Torbay and South Devon NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Torbay and South Devon NHS Foundation Trust is an integrated organisation providing acute health care services from Torbay Hospital, community health services and adult social care. The Trust runs Torbay Hospital and nine community hospitals in Devon. The trust serves a residential population of approximately 375,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

This was the first inspection undertaken at Torbay hospital using the comprehensive inspection methodology. We inspected Torbay hospital between 2 and 5 February and on 15 February 2016. The inspection team inspected the trust's acute hospital services and community-based services as well as social care services provided from two locations.

Overall, we rated the trust as requiring improvement. We rated urgent and emergency care services as inadequate. We rated six other services as requiring improvement, eight as good and four as providing outstanding quality of care.

At the trust level, we rated four of the domains of quality care (safe, effective, responsive and well led) as requiring improvement. However, the caring domain was rated as outstanding, reflecting the compassion, support and patient involvement the trust provided in delivering care.

Our key findings were as follows:

Safe

- Nurse staffing was at expected levels in many areas. However, the emergency department was not always staffed by appropriately qualified, experienced and skilled nursing staff. The numbers of nurses on medical wards regularly fell below the established minimum number. The Child and Adolescent Mental Health Services (CAMHS) had difficulty recruiting staff leading to long waits for some patients.
- Medical staffing was at expected levels in most areas. However, in the emergency department there were not enough consultants or a named paediatric consultant on each shift. In outpatients, there was not enough medical staffing to allow the trust to address its significant backlog of follow up appointments.
- While most services demonstrated an understanding of patient risk, there was an inadequate response to risk in other areas. In the emergency department, patients did not always receive an initial assessment within 15 minutes. This placed patients at risk. The National Early Warning Score (NEWS) system had been implemented in the emergency department but the scores did not always indicate the action needed. Medical patients on outlying wards were not always well supervised and some CAMHS patients had long waits without updated risk assessment being carried out.
- Infection prevention and control procedures were complied with, such as in the case of regular hand hygiene audits. Clinical areas were generally clean although we saw some unclean areas in some outpatient procedure rooms. Some patients without MRSA confirmed status were being placed on surgical wards which presented an infection risk to other patients. In dermatology, minor surgical procedures were taking place in rooms that were not adequately ventilated or maintained.
- There was generally a positive culture around reporting, investigating and learning from incidents. However, in end of life care, it was not clear how lessons were learned from incidents and we were not assured about the effectiveness of incident monitoring. In outpatients, there was a mixed approach to incident reporting. In surgery, information on incidence of falls, pressure ulcers and urinary tract infections was displayed on ward boards providing transparency on incidents.
- Premises and equipment were not always fit for purpose. The facilities in the emergency department were not suitable or well maintained and compromised patient safety. In critical care, intravenous fluids were not stored securely and the safety of babies was compromised, as breast milk was not stored securely. Cautery procedures were carried out in rooms without smoke extractors and without the use of masks.

Summary of findings

- The management of medicines was generally in line with trust policy and legislation, although in outpatients there was inconsistent recording and monitoring of fridge temperatures and there were no records of stock rotation in some areas.
- There were some areas of records management that needed improvement. We found areas for improvement in surgery, children and young people's services and end of life care.
- Staff understood their safeguarding responsibilities and were aware of the trust's policies and procedures.

Effective

- In most services, patient's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based practice. In the emergency department, performance was mixed against national audits to benchmark performance and in end of life care there were inconsistencies in symptom management.
- In most services, there was evidence that patient outcomes were assessed. The trust had a mortality rate in line with the national average. Surgical services benchmarked against other trusts and were performing well in terms of effectiveness and patient outcomes. In the emergency department patient outcomes varied and the results of audits were not always used to improve treatment, including management of sepsis. Unplanned re-attendances to the emergency department were not investigated to identify reasons. Lengths of stay in the trust's community hospitals was significantly lower than average.
- Multi-disciplinary working was evident in many services inspected such as in community and hospital midwifery and in the CAMHS service. However, some areas of multidisciplinary working in the emergency department and medical care were not working effectively.
- There was variable understanding of responsibilities in relation to consent, the Mental Capacity Act 2005 and the Deprivation of Liberty Standards (DoLS), for example in critical care.
- In some areas, the equipment being used was not of an expected standard. In end of life care, temporary fridges were being used on a permanent basis, without effective temperature monitoring. In outpatients, aging equipment was preventing staff from providing effective services.
- Facilities did not always support effective services. The emergency department facilities were not suitable or well maintained. This compromised patients' safety and experience. There was no designated space to assess patients with mental health conditions. The critical care unit did not meet currents standards although the building of a new unit had started. The design and use of some outpatient facilities did not keep patients safe at all times.
- Patients' nutrition and hydration needs were being met.
- Staff were generally competent to deliver services to patients. However, in outpatient services a nurse practitioner was performing procedures without formal qualifications.
- Limited access for mental health services out of hours caused extended waits for patients in the emergency department.

Caring

- Patients were consistently treated with compassion, kindness, dignity and respect and feedback about the care received was very positive.
- Staff demonstrated a good level of emotional support throughout the range of acute and community services the trust provides.
- We saw examples of caring interactions between staff and patients. Staff were observed going 'above and beyond' in many ways to deliver outstanding support patients and relatives, often at difficult times.
- The trust had developed a ward buddy system on care of the elderly wards at Torbay Hospital where buddies were able to provide one-to-one emotional support to patients.
- Patients and their relatives were often involved in their care planning and treatment and staff supported patients to understand their care needs.
- In end of life care staff we talked to had a good understanding of the impact that a person's care, treatment or condition might have on their wellbeing and of those close to them.
- In maternity patients' choices were important when planning and delivering care.

Summary of findings

- In children's services, parents and children spoke highly of the service. Children were involved with the planning of their care wherever possible. In outpatients, we saw relatives and carers being included in decision making.

Responsive

- There was no flow urgency throughout the hospital, which impacted on the emergency department. A lack of available beds in the hospital resulted in poor patient flow through the emergency department. Delays were unacceptable at times placing patients at risk of avoidable harm.
- Emergency department patients were not consistently being seen within an appropriate timescale for initial assessment or by a suitable doctor for clinical review.
- There was a lack of decision makers in the emergency department which also affected the flow of patients out of the department.
- In the medical directorate, a number of patients had been transferred out of wards overnight.
- Delayed discharge rates were consistently high and large numbers of patients spend considerable time on outlier wards without senior medical input.
- Bed pressures also affected timely discharges from the critical care unit. Elective (planned) surgery was affected by the lack of bed availability in critical care.
- In surgery, the pressure on bed availability within the hospital meant patients were not always receiving timely surgery. Numbers of patients who had their surgery cancelled remained above the average for England.
- In maternity, there was a public health midwife to support people to make lifestyle changes and the service had systems to make adjustments for patients living with learning or physical disabilities.
- The gynaecology service introduced enhanced recovery procedures to improve the flow of patients through the service.
- The children and young people's service provided responsive planned and emergency care, although there were delays accessing mental health services.
- There was a long wait (17 months at the time of our inspection) for children aged 5 to 18 to receive an autistic spectrum diagnosis.
- The end of life service collected some information about numbers of deaths of patients on end of life pathway and whether they died in their preferred place of care or not. Most end of life patients had a treatment escalation plan including a resuscitation decision.
- Plans were in place to increase clinics in outpatients. However, at the time of the inspection patients often did not have timely access for follow up appointments due to a follow up back log and the capacity of clinics.
- We saw evidence of person-centred care. In surgery patients living with dementia or learning disabilities had their needs met. The children and young people were at the centre of their care and paediatric services were highly responsive.
- There was a positive culture around dealing with feedback and complaints and learning lessons. In some areas such as the children and young peoples' service this included identifying trends and themes to embed learning.

Well led

- There was a clear and inspiring vision for the future which had been developed in partnership and there was strong senior leadership on place.
- There was a feeling that the change had been managed. Most staff were very positive about the new organisation, with good communication in place.
- The team were not assured that the highly devolved arrangements provided the Board with sufficient oversight in key areas, for example aspects of performance in the emergency department and on mortality and morbidity.
- Dual systems, processes and policies were running in areas key to patient safety, for example, two incident reporting systems and policies.
- The effectiveness of the governance arrangements for the integrated organisation, four months old at the time of inspection, were too new to have been fully tested. There were challenges to improve governance arrangements in some services, most notably in the emergency department and in medical care.
- The sustainable delivery of quality care was put at some risk by the financial challenge.

