere accessible outside of a fridge near to where the patient was situated. However, on some wards the decision was taken by nurses to store them in the medicines room in the fridge as this elongated the shelf life and was less wasteful, this however was against the trust policy and could pose a risk of nurses who did not usually work on this ward being confused as to where to find these medicines. Following inspection, the trust circulated an alert to all clinical areas and the trust confirmed glucagen was now stored in the hypoboxes or stock cupboard, not in the fridge. A project was also underway to improve the consistency of the contents and storage of hypoboxes.

The trust had developed a policy and a checklist to monitor the temperature storage of medicines. During our inspection, we identified temperatures outside of the indicated range were identified correctly, but the actions taken to address this were not in accordance with their policy.

Medical care (including older people's care)

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

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.

All staff knew what incidents to report and how to report them. Staff said they were encouraged to report incidents and near misses. Staff gave us examples of incidents they had reported. However, managers did not always receive feedback from investigation of incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured actions from patient safety alerts were implemented and monitored.

The medical care service did not have any never events in the last year prior to our inspection.

Serious incidents had been reported and recorded in the previous 12 months in line with their policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff understood they should always be open and honest, and patients and relatives were to be asked if they had any questions.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers completed a full investigation report to determine the circumstances of the incident. This process included a standardised approach and included identification of any contributory factors.

Managers debriefed and supported staff after any serious incident. Staff we spoke with told us they received debriefs, and we heard examples of managers supporting staff following a serious incident.

Is the service effective?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement in July 2020. We did not inspect all key areas so were unable to re-rate.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, National Institute for Health and Care Excellence guidance was incorporated into trust policies, standard operating procedures and the implementation of this guidance was monitored.

Staff mostly followed care pathways that detailed the care and support patients needed for specific treatment. These care pathways ensured patients received care and treatment in line with current best practice guidance. However, stroke patients could not always access the correct pathways as demand for stroke services outweighed the capacity of the trust.

Staff mostly protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We saw evidence of capacity assessments, but the documentation required improvement.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs. However, they did not always use special feeding and hydration techniques when necessary.

Improvements were observed with nutrition and hydration since our last inspection in December 2021. For example, water was available and in reach of patients. Patients we spoke with told us they had enough to eat and drink.

Speech and language therapists completed dysphagia care plans, dysphagia is a condition which involves difficulty in swallowing food or liquid and may interfere in a person's ability to eat and drink. Compliance for staff following these dysphagia care plans did not meet the target of 100%.

The most recent clinical audit completed in November 2022 by the speech and language therapists showed food given to admitted patients complied with the dysphagia care plan 85.1% of the time, with fluid compliance measured at 77.4% compliance. The audit discovered thickener tubs were not being successfully returned to their storage areas 35% of the time. This presented a risk of harm to patients if fluid thickener is ingested incorrectly, this is an ongoing risk, a patient safety alert was issued in February 2015 which stated that whilst it is important that products remain accessible, all relevant staff need to be aware of potential risks to patient safety. Appropriate storage and administration of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia. Individualised risk assessment and care planning is required to ensure vulnerable people are identified and protected. The audit highlighted concerns with use of other equipment such as spouted beakers with 62.9% compliance. We were told the trust had observed improvements on wards with dysphagia trained staff or speech and language therapists. The trust had an action plan to address this, however we could not determine how this was being reviewed therefore the trust could not provide assurance improvements would be achieved within the timeframe they had set. The speech and language team were positive and committed in their approach to driving improvement forward in this area.

Specialist support from staff such as dietitians and speech and language therapists were mostly available. However, the dietician team, despite being engaged and passionate about the service they provided to patients, was low in numbers. They felt the service could be improved with more assistance provided to individual wards if their numbers were increased. Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. At the previous inspection in December 2021, we were concerned patients who could not feed themselves or needed assistance were not receiving adequate support. At this inspection we saw evidence these patients were identified and supported.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust audited compliance with the Malnutrition Universal Screening Tool (MUST) and found 92% of assessments were completed within the 24-hour time standard.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They 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. We saw evidence of the use of pain score documents to assess patient pain levels.

Patients received pain relief soon after requesting it. Patients said they were regularly asked about their pain and pain relief was provided quickly when requested.

Staff prescribed, administered and recorded pain relief accurately. During the inspection we saw evidence patients' notes contained details of monitoring and prescribing of pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. However, outcomes for patients were not always positive and consistent and did not always meet national standards.

The service participated in relevant national clinical audits. For example, the trust was involved in the Get It Right First Time Programme to support improvements within their service.

Managers and staff used the results to improve patient outcomes. Recruitment for a Sentinel Stroke National Audit Programme (SSNAP) administrator post had started, along with other vacancies. This post will be used to drive quality improvement across the acute stroke pathway.

However, the SSNAP audit highlighted the trust was outside of the national targets for patients being admitted to the stroke ward. In December 2022, 3% were admitted to the stroke unit within 4 hours and only 28% of patients spent 90% of their stay on the stroke unit against a quality standard of 80%. The trust had a stroke improvement plan and recognised performance was below the standards required. The trust was still working on the plan to drive improvements forward.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This included 5 a day MUST, falls, Mental Capacity Act (MCA) and infection prevention risk assessments. We reviewed audit results displayed on wards. The results were used to celebrate achievement and continued focus on areas, and to share information with both staff, patients and visitors. An audit in April 2023 showed trust wide nutritional risk assessments completed within 24 hours had improved with a trust position of 92.5%. Forrest Ward continued its improvement from 85.3% in March 2023 to 95% in April 2023. EAU4 recorded 93% compliance which was an improved position. Other nursing risk assessments compliance showed waterlow score were 98%, patient handling and falls assessment 99.8%, and pain assessments 97.5% This was based on the audit of 5 sets of notes on each ward daily.

Medical care (including older people's care)

The trust had met targets for patient with conditions which required them to be seen within a week and the trust had improved their cancer standards and were no longer in tier 1 (the most challenged providers with the highest risk of not meeting elective or cancer targets).

Competent staff

The service made sure staff were competent for their roles. Managers appraised most staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust ensured the right people, with the right skills, were in the right place at the right time. We saw evidence of forward planning for the possibility to move staff if required to ensure the correct skill mix was present.

Managers did not always give all agency staff a full induction tailored to their role before they started work. They provided most new starters with a structured and supportive method of introduction to the trust and department, however staff told us that there was no structured induction for agency staff on some wards and that where there was a structured induction file in place agency staff did not always have time to read this before starting their shift

Not all staff had received constructive appraisals of their work, however this was improving. At our previous inspection in December 2021, we were not assured staff were receiving appraisals annually. At this inspection we saw an improvement in the completion rate of these. April 2023 figures showed 80.52% of appraisals had been completed, this was an improvement on the May 2022 figure of 71.29%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us they attended team meetings where information was shared.

Managers identified any training needs staff had and gave them the time and opportunity to develop their skills and knowledge. We were told by staff managers discussed training needs during appraisals.

Managers made sure staff received any specialist training for their role. For example, specialist training such as dysphagia training was available to staff. The trust was developing managers training on Effective Feedback and Achievement Reviews. This training will become part of managers essentials training as part of the trusts Our Leadership Framework.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were paused during Covid-19 pandemic but were being welcomed back to the wards. All staff reported the volunteers were very useful. We spoke with one volunteer who said they were well supported and had a point of contact if they had any concerns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed national guidance to gain patients' consent, they supported patients to make informed decisions about their care and treatment. Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, mental capacity assessments were not always completed fully or contained the relevant detail required.

Medical care (including older people's care)

Staff understood how and when to assess whether a patient had the capacity to consent to treatment. We spoke with staff who had a good understanding of mental capacity and the requirements of the MCA. However, we found recording on MCA assessments, treatment escalation plans and deprivation of liberty assessments were not always clear or contained adequate information and explanation. We looked at 14 patient records and found 10 records in relation to mental capacity to be incomplete or missing full explanation of why a patient lacked capacity.

Staff mostly gained consent from patients for their care and treatment in line with legislation and guidance. Compliance in recording consent ranged from 89.2% in June 2022 to 93.6% in April 2023. Over time there has been an improvement in the recording of consent. However further improvement was needed to reach a consistent practice.

When patients could not give consent, staff mostly made decisions in their best interest, taking into account patients' wishes, culture and traditions. MCA assessments had been completed and best interest paperwork was present, however, they lacked information relating to how the outcome had been reached and why the decision was in the patient's best interest.