We saw several areas of outstanding practice including:

Summary of findings

- Staff in the Emergency Department (ED) were positive and professional under pressure, maintaining a supportive role to patients. They were always kind and thoughtful, ensuring that patient's anxieties were relieved as much as possible.
- The trust was the highest achieving in the south west peninsula for cancer treatment targets and had the highest survival rates in the south west. The trust was also the highest achieving cancer centre in the patient survey and in the 10 nationally.
- We spoke with one patient on the surgical ward who was going through a distressing time as they found out their daughter was admitted for emergency care. The staff in the hospital had arranged and facilitated to take them down to see their daughter and had constant updates from the medical team involved in care.
- In recovery in the middle of the room there was a large clock with four faces on it pointing in different directions. This allowed patients to orientate themselves with the time as soon as they woke up after theatre reducing confusion and distress.
- We found that WHO checklists were completed using a large whiteboard in every theatre allowing all staff to observe and act upon it. These were being developed further to be interactive projection boards where each patient would have a bespoke WHO checklist depending on its requirements.
- The innovative way in which the hospital was managing capacity by making traditionally inpatient surgical stays as an outpatient procedure.
- The innovate way in which technology had influenced the educational facilities at Torbay Hospital. Particularly around the use of virtual reality headsets to train staff for specific situations such as the surgical checklist.
- The use of video calling over the internet using portable tablet devices in the critical care unit was an example of outstanding practice. This technology primarily allowed doctors to have a 'face-to-face' discussion with relatives who were not in the country, but also allowed those relatives to see and speak to their loved ones being treated on the unit.
- The critical care unit's rehabilitation programme was exceptional. As well as having focus on patients while they were in the unit, there was rehabilitation support and follow-up routinely provided in the hospital for patients who had been discharged. This service was then further extended into the homes of patients who had been discharged from the hospital. Because the programme worked so well, the unit's occupational therapist had been invited to speak nationally on the subject to encourage other hospitals to look at ways they could deliver a similar service.
- The care being provided by staff in the critical care unit went above and beyond the day-to-day expectations. We saw staff positively interacting with all patients and visitors and evidence of staff going out of their way to help patients. Patients and visitors gave overwhelmingly positive feedback.
- There was a perinatal mental health team based in the maternity unit. This had led to consistent care for women with mental health conditions and provided multidisciplinary care to women during and following their pregnancy.
- The divisional quality manager provided 'critical incident stress debriefing'. This involved group sessions where people who had been involved in critical incidents or difficult situations were invited to talk through the process and any issues that had arisen.
- The maternity services had secured funding to have short videos produced that were available on the trust website. They were designed to build on the information given to women at the start of and during their pregnancy as it was realised that people do not take in all the information they are given by healthcare professionals. The videos could be watched at people's leisure and aim to provide women with all the information they need to make informed choices for example around screening tests and methods of delivery.
- When women called in to say they thought they were in labour instead of being asked to come into the unit to be triaged a midwife would offer to visit the woman at home to establish if they were in labour or not. Choices about how and where they would like to have their baby could then be decided upon. This had facilitated some unplanned home births which were seen as a positive outcome. The midwives found it had meant less unnecessary attendances at the maternity unit.
- One of the general theatres operating department practitioners had noticed there were sometimes communication issues between midwifery and general theatre staff. They had carried out a project to improve

multidisciplinary communication. As a result of the project a caesarean section and obstetric emergencies information chart had been produced, that was laminated and displayed in the labour ward and a theatre 'do's and don'ts' also laminated and displayed for staff to follow.

- We saw a good level of involvement of children and young people in consultant interviews.
- In end of life care, bereavement officers gave out feedback cards to bereaved relatives and comments which were then discussed with the bereavement officers line manager. This had resulted in the trust introducing free parking to relatives of patients at end of life. Bereavement officers had also been able to reduce the time that death certificates took to be issued through project work. This had increased the efficiency of the process and reduced some of the emotional impact on relatives at a stressful time.
- The medical records department had consistently supplied 98-99% of records to clinics on or before the clinics, with note preparation carried out to suit consultant's individual preferences, and had plans to track notes electronically on a live system.
- The physiotherapy direct referral service, allowed patients to access physiotherapy without the need for a GP referral. Patients using this service normally received an appointment within 72 hours of self-referral.
- In the oncology outpatient department, there was a home delivery service for some oral chemotherapy drugs. Patients received telephone consultations with their consultants for three appointments, and then came into the clinic on their fourth for a review.
- The virtual triage clinic in Fracture clinic had reduced the numbers of unnecessary fracture clinic appointments by 15%.
- The diagnostic imaging department had turned 93-99.9% of reports around within one week across all specialties and patient types. In particular, there was a dedicated inpatient-reporting radiologist for every session, which had reduced the average turnaround time for an inpatient report to six hours. The department also produced run charts to identify any outliers, and investigated the delay in their reports.
- Nursing, medical records and care plans across the eight community hospitals we visited were completed to a high standard. They were accurate, up to date with and good evidence of multidisciplinary team input. Our specialist advisors said these were some of the best care plans they had ever seen.
- Relatives spoke highly about the way in which staff involved them in the patients' care and treatment across all of the community hospitals. They felt involved in the planning of patients' care, in their goals towards goals towards discharge and for when the patient returned home.
- Therapy staff involved family and carers on admission to the hospital. They would go out to the patients' home to meet with families in order to ensure the patient had access to the most appropriate services and equipment to enable their recovery. This enabled staff to understand fully the patients' home situation and whether the family or carer was best placed to support the patient with their ongoing care and reablement. They could support families with this process and assess the level of input the patient would need from other agencies.
- The changes made to the management of diabetic patients in the community by the introduction of new care planning documentation and recording of insulin prescribed and administered. The diabetes Specialist Nurse received recognition from the Royal College of Nursing (RCN) for their work in improving the management of patients with diabetes. Their work was recognised nationally and was published by the RCN for other trusts and community nurses to follow.
- We saw a particular example of outstanding practice for end of life care in the community, in the development of a carer's course where people caring for loved ones with life limiting illnesses could access an ongoing support group. Feedback from this was positive and described by carers as helping them to feel valued and better able to cope with their situation.
- All community minor injury units (MIUs) had reduced their un-planned reattendance rates following a review.
- There was an orientation programme for nurse practitioners at the MIUs, which lasted for a minimum of four weeks and practice during this time was always supervised.
- The trust been selected by NHS England to become one of eight urgent and emergency care vanguards,

which are aimed at improving the coordination of urgent and emergency care services. Planning had started to expand the MIU services at Newton Abbot so that minor illnesses could also be treated.

- The majority of staff at the MIUs had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The computer system featured a flagging system for people with learning disabilities so that staff could be alerted to their special needs.
- A trauma triage system had been introduced which reduced the need for long journeys for people who had sustained fractures. Clinical notes and X-rays were viewed electronically by an orthopaedic consultant in the acute trust. Following this review many patients could continue their treatment at their local minor injury unit. Only people with more complicated fractures were asked to travel to Torquay for specialist treatment.
- Community dental staff in all the locations were passionate about working within the service and providing good quality care for patients.
- Patients reported an excellent dental service. We evidenced highly trained and experienced staff with excellent application of knowledge and skills in practice to meet the needs of this very vulnerable group in a high risk setting.
- The dentists and support staff were skilled at building and maintaining respectful and trusting relationships with patients and their carers. The dentists sought the views of patients and carers regarding the proposed treatment and communicated in a way which ensured people with learning disabilities were not discriminated against.
  - The development of the Brush and Bus scheme taking oral health prevention advice to local schools.
  - The development of a mobile dental service taking treatment to isolated areas and special schools in order to provide timely intervention in a safe manner.
  - The development of a sedation service that is not reliant on waiting list admission therefore providing care on site in a timely manner as required by the patient.
  - The provision of a bariatric chair for the treatment of obese patients.
  - The provision of a hydraulic lift for patients who use a wheelchair to be treated in their chair.
- Specialist and secondary dental staff in all the areas of service provision were passionate about working within the service and providing good quality care for patients.
- Patient's feedback demonstrated they experienced an excellent service within the specialist and secondary dental services. We evidenced highly trained and experienced staff with excellent application of knowledge and skills in practice to meet the needs of this very vulnerable group in a high risk setting.
- One of the patient transport service vehicles was able to take specialist transfer trolleys (one for surgical transfers and one for special care baby transfers). The patient transport service provided the ambulance and driver and the patient was escorted by clinical staff from the surgery ward or special care baby unit. The new fleet due later in 2016 has more vehicles that can be used to take specialist patient care trolleys to improve transfers from the hospital to other NHS units.
- A member of the control room staff from the patient transport service attended the daily bed meeting held in the trust. This was a meeting held at several times a day to look at the capacity and demand within the hospital. The patient transport service were an active part of this meeting and were able to share what resources they could make available and were able to ascertain the pressure points in the trust and where the priorities would be for discharging patients in a timely way.
- The provider had excellent communication systems which allowed them to track each of their vehicles and to get instant messages direct to individual crews or all the crews at once. The system also allowed crews to send messages back to the control room. Paper records and mobile phones were available as back-up systems.
- The patient transport service had good links with other agencies such as social services. These links extended to providing services they were not commissioned to do. The view of the managers was that if it was of benefit to patients and improved links with other agencies it was worth doing. As an example, the department was contacted by social services because a patient needed to be moved downstairs in their

home. The patient transport service allocated a crew to assist the care staff in settling the patient into their new accommodation on the ground floor of their home.

- We observed and heard examples of where patient transport service staff went above and beyond what they were contracted to do. One outstanding example was when a patient died on the ambulance on route to their home. The crews had been instructed to return to the hospice if the patient died, however the family present with the patient wanted to return home as planned. The staff sought advice from their control room and the hospice and followed the family's wishes and continued their journey. The crew settled the patient into their bed at home and waited with the family until the specialist palliative care nurses arrived. This was an example of where staff went above and beyond in the care they provided to their patients and their families.
- The children's and adolescent mental health service (CAMHS) worked closely with local services in health, social care and education. In-reach roles had been developed, including a team of primary mental health workers to work in schools, practitioners to work with social services and a perinatal specialist. Clinics were held in GP practices where patients could be booked in with a CAMHS practitioner instead of a doctor. This enabled patients to get the right help more quickly.
- All clinicians involved in CAMHS received safeguarding supervision every three months even if they had not needed to make a safeguarding alert. This ensured safeguarding was always high on the agenda, staff were supported and that the need to involve the local authority safeguarding team was considered for all patients.
- The CAMHS service ran a group for parents and carers to enable them to learn about mental health and consider how best to help their children. The group was effective and received good feedback from participants.
- Children, young people, their families and carers were involved in the service and its development. Children were included in interview panels and given 50% weighting in the decision process. They were involved in creating videos that were going to be used on a new website for the service. There were forums for children and young people and for parents and carers where they could give feedback about the service. There was evidence that questionnaires completed by people who used the service were making a difference to how the service was delivered.
- Staff at Walnut Lodge were caring, compassionate and motivated to help people to the best of their abilities. This was often demonstrated with staff going above and beyond what was expected of them. For example, providing additional support to people and their families to ensure that they can access appointments, assisting people with support to access voluntary support groups in the community and often taking a professional lead in co-ordinating and organising an effective multidisciplinary approach.
- There was a specialist health visitor integrated within the substance misuse team. This role involved supporting the children of people who were using the service. The role enable staff to support the person using the service and their family. This involved visits at home, comprehensive support plans for the children and family education about the risks associated with drug and alcohol use. The role provided an additional safeguard for the family and children. We received extremely positive feedback for people who had used the service about the support provided to the family as a whole and how it had enabled them to realise that recovery was possible.
- The consent to treatment form identified, for women who used the substance misuse service, the need to monitor themselves for pregnancy whilst in treatment. This is important due to the risks associated with pregnancy and opiate withdrawals.