Staff did not always clearly record consent in the patients' records. We reviewed14 patient records in relation to consent and mental capacity. Although consent was recorded, we found 1 consent form signed by the patient who also had a mental capacity assessment assessing the patient lacked capacity to consent to care.

Staff received and kept up to date with training in the MCA and Deprivation of Liberty Safeguards (DoLS). This was included as part of their safeguarding mandatory training.

Staff implemented DoLS but these were not always in line with approved documentation. In the 14 patient records we reviewed, we found paperwork relating to DoLs consistently lacked quality in explanations and information, 1 patient had a DoLS but no MCA to show capacity had been assessed. There were examples where DoLs were being completed before the MCA. We found 1 record to have a high quality of recording.

Managers monitored how well the service followed the MCA and made changes to practice when necessary. The trust had a rolling audit programme that included reviewing the process for screening for capacity, recording consent and the use of more in-depth MCA assessments for those suspected to lack capacity.

In response to our findings on inspection the trust's head of safeguarding had released additional resource packages and implemented weekly webinars and how to sessions to support wards with the completion of quality MCA's. The trust had started a roll out of a web-based application to support bedside MCA assessments.

During inspection we found 2 elderly care wards had locked doors so people could not exit the ward without a staff badge. There was no discussion with people who had capacity about how they were able to exit the ward. This was not in keeping with best practice. The trust had a long-standing policy where doors were locked with a view to preserve the safety of all patients. The trust was reviewing to implement appropriate safety measures and updating their policy and guidance. In the meantime, they planned to be more explicit and consistent in advice to patients and visitors about the locked door policy within admission packs, and explain they are free to leave whenever they choose.

Is the service responsive?

Good 

Medical care (including older people's care)

Our rating of responsive stayed the same. We rated it as good in July 2020. We did not inspect all key areas so were unable to re-rate.

Access and flow

People could access the service when they needed and received care promptly. However, the trust experienced pressures due to bedsavailability of onward care and timely discharge.

There were significant numbers of patients unable to leave the hospital as they were waiting for social care packages. This a national problem which continued to be a challenge. In April 2023, there were 24 patients who had no criteria to reside (patients who are medically fit for discharge but remained in hospital), this was 7.6% of patients in hospital, in May there were 9% of patients in hospital with no criteria to reside.

Managers and staff started planning each patient's discharge as early as possible. During inspection we saw patient records which included discharge plans. The trust had discharge co-ordinators, although not all wards had a co-ordinator. We witnessed discharge plans being discussed during ward meetings. We were told discharge checklists were different from ward to ward. This had been recognised by the site team and they were looking at ways to standardise this information.

Discharge figures in May 2023 were 22.6 % of pre-noon discharges achieved against the 33% target; weekend discharge was 19.2% against a target of 28%. The trust continued to focus on improving discharges earlier in the day before noon, increasing the number of discharges over weekends, and reducing length of stay. They had many actions to support this such as, planning for the weekend which includes multidisciplinary meetings following Friday 'SAFER' rounds. The discharge lounge had been helpful in generating early ward capacity.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. The trust had a discharge team which included occupational therapists, health and social care co-ordinators, assistant practitioner, nurses and social care assessor.

The trust used an established tool to identify the capacity of wards and assessment units at any point in time and used it to meet the needs of patients. The trust had been consistently over 90% bed occupancy since May 2022, with bed occupancy peaking at 98.6% in March 2023. This made flow throughout the hospital difficult to manage. National Institute for Health and Care Excellence guidance recommends an overall bed occupancy rate as 85%.

At the time in the inspection, there were no escalation areas in use. However, staff told us escalation areas had to be used during the winter period to maximise bed availability. There were systems to ensure outlying patients had access to the correct medical specialities and we were told this process worked well.

The hospital monitored the demand on its service. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. The service had been at OPEL level 3 and 4 for the last 6 months. Level 4 is the highest OPEL level and means the trust is under high pressure. Each day, bed meetings took place to review the flow of patients through the hospital and were attended by bed managers and ward nurses.

Staff did not often move patients between wards at night. We reviewed the data for moves between wards between the hours of 10pm and 6am for the last 12 months. This demonstrated a reduction in moves from 40 in June 2022 to 12 in May 2023.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

Our rating of well led stayed the same. We rated it as requires improvement in July 2020. We did not inspect all key areas so were unable to re-rate.

Leadership

Leaders had the 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.

Leadership within the medical care core service included the leadership team of integrated service units (ISUs) to include an associate director of operations, associate medical director and associate nursing director. There was local leadership at ward and specialist level for example ward level matrons and specialism leads.

Leaders had the skills, knowledge, experience and integrity to run the service. Leaders spoken with understood the challenges to quality and sustainability and could identify the actions needed to address them. Staff told us leaders were visible and approachable.

Culture

Staff felt respected, supported and valued. 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.

Staff were positive and committed across all areas visited. They were passionate about their work and patient care, we observed staff and patient interactions were calm, gentle and kind and staff were thoughtful in their communication.

Team working was positive across the service and we found there was good multidisciplinary presence and input across wards. There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively.

Equality and diversity were promoted, positive cultural work had been undertaken to support integration of international recruits by introducing cooking sessions from their home country.

The trust had staff recognition awards such as the daisy and primrose award. This enabled the trust to give awards to celebrate nurses and health care assistants who go above and beyond to provide care.

Governance

There were differences in governance processes across integrated service units. The trust was undergoing a restructure which would help align governance. Staff appeared clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Medical care (including older people's care)

Governance processes and structures within the service were being reviewed and restructured across the organisation at the time of our inspection.

The medical care core service was currently spread across different integrated service units (ISUs). Moor to Sea ISU was for older people, re-ablement and rehabilitation, this included medical wards Cheetham Hill, George Earl, Simpson and the Stoke Unit and Stroke Rehabilitation. The Coastal ISU was for planned care and included New Forrest ward and endoscopy. Paignton and Brixham ISU was for long term conditions and cancer, this included wards Midgeley and Turner. Newton Abbot ISU was for urgent and emergency care and included the acute medical unit.

The new structure had 4 care groups which were led by a care director with triumvirate teams. The medical care core service would sit within the new medicine and urgent care group. This was launching on 1 July 2023. Staff were positive about the changes which would help to streamline governance.

Governance arrangements ensured there were reporting structures into the board of directors. Decision making took place at the executive committee, care group boards, and oversight and assurance committees. The trust had a wide governance membership which reported into the board of directors and care groups. These groups included the quality and patient safety group and quality and safety care group meetings.

Governance processes were inconsistent across ISUs. Each ISU produced reports which reviewed quality and patient safety performance metrics. We reviewed a governance report for Moor to Sea ISU from February 2023 and a clinical governance quality report for Paignton and Brixham ISU from May 2023. Although metrics presented were similar the reports differed in their style and presentation. There were also inconsistencies with the names and types of meetings held for each ISU, although agenda items were similar.

At a local ward level meetings were held, or information distributed, to keep staff updated on safety and performance.

Leaders had improved communication with staff around incident learning and governance updates. An infographic-style monthly newsletter was produced as well as a template called Learning After Serious Event Reviews, which would be completed after any Healthcare Safety Investigation Branch or serious incident report to share learning and recommendations.

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. Audits were used to review performance and identify issues. However, we did identify follow up of actions or re-audit were not always completed.

Risks were clearly recorded on risk registers, these were managed at service level and ISU level, and would feed up into the corporate risk register if it met the threshold. The risk registers recorded the risks we identified during inspection, or the risks people described to us. We reviewed the Moor to Sea ISU full risk report for May 2023 and saw risks were identified, with controls and gaps in control recorded. The risks were reviewed and updated on a regular basis with actions recorded. The trust held regular risk group meetings to highlight emerging risks and set actions to address them.

Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities.

Medical care (including older people's care)

Monthly audit reports with information broken down by speciality were shared. We saw evidence clinical audits had taken place. However, we reviewed one clinical audit for dysphagia which had an associated action plan, there was not always complete follow up of actions, with completion dates not consistently documented, or re-audit completed.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, there were some modules where compliance with training needed improving.

The mandatory training was comprehensive and met the needs of patients and staff.

Nursing staff mostly received and kept up to date with their mandatory training.

At this inspection we saw the training compliance rates for the emergency department did not meet the trust target in all training modules. Staff told us this was due to the heavy workload causing training to be cancelled. Managers had adjusted the training scheduling to avoid winter periods of high pressure and had plans to meet the attainment when possible. However, compliance had improved since our last inspection.

The trust set a target of 85% for completion of mandatory training for all courses except for information governance, which had a trust target of 95%. Of the training modules provided, 8 achieved compliance and 2 failed to reach the trust target. Compliance for information governance training was 82%, and moving and handling was 63%.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The trust recognised the compliance with mandatory training required improvement. To support staff to keep their training up to date, they arranged for them to have dedicated time to complete the training, or paid overtime of up to 9 hours if requested or needed.

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.

All staff received training specific for their role on how to recognise and report abuse. Training data showed 100% of staff had completed the safeguarding training.

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 knew how to make a safeguarding referral and who to inform if they had concerns. Staff spoke clearly about the processes used to identify patients, including children at risk of abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. They did not keep equipment and the premises visibly clean, because of the condition of the building. However, staff used equipment and control measures to protect patients, themselves and others from infection.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. There was good adherence from staff to hand washing and infection control procedures. Staff were wearing gloves and aprons when it was required for their interactions with patients. Most washed their hands or used alcohol gel before and after any interactions with patients or when entering or leaving the department.

Most of the furniture such as beds, chairs, and mattresses were in good condition to allow for effective cleaning and all the curtains appeared in good condition, were disposable, and dates showed regularly changed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There were cleaning staff working throughout the department during our visit. However, we were not always assured all areas were clean and had suitable furnishings which were clean and well-maintained. Our concerns, as described further in the next section 'Environment and equipment' were with the condition and configuration of the environment or estate. In many areas it did not always support good infection control practice and easy efficient cleaning. Despite the efforts and hard work of staff, the department was too small for its growing needs, and some areas were cramped, crowded with equipment, paperwork, and patients were sometimes too close together.

Some of the walls were missing paintwork, which would not support good infection control practice. For example, there was a large patch of missing paintwork in a bay in the children's clinical area.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment did not follow national guidance. The environment or estate that made up the emergency department was no longer fit for purpose. It was too small and contained thoroughfares to other departments. Extending the department into areas not designed for the original footprint of the department had led to inefficiencies and some safety concerns. However, these were well known to the department staff who described their concerns and how it affected safety and efficiency.

The main entrance to the department was partially obscured from the road and by the ambulance waiting area, and it was not always easy for people to locate the department. The patient waiting area was not big enough for the number of patients it often housed. One of the days we attended was busy (although the department was often much busier) and the waiting area was full of patients and those accompanying them. Several patients were standing up and 2 patients left before being seen as they had nowhere to sit and were told the waiting time was up to 4 hours.

There were no wheelchairs available in the immediate vicinity and the department was located up a short climb from the nearest (often full) carpark or down a slope from the bus stop. A relative was anxious having been unable to park and eventually arrived after 45 minutes and was unable to find their spouse. However, the waiting area was mostly visible for the reception staff who would respond by alerting clinical staff if they had concerns about a patient.

Nursing staff working in one of the 2 triage areas could also see most (although not all) of the waiting area. The advantage of the staff in the triage area being able to oversee most of the waiting room was balanced against the disadvantage of the patients they were assessing being seen, and we noted, were overheard from some seating areas. We were able to overhear much of the conversation when sat close to the triage room, particularly with a patient who was hard of hearing.

One area which was recognised but had not improved to meet fully safe standards since our previous visit was the management and safety of children. The Royal College of Paediatric and Child Health Standards for Children in Emergency Care Settings recommends emergency departments have specific areas for children. These include waiting and treatment areas and those for families in a crisis. The emergency department in Torbay Hospital was not meeting these recommendations. Children and families were required to use a small, penned-off but open area in the small often overcrowded adult waiting area. Children were therefore not protected or removed from seeing and hearing adult patients, some with complex needs. However, the waiting area was not obscured from the reception team, so the children were able to be seen and supervised. We told executives about this issue during the inspection. They confirmed paediatric waiting area was recorded on the risk register as it was recognised that having children within the footprint of the general waiting area did not support the optimum experience for children and their families. The trust had plans for a refurbishment of the department and emergency pathway with specific focus on paediatrics. The ED leadership team were reviewing the waiting provision for children and have written an options appraisal to reconfigure the current layout of the department, to include a designated paediatric triage area. They also confirmed, to keep children safe there were a number of mitigations in place, such as regular oversight from both the triage team, the paediatric nurses and the wider ED silver nurse and medical lead.

The emergency department was struggling for enough space, and there was no area for families with children in crisis or complex medical needs to be placed away from others. The staff working in the children's clinical treatment unit were managing well given the issues with space, but it was not ideal. It was already too warm by mid-morning and the portable air conditioning unit helped but was noisy in the small area and inefficient across the space. Staff were doing their best to make the unit as safe as possible, but the area was too small when caring for children from babies and up to 18-years of age. However, there were two side rooms in the unit which offered some privacy.

There were plans for the children's department to be relocated to one of the areas being used for patients waiting to be discharged, assessed by speciality teams, or waiting to be admitted to a ward. Clearly this would cause disruption while the area was reconfigured for both cohorts of patients, but was an option being explored. We recognised and staff knew this change would solve some problems but result in others due to the ever-rising demand for beds across the hospital.

The layout of the department meant staff were walking long distances every day to reach all the areas that made up the estate. This had been mitigated well to an extent by cohorting the staff into teams so they could stay within areas. However, this cohorting did not extend to the senior staff running the department or other staff such as allied healthcare professionals who had to navigate corridors and extended former ward areas. This could be tiring and physically taxing.

The resuscitation area had 4 bays, one able to accommodate a child, and the unit was well stocked with the required equipment, including that for children, pregnancy complications, and other specialist areas of treatment. We were told the bays could get full in times of high demand, but a 4-bedded area was not untypical provision for a department of its size.

We noted on a couple of occasions, patients had not been given their call bell, which remained on the adjacent wall support and out of reach. Those patients who did have their call bell to hand said staff had responded quickly to them using their call bell, although most had used infrequently. One patient said "I've not had to use mine at all as they've been in and out and checking on me all the time. But it is here, right next to me if I need it." The nurse in charge was checking with patients on their safety round to make sure call bells were in reach and moving those that had not been well placed to be in reach of the patient. Patients were assured they could use them at any time.

During the inspection we found the mental health room was not fit for purpose, the distance to go to this room along a corridor meant there was potential danger to others. It was observed there was a chair behind the door of the escape room. We told the trust executives about this during the inspection who confirmed a thorough risk assessment had been undertaken to ensure any risks were mitigated and only used by appropriate patients after a risk assessment is undertaken. The chair behind the door of the escape room was removed immediately and staff were reminded of the importance of keeping these routes clear. This issue had also been added to the "Environmental Checklist".

The department was well organised by staff for access to equipment. For example, in the minors' department, staff had put together several trolleys with all the key items for suturing and for applying dressings to support efficiency. There were several new reclining chairs for patients in minors which were safer and enabled better and easier care and treatment. However, the bays were too small for them to be optimally used and accommodate anyone else other than the patient and the member of staff. Areas and equipment, such as fridges and cabinets which should be locked and secured met those requirements although 1 clinical room at the end of the assessment unit was left open and unoccupied on several occasions.

Those staff we asked said they felt they knew where everything was but did sometimes have to track things down. Stock was said to be generally good and well managed. Safety checks of equipment such as fridge temperatures and emergency equipment had been carried out and this was checked by the nurse in charge on safety rounds.

Clinical waste was disposed of carefully and those bins we saw for the disposal of sharp instruments were not overfull. General waste bins were being regularly emptied by the cleaning staff.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

The audit data for treatment for patients with sepsis showed compliance needed to improve around the provision of antibiotics within 60 minutes. However, some of this was due to the computer system not being updated when suspected sepsis in patients was ruled out and antibiotics not needed. This meant the data was not entirely accurate, and there remained a cohort of patients who did not receive antibiotics within 60 minutes. There was a project being led by one of the senior sisters and a team of staff to improve compliance with this metric.

Staff were aware when a patient was assessed as at risk from falls, pressure ulcers or other potential unintended harms. Risk assessments were being completed and a flag raised to alert staff on the electronic patient record. Pressure

relieving and falls prevention equipment was being used when indicated. However, we noted how some staff used the set of paper records first when reviewing a patient and there was nothing immediately apparent in those records to flag certain risks. It was an area staff were aware of and had been endeavouring to solve but were struggling with the balance between safety and patient confidentiality. For example, 1 electronic patient record recorded the patient as both hard of hearing and vision impaired, but this was not being immediately highlighted to staff caring for them which meant staff may not have been able to meet their communication needs.

Staff used the National Early Warning Score (version 2 – NEWS2) for all patients and those records we saw were all completed. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. We reviewed 6 records of NEWS scores and found the assessment of the patient and subsequent scoring to be in line with guidance. Patients who were registering a high NEWS score had regular reviews and updates and had been flagged for medical review as required.