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

Importantly, the trust must:

- Make the management of the emergency department environment safe. Patients waiting on corridors to be seen must be reviewed and monitored to ensure their safety.
- Address the 24 hour a day, seven day a week consultant cover for paediatrics in the emergency department and allocate a named consultant for each shift.
- Ensure that there is consultant cover provided to all medical wards and escalation wards seven days a week.

Summary of findings

- Ensure risks to the health and safety of patients when identified are actioned. When Early Warning Scores indicate an increased level of observation that this level is consistently maintained.
- Ensure plans in place to monitor sepsis pathways are completed.
- Ensure there is timely access to psychiatric support in the emergency department. A safe room must be provided to ensure both patients and staff undertaking an assessment are safe.
- Review the process of medically expected patients having to wait in the emergency department.
- Ensure senior decision makers in the hospital are involved in the movement of patients through the emergency department.
- Ensure the escalation processes in place to support the emergency department during busy periods are effective to address the issues causing the escalation.
- Ensure the governance systems in place for the emergency department reflect the known issues and are used to address the concerns identified. The trust should ensure that when areas of anomaly such as the high readmission rates and rates of patients leaving before being seen are audited and investigated.
- Ensure there are sufficient numbers of suitably trained, competent and skilled staff deployed to meet the needs of patients. The trust must provide evidence of the sustainability of these increased levels and how monitoring of sufficient staffing is being maintained.
- Ensure ongoing monitoring of the initial time to initial assessment and clinical observation. Appropriate monitoring and actions must be undertaken to ensure the safety of patients.
- Ensure patients arriving at the emergency department are seen within an appropriate timescale by an appropriate doctor. The trust must ensure monitoring of this timescale to ensure the ongoing care and treatment of patients.
- Take action to ensure patients cared for on escalation wards, outlier wards and at weekends have access to medical input and review from appropriate clinicians.
- Take action to minimise the length of stay medical patients spent as outliers in surgical areas.
- Review staffing skill mix on Elizabeth and Warrington wards to ensure patients cared for there, particularly out of hours, are safe.
- Ensure patients cared for at weekends; in escalation wards or as medical outliers receive appropriate risk assessments.
- Review how staff are trained in fire safety on wards and ensure a named, competent fire warden is in place.
- Ensure critical care staff have a full understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and that patients subject to these are appropriately assessed, supported and authorised.
- Review staffing levels on Louisa Cary Ward to ensure they meet the recommended guidance (RCN 2013) particularly at night.
- Ensure the safe storage of breast milk on Louisa Cary Ward and the special care baby unit was not secure which compromised the safety of babies. This was raised with staff at the time of the inspection.
- Ensure risks for end of life care are captured and reviewed effectively through the governance system.
- Ensure all staff that monitor and adjust syringe drivers are competent and have the skills to carry this out.
- Ensure minor surgical procedure rooms are clean and fit for their purpose and ensure these standards are maintained with regular monitoring.
- Ensure there is adequate ventilation and extraction in outpatient procedure rooms where cautery is carried out.
- Ensure emergency oxygen is checked and records kept.
- Ensure medicines stored in refrigerators are checked and to keep accurate temperature records.
- Take action to capture record and investigate post procedure infection rates in the dermatology general outpatients department.
- Ensure departments carry out regular hand hygiene audits in all outpatient areas and display the results for staff and patients.
- Ensure the systems and processes at community hospitals ensure information in relation to safety, particularly regarding staffing levels and skill mix, was shared and understood between ward and board level.
- Ensure where information is held on paper and electronic systems, staff are able to access information required.
- Ensure initial health assessments for 'looked after' children meet the statutory timescales.

Summary of findings

- Ensure there are sufficient staff to meet people's needs and cover caseloads of health visitors and school nurses.
- Ensure treatment escalation plans and do not attempt resuscitation decisions are appropriately completed and recorded in line with trust policy and that audits of these lead to measurable action plans used to improve performance.
- Ensure healthcare assistants checking controlled drugs and syringe drivers is risk assessed and training is provided and are competency assessed.
- Ensure patients who do not have capacity to be involved in decisions about resuscitation have a clearly recorded capacity assessment along with clearly documented best interest decisions and a detailed record of all discussions with the patient and family members.
- Ensure the clinic room at Walnut Lodge is locked and keys to obtain access to the medicine cupboard and fridge are stored securely.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Torbay and South Devon NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust provides a number of services across South Devon, mainly but not exclusively within the Teignbridge, Torbay and South Hams district areas. The trust provides a service to a population of around 375,000 people, and around 100,000 visitors at any one time during the summer holiday season, with acute services provided at the Torbay Hospital located in Torbay.

The hospital dates back to 1928 and was known previously as South Devon Healthcare NHS Foundation Trust. It was one of the first NHS Trusts established in 1991 and was authorised as one of the early NHS Foundation Trusts in 2007. Torbay and South Devon NHS Foundation Trust was created on 1 October 2015 when South Devon Healthcare NHS Foundation Trust, that provided acute services at Torbay Hospital merged with Torbay and Southern Devon Health and Care NHS Trust, that provided community health and social care services.

The demographic data for Torbay, Teignbridge and South Hams Local Authorities are all very similar. However, Torbay is more deprived than Teignbridge and South Hams. In the 2015 English Indices of Deprivation, Torbay Local Authority is in the 15% most deprived areas in the country as well as Teingbridge and South Hams Local Authorities are both in the 45% least deprived areas in the country. 17% of the population in Torbay are under 16, 16% in Teignbridge and 15.9% in South Hams (all three lower than the

England figure of 19%). The percentage of people aged 65 and over is 26% in South Hams and 25% in Torbay and Teignbridge (all three higher than the England figure of 17%). Approximately 98% of the population in all three Local Authorities are of white ethnicity (higher than the England figure of 85%). There is a lower percentage of Black, Asian and Minority Ethnic (BAME) residents (3% Torbay, 2% Teinbridge, 2% South Hams) when compared to the England figure (15%).

We conducted this inspection as part of our comprehensive inspection programme. We looked at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The inspection team inspected the following eight core services at the Torbay Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

We also inspected community services and looked at:

- Community health inpatient services (we visited eight of the nine hospitals; Asburton, Brixham, Dartmouth, Dawlish, Newton Abbott, Paignton, Teignmouth and Totness Community Hospitals).
- Community services for children's and young people
- Community services for adults (we visited four of the nine hospitals; Asburton, Dawlish, Newton Abbot and Teignmouth Community Hospitals).
- Community end of life care (we visited five of the eight hospitals that provide this service; Asburton, Dartmouth and Teignmouth Community Hospitals).
- Community health urgent care services
- Community dental services (we visited Castle Circus Health Care and Brunel Dental Care)
- Special care dental services
- Patient transport services
- Community mental health services for children and young people (CAMHS)
- Substance misuse services (we visited Walnut Lodge)
- Adult social care services (we visited St Edmunds and Baytree House)

Our inspection team

Our inspection team was led by:

Summary of findings

Chair: Tony Berendt, Medical Director, Oxford University Hospitals

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included 28 CQC inspectors and a variety of specialist advisors including consultants and senior doctors in critical care, end of life and community palliative care, maternity, medicine, outpatients, acute and community paediatrics, and surgery as well as a junior doctor. In addition the team included two directors of nursing, a designated/named nurse for safeguarding, and a variety of senior nurses, midwives, therapists and three experts by experience.

The team was also supported by analysts and an inspection planner.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions in every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Torbay Hospital. These included the local commissioning group, Monitor, the local council, Devon Healthwatch, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held two listening events for the public on 20 January 2016 where people came and told us about their experience of using services at the trust. We used this information during our inspection. People also contacted us via our website and contact centre to share their experience.

We carried out an announced inspection between 2 and 5 February 2016 and an unannounced inspection on 15 February 2016. We held focus groups and drop-in sessions with a range of staff at the hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

We talked with patients and staff from across the hospital. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of their care and treatment.

What people who use the trust's services say

The trust collected patient comments via the Friends and Family test.

We received information from people through listening events, emails, our website and phone calls. Responses were a mix of positive and negative information. Some patients spoke highly of the care they had received, whilst others raised concerns. This information was used by inspectors during the inspection.

The CQC Adult Inpatient Survey 2014 received responses from 479 patients from South Devon Healthcare NHS Foundation Trust . For the majority of questions, the trust was rated the same as other trusts. There was one question relating to the availability of hand-wash gels for patients and visitors, that the trust scored worse than the England average. There was one question relating to receiving an explanation the patient could understand from the anaesthetist or another member of staff about how the patient would be put to sleep or their pain controlled, that the trust scored better than the England average.

The results of the Patient Led Assessments of the Care Environment (PLACE) showed the trust was consistently performing better than the England average on cleanliness, food, privacy, dignity and wellbeing and facilities in 2013, 2014 and 2015.

Summary of findings

From October 2014, the trust scored above 95% in the NHS Friends and Family Test, when asking patients if they would recommend the hospitals. The number of written complaints have remained consistent with a small increase from 2013/14 to 2014/1 (an increase from 241 to 249).