The triage of people who attended the department as walk-in patients was improving. For several years, data showed the safety target of staff seeing all patients within 15 minutes was being missed much of the time. It had been recognised this was unsustainable but was not helped by a shortage of experienced staff. However, it led to safety risks, such as patients deteriorating whilst waiting to be seen, so staffing levels were increased from 1 nurse to 2 nurses and experienced nurses brought in. This had been underway for around 3 weeks at the time of our inspection and was already showing signs of effective improvement. Some of the more junior staff and new staff were being trained to relieve the pressure on the senior staff to fulfil this role and release them back to the department.

Triage of patients took account of many walk-in patients sitting for several hours in the waiting area and long past their initial triage procedure. To ensure patients had not deteriorated, healthcare assistants were repeating observations every 2 hours as prompted by the patient-record system. Any concerns were raised with the triage nurses or other clinical staff.

The assessment of patients who were brought into the department by ambulance or identified as acutely unwell on arrival was carried out by a rapid assessment team. There was a bay in the majors' area set aside for this with higher levels of equipment. Several other adjacent bays could be used if needed when the department was facing high levels of demand. This was a doctor-led process which enabled rapid diagnostic tests to be arranged and requests for speciality input.

One of the key members of the wider team for keeping patients safe was the hospital ambulance liaison officer, known as the HALO. This was a paramedic employed by the NHS ambulance service and on duty at certain planned times of probable capacity escalation. The HALO reported a good working relationship with the emergency department team and well-managed prioritisation of the sicker patients.

Nurse staffing

The service had enough nursing staff 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 staffing levels and skill mix and gave bank and agency staff a full induction.

There had been notable improvements in the number of nursing staff in the department which was heading for full establishment. The vacancy rate had been reduced by the arrival of several cohorts of overseas nurses and newly trained

or recruited staff. However, senior departmental nursing staff were honest and open that this gave them a workforce which did not yet have the skill mix and experience required to be fully safe and efficient. As a result, an increased and improved learning and development programme had been brought in to support staff in embedding and improving their skills and experience. We recognised, as did the department, this would take time to be fully embedded.

There continued to be regular use of agency nursing staff for unplanned and other absence. Many were regular workers for the department. One whom we met at the time of our visit said they had recently returned to the department after a long break but had been given a full induction again and felt supported and welcomed back. They said they always found someone immediately available to help with any questions or support they needed.

The minors' department was now at full nursing establishment. The department was staffed by both nurses and healthcare assistants, but also by a growing cohort of paramedics. Staff said it was far easier to be able to complete training, undertake appraisals and any other competency training with a full establishment. Any unplanned absence was managed more safely.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The department used a combination of electronic notes and paper documents for recording patient care and treatment. Most of those we reviewed were well completed and we saw some comprehensive notes in the electronic records by all disciplines. However, there were some gaps in the paper records and not all were completed as well as they could be, which could lead to potential wrong treatment decisions. Some of this was due to delay in the recorder completing the notes at the time of our review, as they were called away; some were due to the record not being essential so it was not used; but others which should have been more comprehensive required improvement and more attention to detail.

We had some concerns about the confidentiality and safety of patient records. Due to the way the department was organised and to be as efficient as possible, the decision had been taken to keep paper patient documents in a clear yellow plastic folder in the corridor. Although the department was busy with staff around, this did make the records vulnerable to tampering and being seen or removed by people without authorisation. However, staff we asked said they were not aware of any incidents with the security of records, but noted our concerns and said they would review their system. Some of the computer screens were left open and unsupervised with patient records visible. The names and summary of a patient were shown, and we were able to enter and access the detailed records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we identified patient group directions which had passed their review date, expired sterile fluids and oxygen cylinders which were not stored securely and safely.

Staff followed systems and processes to prescribe and administer medicines safely. However, we did see some of the documents used were not always the most current trust document. We also saw some of the patient group directions, which are written instructions to help staff give medicines to patients, had passed their review date and there was no evidence that these had been extended.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Staff did not always store and manage all medicines and prescribing documents safely. In 1 of the areas, we found that not all oxygen cylinders were stored securely. The risk was a cylinder could fall over and land on a person causing injury, or falling over which could potentially damage the valve resulting in a leakage of the gas. In the same area we found that sterile fluids were not rotated effectively and there were some out of date products present. Whilst it is best practice for the dates to be checked on each occasion before administration, if fluids are used regularly there is a potential risk that the date may not be checked. If the product is beyond the expiry date, there is the potential that it is no longer sterile and may contain pathogens which could infect the person who it is administered to.

The trust had developed a policy and a monitoring checklist to monitor the temperature storage of medicines. When these were reviewed on 1 area, we found action had not been taken in accordance with the policy when the recorded temperature was outside of the indicated range, which could affect the efficacy of the medication stored. However, we did also see the trust had developed a system for monitoring when the room temperature was elevated and had a procedure to mitigate the effects of this.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

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

All staff knew what incidents to report and how to report them. Staff were encouraged to report incidents and told us they usually received individual feedback or an outcome. Safety briefs were used to disseminate wider learning.

Staff told us there were quarterly mortality and morbidity meetings in the emergency department where the care of patients who had complications or unexpected outcomes was reviewed. Minutes were available to show these minutes took place regularly. Key learning from these meetings was discussed in governance meetings.

Staff raised concerns and reported incidents and near misses in line with their policy. There were 1134 incidents reported in the previous 12 months prior to the inspection. We noted all the incidents had been investigated and lessons learned were identified.

Urgent and emergency services

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same. We rated it as requires improvement in July 2020. We did not inspect all key areas so were unable to re-rate.

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.

In line with the recruitment drive, the department recognised the need for and focus on continuous professional development and competency training. Several staff were studying for additional qualifications including to become non-medical prescribers, post-graduate, and higher-education qualifications, and to learn other key skills. There was no barrier to them being able to undertake relevant training in valuable and key skills and this was encouraged. The department had increased the provision of practice educators and introduced 'turbo learning' (quick sessions on specific topics delivered by subject-matter experts). There was a programme of Collaborative Learning in Practice which was targeted at all staff but with a focus on supporting overseas and new recruits.

There was bespoke learning in the minors' team every 2 weeks, and this was extended to include any staff from the local urgent treatment centre or minor injuries units who were able to attend. This had included topics such as radiology and case studies. A competency checklist had been developed by healthcare staff working with children which was appreciated and embedding as a valued process with staff.

There was bespoke learning for the paediatric team in the form of a specialist study day. So far, 27 staff had attended. A paediatric competency framework had been introduced for triage nurses. Paediatric Immediate Life Support was now mandatory for all nurses, including adult nurses. The department was on course to achieve 85% compliance by October 2023 with the intensive learning course. Adult nurses were completing a paediatric competency framework as a new initiative and difficult airway management in children was being rolled out by the practice educators. There were much-improved links with the children's team in the wider hospital and plans to rotate staff through departments to increase experience and skill sets.

We met 3 student nurses who were on placement in the emergency department. They felt well supported and were enjoying and benefitting from their time with the nursing staff. They were given time to ask questions and for clarification and were not asked to carry out tasks which were beyond their skills or confidence.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good in July 2020. We did not inspect all key areas so were unable to re-rate.

Urgent and emergency services

Compassionate care

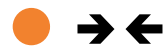
Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were kind and caring with patients and families. We met several patients and their families and all of them were happy with the care and compassion they had received. This included anxious patients, both adults and children, who were taken through the comprehensive triage process. It also included compassion and understanding shown to patients who were waiting for long periods in the waiting room and in the department.

We observed kindness and staff treating people well. They gave as much time to the patient and any family as possible and were respectful and considerate of their privacy and dignity, within the restrictions of the lack of space in the department. They were non-judgemental and respected people's rights to make their own choices, even when they were not in their perceived best interests.

We recognised and were told how staff found it hard to have to regularly explain and apologise, to patients who were being held in the department due to issues with capacity elsewhere in the hospital. We observed how staff were understanding and apologetic to patients in the waiting room and explained how some patients needed more urgent care.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement in July 2020. We did not inspect all key areas so were unable to re-rate.

Access and flow

People could not always 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 not in line with national standards.

Managers monitored waiting times but could not always ensure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

At the time of the inspection, the trust's urgent and emergency care performance was 57.6%, which meant the department was 93rd in England against 107 Acute Trusts who recorded this data. Ambulance delays increased in March 2023, with 74% of handovers over 15 minutes compared to 55% in February 2023, as Covid-19 and Norovirus infections reduced bed capacity. However, these delays were lower than the impact the trust had with previous infection outbreaks.