Facts and data about this trust

Torbay and South Devon NHS Foundation Trust is a new integrated organisation, formed on 1 October 2015, providing acute health care services from Torbay Hospital, community health services, community dental services, patient transport services and adult social care. The trust runs Torbay Hospital, which has a total of 293 beds (including 22 maternity beds and eight critical care beds), nine community hospitals and provides health and social care in Dawlish, Teignmouth, Totnes, Dartmouth, Torbay, Newton Abbot, Ashburton, Bovey Tracey and the surrounding area.

The trust has forecast turnover for 2015/16 of £319.8m and a forecast operating deficit of £8.7m. Monitor's ratings for the trust for quarter 3 of 2015/16 were level 2 for financial sustainability and a green rating for governance. A risk rating lower than 3 for financial sustainability, and failure to achieve financial targets, could lead to further action by Monitor.

The trust serves a residential population of approximately 375,000 people. This population is increased over the summer holiday period with as many as 100,000 visitors at any one time. The population is approximately 98% white with small Asian, Chinese, Filipino and Eastern European Communities.

Deprivation is varied in the geographical area that the Trust provides a service for. Torbay is lower (worse) than the national average although the most deprived of the three main Local Authorities. There are areas of significant deprivation in Torbay and it is notable that approximately 22% of children in the area live in poverty. The local health profile for Torbay shows that incidents of violent crime, long term unemployment, smoking rates, alcohol related harm and hospital stays related to alcohol, self-harm, drug use, diabetes and malignant melanoma are all significantly worse than the England average. Teignbridge and South Hams are also both lower than the national average, however there are approximately 13% and 11% respectively of children in the area living in poverty. The local health profile for Teignbridge shows smoking status at the time of delivery and incident of malignant melanoma are significantly worse than the England average. The local health profile for South Hams shows incident of malignant melanoma is significantly worse than the England average.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of services as requires improvement. For specific information please refer the reports for Torbay Hospital and the community-based service reports. The team made judgements about 19 services. Of these, urgent and emergency services was rated as inadequate, seven services were rated as requiring improvement (three acute services and four community service)s and 11 were rated as good (four acute services and seven community services). Key findings were: • The trust was not consistently achieving good levels of safety in all areas. Levels of staffing and the competences of staff members was not always appropriate for patients' needs. • While many services demonstrated an appropriate assessment of, and response to, patient risk there was an inadequate response in some services. • While most patient environments were fit for purpose there were a number of areas where premises and equipment did not support safe care and treatment. • Staff generally had appropriate knowledge to safeguard vulnerable adults and children although understanding of the Duty of Candour regulation varied. • The management of incidents had scope for improvement particularly in relation to corporate oversight. **Staffing** • Patient safety was compromised in the emergency department, as there was insufficient consultant cover and no named paediatric consultant on each shift. There was a shortage of emergency department consultants and they were not available for 16 hours a day, as recommended by the Royal College of Emergency Medicine. • Nurse staffing in the emergency department did not provide consistently sufficient numbers of appropriately qualified, experienced and skilled staff. This sometimes put patients at risk. For example, we saw at times there were not sufficient nurses in the resuscitation room in the children's emergency	**Requires improvement** 

department. The emergency department did not have timely access to psychiatric support. A same room needed to be provided to ensure that both patients and staff undertaking an assessment were safe.

- The numbers of registered nurses on medical wards regularly fell below the established minimum number. Nurse and medical staffing on escalation wards was inconsistent and often led primarily by agency and bank staff. Patients being cared for on escalation wards often experienced significant delays in receiving a medical review. Weekend medical cover on inpatient wards did not always include routine input from senior clinicians.
- A lack of capacity in the looked after children nurse role had been identified in the community-based children and young people's services, as had a shortage of middle grade doctors. Staff in other roles were trying to cover their duties.
- Staffing levels, skill mix and caseloads were not effectively planned and reviewed for inpatients in community hospitals to ensure patients received safe care and treatment at all times.
- The CAMHS service was having difficulties recruiting staff while at the same time experiencing an increase in demand for the service. There were long waits for treatment for some patients.

Assessing and responding to patient risk

- In many areas we saw evidence of timely and comprehensive risk assessments and responsive treatment. The trust had implemented the National Early Warning Score (NEWS) system for patient monitoring. However, this was not always being applied consistently or on a timely basis in all services.
- There was not an adequate response to risk in the emergency department. NEWS had been implemented but the scores did not always initiate the action indicated. For example, observations needed to highlight changes in a patient's condition were not consistently completed and so placed patients at risk. We saw delays to initial clinical assessment and observations in excess of the 15 minute good practice guideline. Trust data showed only 50% of patients received this assessment within 15 minutes in the period December 2015 to February 2016. The remaining patients waited much longer. This placed patients at risk. Not all patients in the emergency department subsequently received an assessment by an appropriate doctor within the one hour guideline timescale. Patients waiting on corridors to be seen needed to be better reviewed and monitored to ensure their safety.

- Staff identified risks in the emergency department with mental health patients awaiting assessment. Delays encountered in review by the mental health team were seen by staff to cause these patients agitation and distress and staff felt this may cause risks to other patients in the unit.
- The trust was also not taking all practicable steps to mitigate risks to medical patients. Medical patients on escalation or outlier wards did not have risk assessments or care and treatment plans to mitigate the risks associated with the loss of medical oversight or specialist management. Patients in the hospital at weekends did not always have appropriate or up to date risk assessments to reflect reduced staffing levels at weekends.
- In the child and adolescent mental health service (CAMHS) there were sometimes waits of up to 36 weeks for treatment and patients did not have their risk monitored during this period to identify if the initial risk assessment needed to be changed.

Premises and equipment

- While most patient environments we saw were fit for purpose there were a number of areas where premises and equipment did not support safe care and treatment.
- Facilities in the emergency department were not suitable or well maintained and comprised patient safety and the patients' experience. In critical care, intravenous fluids were not secure and were at risk of being with. Storage of milk on the Louisa Cary (children's) ward and the Special Care Baby Unit was not secure which compromised the safety of babies.
- The premises used for the delivery of minor surgical procedures in general dermatology outpatients were visibly not clean, with unclear guidance for responsibility for cleaning, and no records of cleaning were produced during the inspection. Additionally these premises did not have adequate ventilation or extracted for the minor surgical procedures being carried out.
- Emergency oxygen in the dermatology outpatient procedure rooms had not been regularly checked and there were no written records of any checks.
- The processes in place to monitor refrigerator temperatures were not being followed in the dermatology and urology departments. Some temperature registers were missing and other were incomplete.
- The clinic room used by the substance misuse service was not locked and the keys to obtain access to the medicine cupboard and fridge were store on a shelf in the clinic room which presented a risk unauthorised access to medicines.

- There were shortfalls in the compliance of some medical wards with fire safety guidance.

Safeguarding

- There was a trust-wide safeguarding policy and guidance and process documents were available to all staff on the intranet. The policy had to be read and understood as part of the safeguarding mandatory training. The trust recognised in the 2015 Safeguarding Adults Annual Report that it was not currently meeting the required 90% of appropriate people trained, with the largest shortfall in level three training.
- There was an identified team safeguarding team in place to ensure effective and consistent responses to safeguarding issues.
- Staff we spoke with had a good understanding of their responsibilities to safeguard people from abuse and how to report concerns and give examples of scenarios where safeguarding processes had been followed.

Incidents

- At the time of the inspection the trust was running two electronic incident reporting systems in acute and community services. There were plans to migrate to one system but the timescale and plan for when this will be achieved were not clear. There were also two separate incident reporting policies in place. We were told a new overall trust-wide policy was in the process of being developed although timescales were unclear.
- Both current policies were not up to date with recent guidance and/or regulations. For example the recent NHS England serious incident framework, which was updated and published in March 2015, or the revised 2015/16 Never Event list (community policy), or regulation 20 Duty of Candour, appeared not to have been considered.
- The trust wide team reviewed four Never Event investigation reports, a report of a maternal death and three serious incident investigations selected at random. Generally reports were fair and provide evidence that a reasonable investigation had been carried out. The depth and rigour of the investigation may require attention and improvement. The 72 hour reports were comprehensively completed and attached to the serious incident report. There was a lack of consistency in the report template used.
- The current devolved system of governance means that the service delivery units are reviewing their own incidents and investigate their own service serious incidents which potentially may compromise the independence of the investigation. All

incidents are electronically reported and any that recorded moderate to serious harm are reviewed by the Patient Safety Lead and reported as required. All reports that go to the Commissioners are reviewed at the Serious Adverse Events Group first. At the time of the inspection revised arrangements were being put in place that may address this. Specifically the Serious Adverse Events Group, in operation since 2007 in the acute trust, had had new terms of reference agreed in January 2016. The Group had senior leadership involvement (chair, chief executive, medical director and director of patient safety). The new terms of reference refocused the purpose of the group in providing high level oversight of investigations and learning and in holding business units to account.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, to provide reasonable support to the relevant person in relation to the incident and to offer an apology.
- The Trust has a Being Open and Duty to be Candid Policy, which was revised in December 2015. The policy did not make reference to Regulation 20. It did not link to other relevant policies such as complaints, incidents, serious incidents and never events. There was no evidence that compliance with the duty was monitored centrally to ensure compliance with the regulations and reported to the Board. The trust told us they had plans to improve the current arrangements.
- The trust had two incident policies in place at the time of the inspection (see below for details). The duty of candour was clearly set out within the community policy but less so in the acute policy. Neither policy refers to it being a statutory requirement.
- The team found that awareness and understanding of the concept of duty of candour varied significantly across the trust. In some conversations with staff the duty appeared to have become rather muddled with broader concepts of openness and honesty. Whilst those concepts are important components of an overall safety culture it is important that the concepts of moderate and severe harm are well understood and that staff are clear on the steps they need to take.

Safety Improvement programme

- The trust had appointed a director of patient safety to oversee a Safety Improvement Programme. The trust also had an

Summary of findings

Improvement Network, led by the Director for Strategy and Improvement. There was work in hand to simplify and standardise the improvement methodology being used in different parts of the organisation. There was work to do to ensure staff were aware of the new structures and approach.
- There were examples of improvements such as the formation of a virtual fracture clinic which reduced clinic attendance by 30%.
- The trust had a Mortality Surveillance Group but it was not clear that these arrangements were providing oversight to the Board on mortality and morbidity.
- There was a programme of leadership walk arounds "Safe in our hands" within the acute services. All the executives took part. The programme had a clear purpose and there was anecdotal evidence of a positive impact.

Are services at this trust effective?

Requires improvement

Overall we rated the effectiveness of services as requires improvement.

The team made judgements about 18 services. Of these, urgent and emergency services was rated as inadequate, two were judged to be requiring improvement (one acute and one community services), 14 were assessed as good (five acute and nine community services) while community health services for adults were rated as outstanding.

Key findings were:

- Treatment was generally provided in line with evidence-based best practice although we identified areas for improvement, for example in the emergency department.
- The trust achieved better than average patient outcomes in some areas but there were also areas where the trust could improve
- Multidisciplinary working was well established in many services although it was not seen to be effective in some service areas, particularly in relation to the working of the emergency department and medical service
- There was a variable level of awareness with the requirements to obtain consent, the requirements of the Mental Capacity Act and associated Deprivation of Liberty Standards.

Evidence based care and treatment

- We saw that evidence-based practice was embedded throughout the trust. Services were following national standards, guidance and practice. This included guidance from the National Institute for Health and Care Excellence (NICE), NHS England and Public Health England.
- There were some areas for improvement. In the community end of life service, we saw some inconsistencies in symptom management. For example, a patient with breathlessness where the trust protocol had not been followed and the use of morphine had not been considered. There was guidance in place to manage patients' symptoms at the end of life and we saw evidence of the use of audit tools in relation to the use of the end of life care plan. However this did not include an audit of effective symptom management or prescribing.
- In the CAMHS service, while evidence-based therapies were delivered physical health checks were not always undertaken.

Patient outcomes

- For 2014/15 the trust had a rate of in-hospital mortality in line with the Dr Foster Hospital Standardised Mortality ratio. For much of 2015/16 the mortality level had reduced to below the NHS average.
- The four hour standard for the emergency department (excluding the community-based MIUs) was 74% in February 2016. The trust was also not achieving its planned performance in other areas during 2015/16, for example, for fractured neck of femur best practice; the proportion of patients spending 90% of time on a stroke ward. The referral to treatment for admitted patients meetings were taking place within seven days.
- The number of follow up outpatients waiting 6 or more weeks beyond their 'see by date' continues to be high, although in February 2016 this reduced by 353 to 4938.
- There was evidence services understood their patient outcomes and how these compared to services elsewhere. National audits were undertaken to provide information to improve patient outcomes.
- Patient outcomes in the emergency department varied and the results of audits were not always used to improve treatment techniques. These included the management of sepsis. Unplanned reattendance was not investigated to identify possible underlying themes.
- For medical patients the average ratio of actual to expected readmissions was lower (better) than the England average for elective and non-elective patients for the period June 2014 to May 2015. Patient outcomes in medical care were improved by the use of national

- Surgical services benchmarked against other trusts and were performing well in terms of effectiveness and patient outcomes. There were some areas such as in the hip fracture clinic and bowel cancer audit where the trust was not meeting the national standard. However, all other national standards were being met. Average length of stay was lower (better) than the national average and the number of cancelled operations remained low.
- In end of life care, information was not routinely available on the proportion of patients that achieved the preferred place of care or preferred place of death.
- In radiology, turnaround reporting times were the lowest (worst) in a recent benchmarking exercise. However, extra funded sessions were improving the position until more staff were recruited.
- Community inpatient lengths of stay varied between hospital location but overall were significantly lower (better) than the national average. Data provided by the trust showed a length of stay of 14.5 days compared with 28 days nationally on average.
- In the community MIU service by January 2016 all units were performing better than the national average.

Multidisciplinary working

- Effective multidisciplinary working took place across many of the services and locations we inspected, ensuring that all relevant services worked together to provide effective, joined-up care.
- The multidisciplinary working practices in the emergency department did not always ensure the best outcomes for patients. Patients who were referred by their GP for hospital admission (medically expected patients) were admitted via the emergency department because there were no available beds or a facility for examination on the medical wards. The correct process would be for these patients to be admitted directly to a ward but staff told us this was rare. No agreed protocols were in place for direct admission.
- There was a lack of coherent working between the senior team responsible for the medical wards and the emergency department. This meant consultants from some medical specialties did not routinely attend the emergency department which resulted in significant delays in admitting patients to medical wards.
- We saw good integration of the hospital-based and community midwifery teams which meant that information was passed to the right people at the right time.

- In community inpatient services the involvement of social workers in multidisciplinary teams enabled early referral for services the patient would need on discharge.
- There was no trust-wide community and acute end of life multidisciplinary meeting.
- Community MUI services worked collaboratively with teams from community and acute services.
- The CAMHS team had good arrangements in place for joint working with paediatric, education, perinatal, learning disability and social services.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff generally demonstrated a good understanding of their responsibilities in relation to consent, the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Standards (DoLS).
- The trust had a policy to manage the use of DoLS and provided guidance for staff managing the care of someone over the age of 16 who may lack the capacity in relation to specific decisions Training in the Mental Capacity Act was provided as part of mandatory training. Where patients lacked mental capacity, staff made best interests decisions in accordance with legislation. There was a trust-wide procedure for recording consent including procedure details, anaesthetic information and patient information.
- In some areas there was a variable level of understanding of the requirements of the MCA and limited knowledge of DoLS, for example in critical care and in outpatient services.
- In end of life services in the community setting we saw inconsistent recording of mental capacity assessments where patients did not have the capacity to be involved in decisions about resuscitation and we did not see best interest discussions with relatives being recorded.
- In the CAMHS service not all staff had sufficient knowledge of the MCA and Gillick competence, to assess whether a child under 16 was able to give consent without the need for parental permission or knowledge.
- Staff in the substance misuse service reported that MCA training was not part of their mandatory training, although staff members were of the principles of the MCA.

Are services at this trust caring?

Overall we rated caring for the services in the trust as outstanding. For specific information please refer to the reports for Torbay Hospital and the community-based services.

Outstanding ☆

Summary of findings

The team made judgements about 19 services. We judged the caring provided by staff as outstanding in critical care, patient transport services, community urgent care services, specialist care dental services and community dental services. All other acute and community services were judged to be good.

Key findings were:

- Patients were treated with compassion, kindness, dignity and respect.
- Staff were focused on the needs of the patients and ensuring patients felt they were truly respected and valued as individuals.
- Staff were observed going 'above and beyond' in many ways to support patients and relatives.

Compassionate care

- Patients were treated with compassion, kindness, dignity and respect throughout the acute trust and within the community. Staff were observed being polite, introducing themselves, welcoming patients by their preferred name, and being professional and sensitive to the different needs of patients. Staff from a number of departments were observed on numerous occasions to go 'above and beyond' to provide their patient and relatives with care and support.
- Patients told us they were well informed regarding their care and treatment and staff were observed to be supporting patients to understand leaflets and informing patients of any delays to their appointments.
- Call bells were responded to quickly and efficiently with patients' needs being attended to appropriately.
- The Patient Led Assessments of the Care Environment (PLACE) 2015 scored the acute trust at 90% for privacy, dignity and wellbeing. The comparative England average was 86%. Feedback from people we met, including patients and their families, was mainly positive. However, privacy and dignity was not always being maintained in the emergency department, children and young people's service, maternity and gynaecology service and outpatient services.
- In the 2014 A&E survey, the trust performed worse when compared nationally for the question 'Were you given enough privacy when being examined or treated?'. We saw that in areas of the emergency department (ED), because of the way curtains were made, they did not fully close and this enabled other people in the emergency department to see into closed areas compromising patient's privacy.

- In the 2014 Children's Survey, 80% of children and young people in the eight to 15 age group said they were not given enough privacy when receiving care and treatment.
- Privacy and dignity was reported as sometimes being an issue when women were waiting in the day surgery area for surgical termination of pregnancy due to children sometimes being present and being able to overhear conversations.
- In most outpatient clinics, patients were able to speak with reception or clinical staff without being overheard. However, in the physiotherapy department, a lack of space was preventing staff from respecting patient's privacy and dignity. Staff had to have conversations about care with patients in cubicles that were separated with a curtain. There were consulting rooms available, but staff told us that due to the number of patients, it was not possible to see every patient in one of those rooms. Staff had to identify patients who needed additional privacy, or who asked for it before their appointment.
- The Patient-Led Assessments of the Care Environment (PLACE) scored the community trust for 2015 an average score for privacy, dignity and wellbeing across all nine community hospitals of 89%, which was above the England average of 87%. However, Dartmouth Hospital scored 85% and Bovey Tracey Hospital scored 74%. Feedback from patients we met on our inspection regarding privacy and dignity was positive. Bovey Tracey Hospital was closed during our inspection.
- From October 2014, the trust scored above 95% in the NHS Friends and Family Test when asking patients if they would recommend the hospitals. As this data pre-dates the merger on the 1 October 2015, this figure pertains to the acute trust.
- From March 2015 to February 2016, the trust scored an average of 97% for the NHS Friends and Family Test for the community trust.

Understanding and involvement of patients and those close to them

- Overall patients understood and were involved in their care and treatment. Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. However, although the consultants explained people's condition to them as well as their treatment plan on the medical wards, the patient's understanding of this was not always confirmed.
- Nurses on care of the elderly wards had a detailed knowledge of the needs of patients living with dementia, although specialist dementia training was not a requirement to work in

these areas. One nurse on Cheetham Hill ward had completed a specialist dementia degree module and used their new knowledge to raise funds for dementia-friendly resources for the ward.