Another important indicator for patients who require admission to a hospital ward is the time it takes for their transfer to take place from the time of decision to admit. At our last inspection in 2020 we saw some patients spent too long in the

emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding. This continued to be the case at this inspection with patients being delayed in the emergency department while beds were sought in the wider hospital and community.

We saw managers and staff in the department worked to make sure they started discharge planning as early as possible, but discharges and transfers were regularly delayed as a result of wider system delays.

Capacity in the department was regularly reviewed by both the department from a safety perspective and by the site team as a view of capacity pressure. The site team role was to monitor the flow of patients through the hospital and coordinate action to prompt the flow of patients. The trust held 4 site meetings a day to improve patient flow, which were attended by senior staff from the ED. Escalation processes were used to address surges in demand caused by increased attendances in the emergency department.

Patients requiring discharge were actively managed throughout the day to support capacity within the department, specifically addressing the decisions made to admit patients. The discharge lounge was used during the day to increase the experience of patients on the day of discharge. The trust recognised the two main challenges to patient flow were pre-noon and 5pm discharges from the acute hospital. Steps had been taken to improve discharges, although it was recognised that further improvements needed to be made.

The department included a joint emergency team, who saw patients that required assessment and care package within 24 hours of referral. They worked with patients in the emergency department, acute medical unit, and the discharge lounge. Part of their role was to plan discharges for patients at the time they were admitted into the department. They worked closely with colleagues in social care and GPs across Devon and Torbay to get people back to their home. They also undertook welfare follow ups, and signposted patients to information and services to reduce readmissions. However, staff acknowledged the capacity of the team was low, and there were no plans to increase this.

At the last inspection, we saw crowding and caring for patients on a corridor had become normal practice, which did not always ensure patient privacy and dignity. Being cared for on a corridor meant there was no privacy to use washing facilities and the toilet. Because of the wider system issues, this remained an issue. Staff told us they were frustrated when they had to use these spaces for patients.

Patients were not always seen in a timely way. Data from January to March 2023 showed only 38% of patients were seen within 4 hours, and 15% of patients were not seen within 12 hours.

Staff supported patients when they were delayed in the department. There was a rapid assessment area in the majors' area of the emergency department. This was designed to improve patient flow by ensuring patients were examined promptly by a senior clinician so decisions about diagnostic tests, and treatment plans were made more quickly.

Staff had created an emergency department long stay booklet, to improve patient experience. This included ensuring patients had completed drug charts, been referred to a speciality, been offered a hot meal and drinks, and ensuring contact had been made with relatives. It also covered ulcer prevention risk assessment, and a malnutrition universal screening tool.

During our inspection, an internal critical incident was managed calmly in the department, patients would not have been aware of the pressures the department was experiencing or likely to experience.

Urgent and emergency services

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the 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.

Some of the senior leadership in the department were relatively new and finding their feet, but despite this, staff felt supported by their leadership. They said they were visible and approachable. No one we met in the staff team said they did not feel confident and able to speak up to senior staff and managers. Several staff we met had been supported and enabled to train and develop for more senior roles.

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment.

Culture

Staff felt respected, supported and valued. 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.

Staff in the department felt valued by one another. We were told culture had improved and this was evident from our observation of staff working well together, knowing each other well, and being supportive and kind. Some said the culture had not always been strong, and the pandemic and the exceptional stress on capacity over last winter (2022/23) had been the worst things they had experienced. However, the teamwork and camaraderie would support them to come through the other side, although that might take some time.

A key number of staff felt the department would be improved if it had a higher priority and focus from those running the hospital in conjunction with the integrated care board (those responsible for the quality and safety of the whole system of health and care in the region). Emergency departments placed at the heart of an organisation and given priority by multidisciplinary teams have seen an improvement in performance and capacity problems. Staff did not feel, not least given the problems they had to overcome with the environment, they were placed with enough priority and seniority within the wider organisation. By way of example, we found the portacabins, which had been set up temporarily many years ago as offices for administration staff and consultants, to be leaking rainwater. This was the source of some genuine unhappiness for some of the staff affected by this and created the feeling of not being valued. We told trust executives about this as part of our inspection feedback. They told us the decision was made to move staff offices into the portacabins to allow for improved patient facilities, recognising that this is not an ideal working environment for staff. However, the portacabins have been weather proofed and all staff had access to hygiene and refreshment facilities

which are located on level 4 of the main building. Longer term funding had been identified to redevelop the current patient waiting room facilities and to provide a second story of administration accommodation. An approved plan will be in place by September 2023 and building works will commence in November 2023 with occupation planned for early 2024.

Several staff said how the introduction of staff from overseas and different ethnic backgrounds had done much to improve the culture and positive diversity of skills and life-experience. New staff enabled them to be more thoughtful of others and how they could help them integrate in not only a new hospital but a new country for many. There was a culture week held once a month where staff from different backgrounds and ethnicities were encouraged to share their cultural heritage and aspects of their life. A lot of staff referred to the culture event the previous week with genuine enthusiasm.

There was recognition of the challenges around staff leaving and new stay interviews had been introduced. This gave senior and managerial staff the opportunity to talk with staff who were thinking of leaving to endeavour to retain them. Some staff talked with us about these interviews and said they were proving to both support staff who were unhappy and to change their minds too.

There were services available to staff who had to deal with difficult or upsetting situations, or who had been abused by patients or families. This included referrals to services such as occupational health or other psychological post-trauma support. Some of the staff were also TRiM trained, this is Trauma Risk Management which is designed for trained staff to be able to spot the more subtle (or indeed more obvious) signs of distress in colleagues which could go unnoticed and to put together a plan of support.

The emergency department minors' team were proud to have won the daisy award in November 2021 which was a national award given for "exceptional nursing."

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.

Governance processes had improved since our last inspection and were effective in developing the service. Staff at all levels were clear about their roles and accountabilities.

There was an agreed clinical governance structure and a clinical governance lead for the department, who attended clinical meetings.

Managers within the department produced a monthly quality and safety report which fed into the wider quality improvement group meetings. Information discussed included incidents and interventions, workforce, vacancies, clinical audits, workstreams, performance metrics, and quality improvement. Medical reports also included mortality and morbidity, case presentations and learning from incidents.

Governance meetings were well attended, and managers confirmed representatives attended to reflect the department. Minutes produced were comprehensive. Not all staff were able to attend team meetings due to time constraints and pressures. Communication folders were used by managers to relay key messages and staff attended a daily huddle to be able to discuss patient safety issues.

Operational and clinical audits were used to drive service improvement, and results from national audits were formally discussed.

Departmental policies were readily available on the intranet and supported by standard operating procedures and processes.

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.

The department monitored risks well. We looked at risk register items and saw the highest identified risks included patient flow and the environment not being fit for purpose. This matched what staff told us were the highest risks. We saw the risk register was reviewed regularly, identified what controls were needed to mitigate risks, and what the gaps were. The risk register also noted action plans and progress. For example, the risk relating to patient flow had several mitigations including an escalation policy, and daily meetings to review discharges.

The register also included the risk of the ED environment not being fit for purpose for children, including a lack of paediatric space when the department is overcrowded, and no suitable waiting area. The department had increased the number of paediatric nurses to 2 per shift. There was an acknowledged gap in controls, as this could not be overcome until significant building works were completed.

The highest rated risks were ‘owned’ by the chief executive and chief nurse, to ensure these issues were addressed at board level.

The department risk register was a ‘live’ document’ which meant the managers could update and add risks as necessary. Risks were discussed at each governance meeting, and discussions identified which risks needed to be escalated to the quality improvement group.

Outpatients

Requires Improvement ↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in most key skills to all staff and made sure most staff completed it.

Staff received and kept up to date with their mandatory training. Senior leaders monitored mandatory training and alerted staff when they needed to update their training.

The trust had a target of 85% of staff being trained in a range of subjects designed to keep staff and patients safe. The mandatory training was comprehensive and met the needs of most patients and staff. The 85% target was exceeded for all training modules apart from moving and handling. Moving and handling training had not reached above 77% compliance in the past 6 years. Senior leaders told us staff in their department found booking onto and attending the face-to-face element of this 2-part training difficult. We were not aware if staff or patients had come to harm because staff had not completed this training.

Since 1 July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their role. This new legal requirement was introduced by the Health and Care Act 2022. Senior leaders told us clinical staff were given the opportunity to undertake training on recognising and responding to patients with learning disabilities and autism, but this did not form part of their mandatory training requirements. Most of the staff we spoke with told us they were not provided with training on recognising and supporting people with autism. This meant staff might not have been able to meet the needs of patients with autism.