- Staff went 'out of their way' to ensure patient's relatives were involved in their care and recovery. There were many examples of this from staff identifying a patient's birthday and arranging a surprise party and arranging for a patient's young children to visit outside of visiting hours, to reserving a parking space for a relative after finding out a relative was unable to visit due to not being able to park.
- The trust have developed and are delivering a training course for people caring for a relative with a long term or life limiting illness. Feedback from participants who attended the course was positive with a feeling of being valued and better able to look after themselves while supporting their loved ones at the end of life. The Gold Standards Framework, designed to help involve people in the planning of their care, was widely used in the community for patients in the last year of their life.
- Staff in the community mental health services for children and young people said children are always involved in their care plans and in setting objectives, however this was not clear from some records. The service had a 'jigsaw' care plan template, which was being used in some cases to make the care planning process more age appropriate.
- Staff in the community ensured they had all the information required to enable the best recovery for patients by gaining consent to include family members and other care agencies where appropriate, in the patient's discharge and rehabilitation plans.
- Staff in the community hospitals were praised for the quality of communication to families regarding the sequence of events, the likely timings and advice about what to do when they are home.
- Children in the community were informed in an age appropriate manner about what was going to happen and encouraged to ask questions about the treatment. Interaction between health visitors and parents were parent-led, meaning the needs of the parents were foremost, listened, and responded to. Team members within the children's learning disability team were able to use Makaton, a form of communication using signs and symbols.

Emotional support

Summary of findings

- Staff demonstrated a good level of emotional support throughout the acute and the community services the trust provides.
- Chaplaincy support was available for patients and relatives at Torbay Hospital 24 hours a day, seven days a week, and offered both spiritual support and someone to talk to for emotional support, regardless of the individual's beliefs. In the community Chaplaincy services could be arranged if required. Patients at community hospitals had access to their own local Clergyman who visited the wards on a weekly basis. At Torbay Hospital, there was a large chapel as well as a small quiet room for people of different or no faith, which included dedicated washing facility for people to wash before prayers, the direction of East marked on the floor and a number of holy books including a bible, Quran and Bgahavad gita - a key Hindu text. At Newton Abbott Hospital, there was a beautifully constructed multi-faith room, which provided a calm environment for peaceful thought or prayer. We were told that communion could be arranged as patients required. Staff also described being able to access support for those of other religious denominations. The trust also has a large chaplaincy volunteer support service who are able to spiritually and emotionally support those patients receiving end of life care who do not have any family, friends or carers to support them.
- The trust had a ward buddy system on care of the elderly wards at Torbay Hospital where buddies were able to provide one-to-one emotional support to patients, including taking time to get to know them and find out about important events in their past.
- The Critical Care unit set up patient diaries for all patients who were in the unit for more than four days. The diaries were contributed to by staff and visitors, with entries being personal and relevant to the patient and have been shown to provide comfort to patients and their relatives, both during the stay and after discharge. They provide an opportunity to fill memory gaps, and have also been found to be a caring intervention which can promote holistic nursing. The patient diaries were reviewed as part of the follow-up clinic to help work through any emotional concerns that remained after discharge.
- Children and young people who required surgery were able to be accompanied by their parents to the anaesthetic room and stay with them until they went to sleep. Where appropriate parents were able to accompany the child or young person into

theatre. This ensured that parents were able to continue to provide emotional support for their children. Parents were able to see their child in the recovery area as soon as they were awake to provide reassurance and support.

- At Torbay Hospital there was a bereavement suite on labour ward (known as the Mary Delve suite), which enabled parents to stay in the unit with their stillborn baby for longer periods of time if they wished. A memorial garden located at the rear of the maternity unit also allowed families who had suffered the loss of a child to go to place a memorial and spend some time in quiet contemplation.
- The trust had a bereavement standard in operation including guidance for staff in both community hospitals and district nursing roles with regards to supporting relatives and people close to someone who died. The standard stated that a bereavement telephone call to offer condolences and a bereavement face-to-face visit was available to family members of patients who had been supported by community nursing teams.
- The trust had set up a carers support programme where carer support workers were part of a GP surgery but funded by the trust. Their role was to identify the carer and offer them support and help.

Are services at this trust responsive?

Requires improvement

Overall we rated responsive for the trust's services as requiring improvement. For specific information please refer to the reports for Torbay Hospital and the community-based service reports.

The team made judgements about 19 services. Of these, urgent and emergency services were rated as inadequate, four were rated as requiring improvement (three acute services and one community service), 12 were rated as good (four acute services and eight community services) and two were rated as outstanding (Community Health Dental Services and Special Care Dental Services).

Key findings were:

- Service planning and delivery did not consistently ensure care and treatment was responsive to patients' needs.
- Services were planned so that in many cases individual patient needs and wishes could be met.
- There was no flow urgency through the hospital which impact on patients' access to service

- There was scope to improve learning from complaints and concerns, particularly taking the best from the legacy systems the integrated care organisation took over.

Service planning and delivery to meet the needs of local people

- Services had a focus on meeting the wishes of patients as much as possible in delivering their care and treatment.
- Services provided by the emergency department were not always responsive to patient needs. As set out in the 'Assessing and responding to patient risk' section in the 'Safe' domain above the trust did not have arrangements in place to ensure that patients would be seen within an appropriate timescale for initial assessment and then by an suitable doctor for clinical review. The trust needed to improve its systems for monitoring the responsiveness of treatment.
- In the medical directorate a number of patients had been transferred out of wards overnight. Delayed discharges rates were consistently high and large numbers of patients spent considerable amounts of time in medical outlier wards, without regular senior medical input
- Due to pressure on beds, patients undergoing planned procedures were not always receiving their surgery in a timely way. The number of patients who had their operations cancelled remained higher than the England average.
- In maternity services there was a public health midwife who was able to offer tailored support to patients who wanted to stop smoking, drugs and alcohol or were subject to domestic abuse. The service made adjustments for patients living with learning or physical disability.
- In outpatient services the hospital cancellation rate was 9% but no analysis of the reasons for this had been undertaken. Plans were in place throughout outpatient services to help meet increasing demand.

Meeting people's individual needs

- A trust-wide flagging system was accessible for people with limited mobility or learning disability which ensured patients' needs could be identified early in their journey. This did not automatically alert the learning disability liaison staff so any alert to or services was dependent on services to make the link. Staff knowledge of this process varied. Specialist teams in the hospital supported staff and patients in the care of patients living with dementia and learning disabilities.

Summary of findings

- In medical services we found that staff had not always been trained adequately to meet the needs of people who presented violently or with complex conditions such as alcohol-related dementia.
- However, there was good practice in medical services including modifications to meet the needs of patients living with dementia and learning disabilities.
- The surgical division had clear processes in place for the management of patients living with dementia and learning disabilities. Wards were awarded a 'purple angel' status when 90% of their staff had received training on the management of patients with dementia.
- In critical care there was evidence of the service responding well to individual patient needs.
- Services for children and young people were highly responsive. Young patients were listened to and involved in planning their care.
- In end of life care the majority of patients had a treatment escalation plan including a resuscitation decision which had been agreed with the patient. The palliative care team monitored patients who were at the end of life on wards through a system of gold stars on ward interactive boards.
- In outpatient services staff struggled to maintain patient privacy and confidentiality in the physiotherapy and diagnostic imaging departments mainly due to lack of space.
- The oncology service provided a delivery service for some types of oral chemotherapy which meant some patients did not have to attend hospital appointments regularly.
- Services for inpatients in the trust's community hospitals were planned, delivered and coordinated to meet the needs of patients living with dementia. All of the community hospitals had dementia champions who worked across a variety of disciplines.
- In children and young people's service physiotherapists were able to do a report with pictures for parents with a learning disability and had done videos for those unable to read.
- In the community MIUs people with dementia or learning disabilities received care and treatment that sympathetic and knowledgeable to their needs.
- We found that the needs of patients with disabilities had been considered with the community dental setting.
- The CAMHS service was flexible about seeing patients in their own homes, at school or in GP practices to ensure children and young people were as comfortable as possible.
- In the special care dental service the needs of patients with disabilities had been considered.

Summary of findings

Access and flow

- There was no flow urgency throughout the hospital, which impacted on the emergency department. A lack of available beds in the hospital had resulted in poor patient flow through the emergency department and delays in treatment for patients. This was an ongoing problem and national standards of being admitted, transferred or discharged within four hours had not been met since October 2014. The processes put in place to trigger action to deal with poor flow through the emergency department were seen to be delayed and slow. Patients frequently and consistently could not access the hospital in a timely way and experienced unacceptable waits.
- There was a lack of decision makers in the emergency department, which impacted on the flow of patients out of emergency department. Delays in admitting patients to a hospital bed meant the emergency department was often full, crowded and could not immediately treat new patients.
- The number of ambulances waiting more than an hour to hand over patients had reduced since the introduction of a triage system but delays were encountered when the Rapid Assessment Area was full. Delays were seen for patients to receive their initial clinical as assessment which placed them at risk of avoidable harm. Patients were seen to be on corridors and waiting up to three hours to be seen by a doctor. The trust did not have an adequate process for reviewing medically expected patients in the emergency department which led to unnecessary delays for these patients.
- Access and flow issues meant many patients on medical wards were transferred or discharged overnight and a low discharge rate from the Emergency Assessment Unit meant patients were often treated unnecessarily in these units.
- Delayed discharges rates were consistently high and large numbers of patients spent considerable amounts of time in medical outlier wards, without regular senior medical input.
- A lack of coordination in access and flow meant there were often empty beds available on Elizabeth ward whilst patients were being held in the Acute Medical Unit or as an outlier on a surgical ward unnecessarily.
- We found that due to capacity issues within the hospital, patients were waiting too long for their operations. Elective (planned) surgery was impacted on by bed availability in critical care.
- The gynaecology service had introduced enhanced recovery to improve the flow of patients through the service. Antenatal clinics were held in GP surgeries or health centres to allow women to access services closer to where they lived.

- There were delays in accessing the Children's and Adolescents Mental Health Services (CAMHS), particularly out of hours and at weekends. This meant that children, young people and staff were vulnerable whilst in the hospital setting. There had been an increase in the number of admissions to the ward by young people with mental health issues and a corresponding rise in the number of reported incidents.
- Initial health assessments for looked after children were not meeting statutory timescales. There was a long waiting list for an assessment to diagnose an autistic spectrum disorder at the Child Development Centre. At the time of the inspection, there was a 17 month wait time for those aged five to 18 years. This risk was recorded on the trust's risk register.
- We found that due to a follow up backlog, and the capacity of clinics, people were frequently not able to access outpatient services in a timely way for follow up appointments/. However, the hospital was meeting 96% of its referral to treatment targets and consistently met cancer waits across all specialties. At the time of the inspection, 9756 patients were in breach of their follow up 'see-by date', across all outpatient specialities. The biggest backlog was in the ophthalmology department, with 3980 patients past their to-see by date.
- Community MIUs provided good levels of access with 99.8% of patients treated, discharged or transferred within four hours during 2015. The average time to treatment was 23 minutes.
- The patient transport service operated a seven day service to make sure patients had access to timely admission and discharge transport.

Learning from complaints and concerns

- At the time of the inspection the trust was running with the two legacy systems and policies for handling complaints for the acute and community services. The numbers of formal complaints in 2015, 259 for acute and 172 for community and informal concerns and comments, 667 for acute and 270 for community, were in line with the average numbers for trusts of a similar size. A total of 770 compliments were recorded over the same period.
- There was evidence that people were supported to be confident to speak up. Posters and leaflets were available in some clinical areas but not all (for example neither were seen in the stroke unit at Newton Abbot Hospital). Community nurses in the Torbay area said that complaints leaflets were in the patients welcome pack which they were given at any early contact. The leaflets themselves were wordy, without graphics and in comparison to the best seen elsewhere had room for

Summary of findings

improvement. Basic information on the trusts website about how to make complaints is not on the front page and has to be searched for. Complainants can write, email or phone, social media is not offered as a route to complain. Work was in hand, involving a panel of volunteers, to help ensure that it is as easy as possible to make a complaint but had not concluded at the time of the inspection.

- The team reviewed six randomly selected complaints from acute and community services. In general the standard and quality of complaint handling was higher in the community. Final response letters varied in terms of the level of compassion and empathy. The tone of community letters were more consistent in style and coverage and generally of a higher standard than the acute responses. This could be attributed to the centrally run quality assurance system in place in community which was not in place in acute services. This team reviewed the whole process to ensure the standard of complaints management was met. This was devolved to the local team and different senior managers in acute services and is not seen centrally. The evidence from the review was that different styles and standards had emerged. All letters offered apologies. The final letters from the acute services did not include contact details of the Parliamentary Health Service Ombudsman. It was explained that this was a deliberate decision in order to encourage further contact and resolution through the trust. However including such details is regarded as standard and the acute service practice is contrary to the 2009 Department of Health guidance.
- The trust had a Learning from Complaints Group attended by the deputy director of nursing, the associate nurse directors from the acute services, representatives from the patient liaison service and complaints co-ordinators. A patient representative and a the patient experience lead from the clinical commissioning group also attended. The team reviewed recent minutes of these meetings. It seemed that this meeting was not consistently well attended. The minutes were very brief in style and it was not possible to see what the learning was from the complaints discussed. Recognising the team only saw a sample of this group's work it is possible that the impact of this group could be increased.

Are services at this trust well-led?

We rated the trust as requires improvement for well led because:

Requires improvement

- The effectiveness of the governance arrangements for the integrated care organisation, four months old at the time of inspection, were too new to have been fully tested.
- The team were not assured that the highly devolved arrangements were providing the Board with sufficient oversight in key areas, for example aspects of performance in the emergency department and on mortality and morbidity. There was improvement needed to ensure trust wide themes and issues could be identified and addressed.
- Dual systems, processes and policies were running in areas key to patient safety, for example two incident reporting systems and policies.
- The sustainable delivery of quality care was put at some risk by the financial challenge, recognising that significant financial risks are posed to the trust by the financial challenges within the commissioners and key partners.

However

- The chair and chief executive were strong, experienced and effective in their roles. They were highly regarded and widely respected as individuals and as a team both within the trust and by partners.
- There was a clear and inspiring vision for the future which had been developed in partnership.
- Change was being managed well and the overwhelming majority of staff were very positive about the new organisation.
- Communication was highly valued and was a strength.

Vision and strategy

- The trust had set out their vision as follows; "Our vision is a community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes. When we need care we have choice about how our needs are met, only having to tell our story once".
- The trust had set out their purpose as follows; "Our purpose is to provide safe, high quality, health and social care at the right time, in the right place to support the people of Torbay and South Devon to live their lives to the full".
- This had been summarised in the strap line " Working with you, for you". This had been created and decided by staff through a ballot.
- The trust had six values as follows;
  - Respect and dignity
  - Commitment to quality of care
  - Compassion

  - Improving Lives
  - Working together for people
  - Everyone counts
- The strategy, purpose and values had all been developed in consultation with staff and partners had also been closely involved.
- The formation of the new integrated care organisation (ICO) on 1 October 2015 was a significant event in the achievement of the vision and the strategic plan to improve quality and outcomes for people receiving services. This development built on the history of integrated care in the area and had involved significant work with partners and commissioners. The trust is the first in England to join up hospital and community care with adult social care.
- Staff across the trust at all levels displayed awareness of the strategy, vision and values. The formation of the organisation was recognised as a step in a longer term process of making real changes to the way that services were provided. Further significant organisational change was in progress at the time of the inspection. Progress against delivery of the strategy was being monitored and reviewed by the Board.

Governance, risk management and quality measurement

- The overall governance arrangements of the trust had been extensively tested as part of the acquisition and merger process. This had involved Monitor, the Trust Development Authority, NHS England and commissioners. The formation of the new organisation on 1 October had been achieved in a safe way. To that extent arrangements had and were working well. However in many areas the trust was running dual systems and policies. The risks of this were recognised and there was work in hand to develop single systems and policies. However the scale of this was significant and at the time of the inspection it was not possible to be assured about the pace and quality of some of this work. Overall corporate governance needs attention to ensure that it is fit to continue to support the new organisation and the further changes that are planned.
- The formation of integrated care organisation were managed through a programme office with four work streams, each having a risk register and internal audit. Oversight was provided through an internal transition board. At the of the inspection the risks associated with the process were largely closed down. Risk management systems had continued to run alongside those and were providing continuity.
- The trust had had a settled structure of sub committees and groups, each with clear terms of reference and reporting

arrangements. These were all under review and were being changed to meet the needs of the integrated organisation, for example, a new quality assurance committee had been formed. At the time of the inspection the trust was operating with the inherited divisional structures. There were plans in place to change this arrangement with a new divisional structure being developed and a move to be a locality based organisation with a collection of specialities.

- The chairman and chief executive had influenced significant changes to board meetings. The format of papers had changed to link the purpose of a paper to a strategic objective and to include an effective summary. This had in turn changed the way in which papers were presented and discussed and board members were agreed that this amounted to a significant improvement.
- Governance arrangements seemed to be working well in most areas with responsibilities devolved to business units with each one having a clinical governance committee and their own divisional governance meetings. However, there was a need to improve arrangements in some service areas such as the emergency department, medical care, critical care and parts of the outpatient services. These meetings reviewed incidents, complaints, serious incidents, risk registers, patient experience and learning. However it was less clear how this was coordinated at a corporate level and how trust wide trends and themes would be identified. It was also not clear where the expertise came from both in terms of providing check and challenge and ensuring that people were kept up to date with new initiatives and thinking.
- The trust had a deficit of £6.7 million which was in line with their plan. There had been additional financial support for the transition to the new organisation. Health and social care commissioners were facing very significant financial challenges and these presented a risk to services and to the organisation going forward.
- The team were not assured that the current arrangements were giving the Board sufficient assurance on key areas, for example on the quality of care and safety of patients in the emergency departments. At the time of the inspection the Board had not seen indicators on time to triage or assessment and treatment.

Leadership of the trust

- The chairman, who was highly visible, had been in post for 18 months at the time of the inspection, having been appointed to the predecessor acute trust. At that time there was significant instability at Board level with four vacancies and three interim

appointments. The chief executive and previous chair had left in less than optimal circumstances. This was played out publicly and the team were told that the organisation had been "shocked and rattled" by events. It was clear throughout the inspection that this was regarded as history at all levels and that staff credited the chairman with this. Staff across the trust at all levels talked about their confidence and trust in him.

- The chief executive, appointed in 2015, had extensive experience of leadership in an integrated health and social care environment and of leading significant organisational change. Together the chair and chief executive made a formidable team.
- A substantive board had been recruited with the final appointment to be made within two weeks of the inspection. A new post, director of strategy and improvement, had been created and filled. A further post, direct of adult social care, was under consideration. Whilst some appointments were relatively new the executive presented themselves as a skilled, cohesive and mutually supportive group.
- The non-executive directors were a skilled and experienced group who had played a positive role in the formation of the integrated care organisation. There was evidence of effective challenge being given in board and committee meetings. The observation of board meetings showed a respective constructive atmosphere with good discussions taking place.
- The team met with a number of the Governors. The Governors had previously and understandably had a focus on the acute services as all governors were appointed before the integrated care organisation was founded. There was a sense of frustration that arrangements had not worked as well as they could in the past but that this had changed since the arrival of the new chair and chief executive. Communication and involvement had improved significantly. There was regular formal and informal contact. Governors held constituency meetings and fed points raised to the trust. Governors could see their influence in a number of areas for example in the dementia strategy. There are 11 governors being replaced in 2017 which will give an opportunity to broaden involvement across community and adult social care.
- A new board development programme was planned and was being commissioned at the time of the inspection.
- The formation of the new organisation had been managed well. There was strong evidence of managerial continuity and good

partnership working with a range of stakeholders throughout the transition. The change had been managed without a single redundancy, grievance or dispute which the inspection team considered to be remarkable.