Training in supporting patients with mental and health needs and dementia was available to staff but did not form part of the trust's mandatory training requirements. Only 1 member of staff when asked "how would you support someone with an acute mental health problem" was clear about the referral process to the mental health crisis team.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Outpatients

Trust records showed 100% of staff received level 1 safeguarding adults and safeguarding children training, and 97% of staff had received level 2 safeguarding adults and safeguarding children training. Trust records showed 90% of staff who required level 3 safeguarding adults and safeguarding children training had received it. A senior leader told us when staff duty rotas were completed, they ensured staff trained to level 3 were included on every shift.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. However, staff did not always know how to make a safeguarding referral or who to inform if they had concerns. Only 1 member of staff could tell us the name of a safeguarding lead. Most staff said they would share a concern with the safeguarding team based within the hospital or with the patients GP. However, all staff told us they would share their concerns with their line manager.

OPD clinics for children and young people mostly took place in the designated paediatric department which did not form part of this inspection. Some children attended the main OPD because the specialty they were under did not run a paediatric clinic because they had limited numbers of children requiring appointments. Paediatric patients seen in the department were supervised by a registered children's nurse or a dual registered nurse. Some services had separate adult and paediatric waiting areas. However, each clinic should have a separate or segregated child-friendly area in line with best practice guidance Health Building Note 12 Designing an out-patients department and Health Building Note 23 Hospital accommodation for children and young people.

Senior leaders told us they did not have a policy to guide staff on safe procedures for children visiting the department. This meant staff did not have clear guidance to guide their practice or if something went wrong.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They mostly kept equipment and the premises visibly clean.

The service generally performed well for cleanliness. Patient-Led Assessments of the Care Environment (PLACE) results from April 2022 showed the service received 100% for cleanliness.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Matrons performed regular cleanliness, infection control and hygiene audits and hand hygiene across the department which mostly scored 100%.

Most of the clinical areas we visited were clean and had suitable furnishings which were clean and well-maintained. We saw evidence staff cleaned equipment after patient contact and labelled desks and equipment to show when it was last cleaned. However, we saw a dirty ophthalmoscope and an examination chair that had not been wiped down. We saw a chair in a waiting area with a ripped seat cover that posed an infection and hygiene risk. When we raised this issue with senior hospital leaders, they added cleaning of ophthalmoscopes to the matron's audit of the environment to ensure standards of cleanliness were maintained. They also reminded staff of the need to use green 'I am clean' stickers on equipment in between patients.

Staff followed infection control principles including the use of personal protective equipment (PPE). Handwash gels were available at sinks and there were supplies of PPE in every room.

During our inspection in 2018, there was a breach in regulation related to infection, prevention and control because of risks linked to renovations in the fracture clinic. We saw these risks had been removed by the completion of building works.

Outpatients

Environment and equipment

There was suitable equipment to keep people safe, staff were trained to use equipment and kept them maintained. Clinical waste was well managed. Areas were mostly maintained but we identified fire risks.

The service had enough suitable equipment to help them to safely care for patients, staff were trained in its use and kept equipment maintained. However, technological advances in health care equipment meant there was an increased need for space to house the equipment and also for staff to operate it. Staff gave an example of some new equipment in the ophthalmology department which supported improved treatment outcomes but required the use of a whole treatment room to house it. This meant when the equipment was not being used the room could no longer be used for other treatments.

Outpatient areas were generally well maintained with appropriate facilities to keep people safe. Rooms that contained lasers did not have reflective surfaces, this was in line with guidance to ensure patient and staff safety. The rooms had the correct safety and warning notices on the door for when the laser was in use. However, we saw fire doors to a cleaning cupboard that could not close because the cupboard was too full. This had the potential to pose a risk to staff trying to exit the building in the case of a fire. When we raised this as an issue with senior hospital leaders, they removed some of the cupboard's contents and installed a lock on the door to ensure it was kept closed.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. Sharps and hazardous waste bins were stored safely.

Assessing and responding to patient risk

Risks to patients on waiting lists was not always identified, resulting in harm to patients waiting for care and treatment in ophthalmology. 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.

Harm had come to patients waiting for care and treatment in ophthalmology. New and existing patients sometimes had to wait for a long time to be seen by a doctor. The trust identified patients who had come to harm as result of their condition deteriorating while they were waiting so they could understand what had happened and learn from it. We looked at an investigation report that had been carried out because 45 ophthalmology patients had been identified as coming to harm (having irreversible sight loss) because they had been waiting a long time for treatment. Six patients had suffered severe harm and 39 had experienced moderate harm.

The report identified that as deterioration to eyesight was not always perceptible to the patient there was a chance a greater number than 45 patients may have come to harm.

The report concluded the department had been under pressure since 2012 in terms of clinic capacity, staffing and equipment. The caseload of patients increased year on year, as more patients remained on the ophthalmology caseload long-term due to improvements in treatments, but which require patients to be reviewed every 4 weeks. In addition, the administrative process for booking follow-up appointments was identified as not robust enough to ensure patients were always contacted to have their follow-up appointments booked. The process for booking appointments was overly complex as it relied on a combination of paper and electronic systems.

A business case to employ 11 additional nursing staff in the department had been submitted, and an electronic patient record was planned to be introduced by Autumn 2023 which would reduce the complexity around booking

appointments and therefore the likelihood patients would be lost in the system. However, leaders within ophthalmology told us to reduce the backlog of patients waiting to be seen, and to see all patients in safe timescales they would need at least 3 more consultants, another 2 operating theatres and an additional 3 consulting rooms. Steps had been taken to recruit a locum ophthalmologist in 2022, but the recruitment advert was withdrawn when it was recognised there was not enough consulting space for an additional consultant to see patients in.

We saw evidence senior staff met in April 2023 to discuss harm to patients that could be caused by lengthy waits to see doctors. In minutes of harm review meetings staff discussed ways they could assess the harm. Waiting lists were being validated by a third-party provider. This meant patients were contacted to see if they still needed to be seen or if they could be removed from a waiting list. However, staff agreed a plan to assess a sample of patients who had been waiting a long time to be seen could provide them with more information about the extent of harm long waits were causing. They had a plan to look at how this could work in practice, the next step was to convene a meeting to work out how this could be achieved by the existing staff group.

Staff identified and quickly acted upon patients at risk of deterioration. Staff told us how they would respond to any sudden deterioration to the health of a patient in the OPD. They knew who to call and what to do if there was a medical emergency, they would use the alarm to call the resuscitation team (medical team with special equipment able to be mobilised quickly to treat cardiac arrest). The trust did not have a policy for staff in the OPD to follow to manage a rapidly deteriorating patient or member of the public. Immediately following our visit, the trust advised us they were updating the deteriorating patient policy to include OPD. However, each area of OPD had emergency resuscitation equipment and anaphylaxis packs. Staff were trained to use this equipment. We saw the resuscitation trolleys were checked regularly and staff recorded when equipment was due to go out of date so it could be replaced in a timely manner.

We observed safety checks being performed prior to minor surgery. These included patients being asked to explain what procedure they were expecting to undergo, details of allergies, and what medicines they were taking. Staff explained what would happen during the procedure, and once it was complete, they gave patients information about what happens next. This included information about what to do if they experienced any problems. Patients were also given information sheets to take away so they could refer to these when they got home.

The trust had a policy regarding the use of the World Health Organisation (WHO) Surgical Safety Checklist. It stated a WHO Surgical Safety Checklist will be completed for every patient undergoing a surgical intervention including procedures under local anaesthetic and filed in the patient's notes. The audit to ensure a WHO Surgical Safety Checklist is filled in accurately and at each stage of the surgery process for surgery in OPD (dermatology) showed 100% compliance for the 3 months before we inspected.

Staff teams used a range of checklists that incorporate the WHO Surgical Safety Checklist to help check that procedures were being carried out safely. For example, the intercostal chest drain checklist and report included all of the preprocedural checks that needed to take place before the procedure, the checks that needed to be completed during the procedure, and a post procedural checklist. These checks included baseline observations to detect signs of patient deterioration.

OPD services had processes to admit patients who were too unwell to continue to be seen as an outpatient and required inpatient care.

Outpatients

Emergency appointments were utilised so people with urgent and emergency issues could be seen quickly by the appropriate team. One of the patients we spoke with had experienced an eye injury at work. Initially they had been seen in the emergency department but were quickly transferred to the care of the eye clinic where they were seen by an ophthalmologist. They received follow up care over the next week in the eye clinic.

Staff met at the beginning of each day to share key information to keep patients safe.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe.

Nursing staff told us they sometimes needed to work extra hours to ensure there was enough staff to keep patients safe. For example, oncology staff said leaders relied on the good nature of staff to keep services running. However, staff were paid overtime or were able to take the time back for these extra hours. Staff told us this arrangement was closely monitored to make sure staff were not doing unpaid work.

There was a registered children's nurse (RCN) and staff had access to support from registered children's nurses in the paediatric department if the OPD RCN was not working.

There was an ongoing recruitment campaign to increase the number of reception staff, medical secretaries and administrative assistants that supported the department. These vacancies meant current staff had additional duties to cover including a backlog of 2 weeks for patient letters to be typed. Administrative staff dealing with booking patient appointments told us because they were short staffed there were delays in adding new patients' details to the system and consequently a delay in sending them appointments to be seen. However, staff told us patients who were required to be seen as urgent were prioritised despite staff shortages.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

During our inspection in 2018 some patient files had not been stored securely. All the records we looked at during this inspection were stored securely in lockable cabinets and / or lockable rooms.

However, staff told us sometimes patients' paper files did not arrive from the central patient file store because they were located elsewhere in the hospital. This meant staff had to spend time searching for files before clinics began. It also meant some patients were seen without their medical history being available to the medical team. When we raised this as an issue hospital leaders told us about their plans to procure a trust wide Electronic Patient Recordin Autumn 2023. This will reduce the need for paper-based patient records and therefore reduce the burden on staff to locate patient files and the risk to patients of being seen without their medical records.

Medicines

Staff did not always store prescribing documents safely.

Outpatients

Staff did not always follow procedure to store prescribing documents safely. We found OPD prescription pads on the desk in an unlocked laser room that could be accessed by members of the general public and in a resource room that could be accessed by staff. When we raised this issue with hospital leaders a security alert was circulated to all staff in clinical areas to make sure prescription pads were stored securely and to remind staff about the procedure for their safe storage.

Incidents

The service managed patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support.

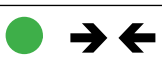
Staff knew what incidents to report and how to report them. Staff told us they reported incidents electronically and mostly received feedback on the incident once a manager had reviewed it.

Senior hospital and department leaders were aware that patients were coming to harm as a result of long waits for treatment. Staff reported serious incidents clearly and in line with trust policy when it was apparent harm had been caused by a direct result of a long wait a full investigation was carried out. However, staff were concerned the number of patients experiencing harm was not being captured. This was because some patients might not realise their condition was deteriorating and it would only be when the patient saw a doctor the true extent of the harm could be assessed.

Staff understood the duty of candour. The duty of candour is the responsibility of a service to be honest with patients when things go wrong. Staff were open and transparent and gave patients and families a full explanation if things went wrong. We saw evidence patients had been contacted with an explanation of what had gone wrong even when the patient had not identified they had come to harm. For example, not all the patients had experienced harm during a long wait for ophthalmology appointments had perceived this was the case, but they all received an apology and an explanation for the harm that had occurred under the duty of candour.

We saw learning from incidents was available to staff. For example, we saw a file in the matron's office that contained learning from incidents which was available to all staff. However, most of the ophthalmology staff we spoke to were not aware of the incident report completed for the 45 ophthalmology patients who experienced irreversible sight loss because they had been waiting a long time for treatment, and the plans that had been put in place to try and prevent this from happening to other patients.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good in May 2018. We did not inspect all key areas so were unable to re-rate.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. However, there were examples where privacy was not maintained.

Outpatients

We saw staff treating patients with compassion and kindness and patients told us they had positive experiences of the care and treatment they received and received good standards of care. However, we observed several instances where doors were left open in phlebotomy and ophthalmology during patient appointments which did not respect their privacy and dignity. When we raised this issue with senior hospital leaders, they told us a trust wide privacy and dignity campaign had been launched to remind staff of the utmost importance of maintaining this standard including screensavers, 'Fantastic Fundamentals' seminars, audits and action plans for ongoing monitoring, discussion and continuous improvement.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service Planning

The design of the outpatients' service did not meet the needs of all patients.

The footprint of the outpatient department was problematic for staff and for patients. The original part of the hospital building was almost 100 years old. As the size and needs of the population it serves had grown, the hospital had not grown along with it. The original outpatient department at Torbay Hospital was not big enough to house all the services that delivered outpatient care hence the layout of the OPD was fragmented and sometimes difficult for patients to navigate. The main OPD is on level 2 of the hospital building. Other OPD services are located on different floors or in different parts of the hospital. We observed and spoke with patients who were lost or disorientated because of the layout of the hospital which may or may not have been improved by better signage.

We saw staff frequently being asked to give directions to help patients understand how to find their way out of the main OPD. Staff told us they are asked to give directions numerous times each day and said it was often easier to accompany patients to the lifts than explain how to find them.

Staff explained patients being seen in the Crow Thorne OPD sometimes had to navigate their way to the main OPD to get blood tests or an electrocardiogram (ECG) as part of their appointment. The route from Crow Thorne was difficult to navigate, although both OPDs were based on level 2 they were on different parts of the level that could only be reached by taking a lift to level 4, finding another set of lifts that take you to level 2 of a 'newer' part of the hospital. The same route would need to be followed in reverse if the patient had parked in a car park close to the Crow Thorne unit. An internal agreement had been made between OPD and phlebotomy to provide blood tests to patients at Crow Thorne who would struggle to travel to the main OPD. However, we heard from staff that this agreement was not yet operational.

The hospital leaders were aware of the difficulty of patients trying to locate the area they were scheduled to be seen in and had recruited volunteers as 'pathfinders' to help patients and visitors find their way around the hospital. Pathfinders wore brightly coloured t-shirts, so they were easy to locate and request help from. We saw lots of pathfinders helping patients and visitors find their way around the hospital. Unfortunately, there were not always enough pathfinders to match the number of patients looking for support from them.

Outpatients

Patients and staff told us it was very difficult for patients and their carers to find car parking spaces who consequently arrived late for their appointments. This problem had been compounded by the temporary removal of some car parking spaces while building works were being completed. As commented on by the PLACE team in 2022 “the car parking was not fit for purpose with many frustrated visitors” and the hospital had “very poor and inaccurate signage for car parking”. Once inside the hospital patients told us they could not always easily work out how to get to the part of OPD they were scheduled to be seen in because of the layout of the hospital. We witnessed 1 patient being too out of breath to stand for a 3-minute standing blood pressure check after arriving from the closest car parking space he could find to the Crow Thorne OPD.

National guidance for the design and layout of OPD takes into consideration that many patients who attend will have mobility problems, for example physical, auditory or visual impairment and recommend the OPD should be located on the ground floor and that parking areas for disabled people and wheelchair users should be provided close to the main entrance. When parts of OPD are not located on the ground floor the guidance recommends easy access by lift and stairs must be provided, and access and circulation routes to and within the OPD should be sufficiently direct and clearly signposted to prevent patients losing their way ((HBN 12) Designing an out-patients department).

Hospital leaders understood the problems with the design, maintenance, and use of facilities. They told us about the hospital transformation programme that included optimising space to ensure OPD meets the needs of patients. The transformation programme has identified the extent of current OPD capacity and measured that against what is required to improve services. The outcome was a plan to increase capacity by 10% through better utilisation of the space already available. There was not a focus on how OPD services are going to be delivered on the ground floor or how improvements could be made to prevent patients losing their way while navigating the hospital.

The service did not always have suitable facilities to meet the needs of patients' families. At busy times the waiting area did not always have enough seats for chaperones to sit with patients. Staff told us during busy clinics patients and or their carers had to stand to wait to be seen.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment were not always in line with national standards. The service used multiple information systems as well paper records to manage appointments which increased the risk of error.

Managers monitored waiting times and tried to make sure patients could access services when needed to receive treatment within agreed timeframes and national targets. However, the trust had a significant backlog of patients waiting to be seen by some of the different OPD services. In April 2023, over 30,000 patients were waiting for a new OPD appointment, of these 2,500 were waiting for an appointment with ophthalmology services.

The backlog of patients waiting to be seen across OPD was partly due to the COVID-19 pandemic and associated social distancing requirements when patients could either not be seen at all or could only be invited to attend in small numbers. Before the pandemic, there were less than 14,000 patients waiting for a new OPD appointment.

In addition to the backlog created by the COVID-19 pandemic there was an aging population; this means people are living longer. The impact of this is people are more likely to develop an increased number of health problems that require medical treatment. Also, advancements in medical treatments mean there are more and better ways conditions can be treated. These factors combined meant more people were waiting for more treatments creating an increase in the backlog of patients waiting for appointments.

Outpatients

Initiatives to reduce backlogs had been introduced and in March 2023 30% more new patients were seen in OPD services than in March 2020. For example, ophthalmology ran weekend clinics, patients who could travel to Exeter could be seen there more quickly, and some surgical procedures were carried out by an external service provider at the weekend using the hospital's facilities. These initiatives were making a difference. For example, in February 2023 the trust saw a 4% decrease in the number of people on the waiting list which was the biggest decline for at least 18 months.

The maximum number of weeks patients should wait to be seen by a doctor is set by the NHS Constitution to try and ensure people are seen in a timeframe that means their medical condition will not get worse while they are waiting. The longest time the Constitution says people should wait is 18 weeks for most non urgent referrals, and 2 weeks for suspected cancer. Trusts were required to put in place systems and dedicated teams to ensure patients were tracked and monitored along their two-week wait or 18-week pathway, with audit processes in place to ensure appointments have been made.

From April 2022 to March 2023, 21,971 patients were referred to the trust on a 2 week wait for suspected cancer. They were able to see 78% of those patients within 2 weeks. Since December 2022 the trust exceeded its target of 75% of patients receiving a cancer diagnosis or cancer being ruled out in 28-days under the faster diagnosis standard. In March 2023 76.2% of patients had received their diagnosis in this timeframe.

Some non-urgent referrals had waited for 65 weeks to be seen. In April 2023 nearly 10% of patients had been waiting more than 52 weeks for treatment and 30% of patients had been waiting for over 30 weeks. However, the percentage of patients who had been waiting less than 18 weeks from referral had steadily decreased since April 2022 and in February 2023 was 61% which is the lowest it had been for 18 months.

We saw minutes of meetings that showed hospital and department leaders understood people waiting for appointments could experience harm because they were not being seen in a timely manner. Waiting lists were being validated by an external third-party provider. This provider contacted patients to see if they continued to need treatment or if their condition had deteriorated and required escalation. Senior leaders understood patients should have a clinical review of their case every 3 months while they were waiting to be seen but they did not have the resources to do this. This meant they could not be assured people were not coming to harm. However, leaders were looking at ways they could clinically assess patients with their current resources. For example, they considered reviewing a sample of patients to help them understand what might be happening to wider groups of patients.

In addition to the number of new patients waiting to be see in May 2023, there was a total of 26,461 patients waiting to be seen for follow up appointments. Ophthalmology had the largest number of people waiting for follow up (8,005), followed by rheumatology (2135) and orthoptics (1174).

All the patients we spoke with said they had been seen on time and all of the clinics we visited were running on time. Staff told us most clinics ran on time. On the rare occasion clinics ran late this was because the doctor arrived late because they had been caught up in surgery or on the ward, because patients who needed seeing urgently had been fitted in, or because an appointment had run over due to complexity of a case or a distressed patient.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us it was rare for clinics to be cancelled and when this did happen it would be because of staff sickness and an inability for staff to be sourced to cover the clinic. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged for as soon as possible.

Outpatients

Managers and staff worked to make sure patients did not have to attend OPD more often than they needed to. If they were required to see multiple practitioners' staff would try and ensure all appointments were scheduled for the same day. For example, staff would try and arrange for a patient to see a doctor, dietician, and phlebotomist on the same day. However, senior leaders told us they were unable to always check patients had been given all appointments for the same day as they did not have access to the IT systems used by dietician or physiotherapy services.

We saw a lack of interoperability between IT systems added a layer of complexity and increased the likelihood of error in the outpatient appointment booking process. It also placed the burden of responsibility on patient access centre (PAC) staff and medical secretaries to be the safety net for ensuring patients received appointments and were not lost in the system. Within OPD there were different IT systems used by different specialities to record some of the aspects of treatments that were delivered.

There was a lack of alignment between IT systems which meant the different systems were not able to communicate and share data with one another and there was a large reliance on paper records including to give patients follow up appointments. Paper-based notifications that specified the timeframe patients needed to be seen within went to the PAC while the paper-based patient file went to the medical secretary's team. The medical secretaries checked the PAC had issued appointments. We saw this system mostly working well although sometimes patients rang to say they had not received their next appointment. The PAC were issued clinic slots 6 weeks in advance however, we saw clinic slots for 5 weeks in advance just being made available and no 6-week clinics having been made available in 1 speciality.

We saw PAC staff trying to add new patients from paper-based records to their system in between answering phone calls to other patients. Staff kept a paper-based record of patients who had not responded to appointment letters and who required further appointments being sent out. We saw staff making repeated checks to ensure the correct details had been transferred from paper to their electronic system.

When we raised this as an issue hospital leaders told us about their plans to procure a trust wide Electronic Patient Recordin Autumn 2023 which will reduce the need for paper-based patient records and therefore reduce the burden on staff.

Is the service well-led?

Good 

Our rating of well led stayed the same. We rated it as good in May 2018. We did not inspect all key areas so were unable to re-rate.

Leadership

Leaders had the 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.

Outpatients

All staff spoke positively about their line managers who they said were approachable, supportive, and helped them develop their skills. Staff described their senior leaders as having an 'open door'. They gave examples of training opportunities that were available to them including nurse training courses for health care assistants. However, most the staff we spoke with said they did not know who the hospital leaders (trust executive team) were as they did not visit their department.

Senior leaders told us about the issues the service faced and plans they had to overcome these. For example, patients seen at the Crow Thorne unit had a long walk through the hospital for blood tests in the main OPD, sometimes patients required the support of nursing staff to make this journey. To enable patients to have a blood test at the Crow Thorne unit senior leaders arranged for nurses to be trained in phlebotomy.

Leaders understood what needed to be done to reduce the backlog of patients waiting for treatment. They told us this included giving departments more space to see patients in and more staff to see patients. They escalated their concerns about the potential risk of harm to patients waiting a long time for treatment to the executive board and had added the risk to the departmental risk register.

Culture

Staff were focused on the needs of patients receiving care. However, staff did not always feel respected, supported and valued by the hospital leaders.

Staff told us they worked within supportive teams who were focused on the needs of patients receiving care. They were proud of the care they provided. However, the core OPD staff (staff who only worked in OPD and were not part of a medical or surgical speciality who sometimes or mostly worked in other parts of the hospital) told us they felt like a forgotten part of the trust. They said hospital leaders did not visit their department, their work was not included in the staff newsletters, and they did not have a direct line of communication with the trust's executive board.

When we raised this issue with hospital leaders, they told us they have begun to implement the '15 Steps Challenge' with the aim of strengthening executive visibility and enhancing their understanding of patients first impressions of the hospital, and ensuring high levels of confidence are built between staff and patients. The '15 Steps Challenge' includes executives, a patient representative, and a senior nurse visiting different areas of the hospital each week.

Hospital leaders also told us about planned changes to the way OPD will be managed in future. OPD will be part of the planned care directorate and will have a direct line of communication with the executive board in the same way the medical or surgical directorates do.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The current OPD governance process is managed by the individual specialisms that see outpatients, for example, ophthalmology or urology and their wider core service, for example, medicine. Although governance arrangements within each speciality function effectively and involved regular audits of performance and escalation of risk issues, they

were not always coordinated as a single OPD. This is a structural issue which had been identified by trust leaders as needing alteration. A new structure for OPD had been planned and will sit under the centralised function of planned care. While specialties will remain as the primary management function there will be a centrally defined outpatient department and an access manager with responsibility for delivery of activity, quality and patient care.

Arrangements with partners and third-party providers were governed and managed effectively. For example, the outsourced ophthalmology service at a local NHS hospital and the insourced third-party ophthalmology service delivered within the hospital were managed through business meetings with a regular review of key measures.

Staff were clear about their roles and responsibilities. However, there was limited shared learning or collaboration across outpatient specialties, although there was a desire from staff to work collaboratively. We raised this as an issue with hospital leaders who said the new structure will address this and they will ensure any barriers to collaborative working are addressed and staff feel encouraged to share learning and best practice across specialties.

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.

Each speciality had assurance systems, and performance issues were escalated through clear structures and processes. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. However, although staff were able to demonstrate where investment in higher staffing levels, more space to see patients in and in the procurement of more equipment would reduce risks for patients waiting for treatment, hospital leaders did not have access to the resources required to make these improvements.

Risk for patients with suspected cancer who needed to be seen within 2 weeks were monitored and escalated through a framework of specialty level weekly meetings. The most challenged specialties were monitored at weekly meetings with the Regional Cancer team and the Cancer Alliance.