Culture within the trust

- The culture of the new organisation, just over four months at the time of the inspection, was in the process of being built. The way in which the significant organisational change had been handled had given this process a very positive and upbeat start.
- We were told that the predecessor organisations had very different cultures but that there had been close links. In the meetings held with the inspection team it was clear that people were focusing on what they had in common as opposed to any historical or current differences.
- There was a positive and happy atmosphere in the trust. Staff engaged very positively with the inspection process and there was good attendance at focus groups. Staff were visibly proud and dedicated to their work.
- Staff across the organisation spoke positively and proudly about their roles and described how their work impacted on the care given to patients. This included people who did not work at the front line.
- Staff talked about being encouraged to speak up and to raise any concerns that they had whether related to patient care or not. Freedom to Speak Up Guardians had recently been appointed and the chairman had launched a "See something say something" campaign.
- There was a clear culture of involving staff in significant decisions. For example the overarching information technology strategy was addressing the multiplicity of systems being used in the trust. There had been significant clinical involvement in the strategy and there was a determination have full staff engagement before systems were chosen.
- The importance of communications was recognised and had been key to the successful transition. A Rumours Board had been established where any member of staff could ask about any aspect of the changes. This had been widely used and had proved very effective in addressing and dispelling myths and rumours. It had been so popular that it was continuing under a new name. The team saw that questions had been raised about the inspection and answered appropriately.

- The 2015 staff survey results, the first for the organisation, were slightly better than the legacy organisations and were above the national average. Given the timing of the survey, in the month following the start of the new organisation, these were understandably being viewed very positively.
- Staff efforts were recognised by two award schemes. The trust participated in the WOW awards that recognise hard work and staff who go the extra mile. The trust also had its own Blue Shield Award scheme. Nominations for this scheme could be made by staff, patients and their families and members of the public. The purpose was to recognise teams and individuals who had made a deal difference within health and social care in Torbay and south Devon.

Fit and Proper Persons

- The trust was in the process of setting up arrangements to ensure it met the Fit and Proper Persons (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). The regulation ensures that directors of NHS Providers are fit and proper to carry out this important role.
- The regulation came into force in November 2014, two years before the current organisation came into existence.
- The trust had a Recruitment and Selection Policy which had been amended in February 2016 to take account of this regulation. This policy covers pre-interview verification of identity, the right to work check and residencies permits and visas. It also included relevant pre-employment checks in line with current best practice in the NHS and wider public sector.
- We were told that the trust was in the process of introducing an annual employment declaration to be completed by all staff to monitor any changes to individual circumstances. Directors will be asked to complete additional questions. Whilst this may be good practice it was not clear whether this would, when applied to directors, be sufficient to provide ongoing assurance that this regulation was being met.
- The team reviewed a selection of personal files for executive and non-executive directors. This provided some evidence that appropriate checks had been carried out before appointment. However, there was no evidence to indicate that non-executive directors had had a DBS check completed although one file had evidence of a CRB check in 2009. There was no evidence that any searches had been carried out on the director's register, or on bankruptcy/insolvency via Company House in the files examined. It is possible that these checks were carried out but the team could not find evidence of them. This needs attention.

Public engagement

- The trust had engaged extensively with the public directly and through partners in the development of the new integrated care organisation.
- Governors held constituency meetings and met with trust members and members of the public.
- A survey of trust members had been conducted and there was an improvement plan in place.
- The trust had over 700 volunteers. At the time of the inspection there was a hold on volunteer recruitment to enable a major review of policies and procedures around their recruitment and management. The volunteers that the team met during the inspection felt well supported and were actively engaged and listened to. Volunteers were undertaking a range of roles across 10 hospitals. The volunteers we met included cancer buddies, chaplaincy volunteers and members of quality improvement groups.
- There were a number of initiatives where patients and their families were directly involved in the improvement of services. Examples included having a patient represented on a group that looked at the learning from complaints.
- The trust's Friends and Family Test scores were slightly average. For February 2016 the trust scored:
  - 96% for inpatient services (NHS average 95%)
  - 90% for urgent and emergency services (NHS average 85%)
  - 98% for community services (NHS average 95%)
  - 94% for outpatient services (NHS average 92%)

Staff engagement

- The trust was proactive in engaging and involving staff and there was evidence that staff views were heard and acted upon. Listening to staff and actively encouraging people to give their views was a priority for the leadership team.
- There was an very strong sense of effective staff engagement across the trust. Staff talked about feeling valued, supported and listened to. They reported that the trust put patients and staff first.
- The trust had sought volunteers from across the legacy organisations to act as champions for the integrated care organisation. There were about 100 champions in place and they had played a key role in engagement around the organisational change. They had proved so effective that they were being kept in place.
- The champions had played a key part in the engagement with staff to develop the new vision and values. The summary of the strategy and purpose "Working with you, for you" had been created and decided by staff through a ballot process.

- The leadership team regarded the champions and the trade unions as critical partners. The unions reported an effective working relationship and were able to see their influence on key policies.
- The staff survey results from the legacy organisations gave a positive picture of staff engagement and these indicators had improved further in the 2015 staff survey results.
- In a number of interviews during the inspection it was apparent to the team that significant decisions, such as decisions about new IT systems, would not be taken with extensive staff engagement.

Innovation, improvement and sustainability

- Innovation and improvement is actively encouraged and there is a culture and history of pioneering development and change. The formation of the trust, the first in England to cover acute and community health services with adult social care is a testament to that. The trust is committed to transforming the way that services are delivered now that the new organisation has been formed.
- The Horizon Institute was created in 2014 as part of an initiative to stimulate research, innovation and improvement and is on the campus at Torbay Hospital. It is a multidisciplinary centre and the facilities include a simulation floor with virtual reality simulators and patient simulators. The team observed a team training exercise which created a highly realistic scenario of a patient moving between a surgical and medical team. The virtual reality simulations include simulations from a patient's perspective, for example that of a patient arriving by ambulance and moving through the emergency department.
- The trust encouraged the participation of staff and patients in research and was involved with a number of different research studies involving both treatments and medical devices. The research projects are appropriately governed and controlled.
- Examples of the trust's innovative approach to learning and education include their involvement with Project Search which supports young people with a learning disability into paid employment and Hiblio, a web based television channel that provides information on health and wellbeing.
- The trust was working in a financially challenged area. There was no evidence that financial pressures had compromised care and the plans and developments were focused on quality and safety of services. The commissioners and local authorities

Summary of findings

were very financially challenged, especially in terms of funding for adult social care. The trust was an active partner in system wide planning with the aim of achieving a sustainable financial future.

Overview of ratings

Our ratings for Torbay and South Devon NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	☆ Outstanding	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Torbay and South Devon NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	☆ Outstanding	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding
Community health services for children, young people and families	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community health inpatient services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community End of Life Care services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health urgent care services (MIU)	Good	Good	☆ Outstanding	Good	Good	Good
Community health dental services	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Special care dental services	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Overall Community	Requires improvement	Good	☆ Outstanding	Good	Requires improvement	Requires improvement

Our ratings for Mental Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
CAMHS	Requires improvement	Good	Good	Good	Good	Good
Substance misuse	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall for service	Requires improvement	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for the Adult Social Care Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
St Edmunds	Good	Good	Good	Good	Good	Good
Baytree House	Good	Good	Good	Good	Good	Good
Overall for service	Good	Good	Good	Good	Good	Good

Our ratings for Patient Transport Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Overall for service	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatient services or to rate any of the domains for substance misuse services.

Outstanding practice and areas for improvement

Outstanding practice

- Staff in the Emergency Department were positive and professional under pressure, maintaining a supportive role to patients. They were always kind and thoughtful, ensuring that patient's anxieties were relieved as much as possible.
- The trust was the highest achieving in the south west peninsula for cancer treatment targets and had the highest survival rates in the south west. The trust was also the highest achieving cancer centre in the patient survey and in the 10 nationally.
- We spoke with one patient on the surgical ward who was going through a distressing time as they found out their daughter was admitted for emergency care. The staff in the hospital had arranged and facilitated to take them down to see their daughter and had constant updates from the medical team involved in care.
- In recovery in the middle of the room there was a large clock with four faces on it pointing in different directions. This allowed patients to orientate themselves with the time as soon as they woke up after theatre reducing confusion and distress.
- We found that WHO checklists were completed using a large whiteboard in every theatre allowing all staff to observe and act upon it. These were being developed further to be interactive projection boards where each patient would have a bespoke WHO checklist depending on its requirements.
- The innovative way in which the hospital was managing capacity by making traditionally inpatient surgical stays as an outpatient procedure.
- The innovate way in which technology had influenced the educational facilities at Torbay Hospital. Particularly around the use of virtual reality headsets to train staff for specific situations such as the surgical checklist.
- The use of video calling over the internet using portable tablet devices in the critical care unit was an example of outstanding practice. This technology primarily allowed doctors to have a 'face-to-face' discussion with relatives who were not in the country, but also allowed those relatives to see and speak to their loved ones being treated on the unit.
- The critical care unit's rehabilitation programme was exceptional. As well as having focus on patients while they were in the unit, there was rehabilitation support and follow-up routinely provided in the hospital for patients who had been discharged. This service was then further extended into the homes of patients who had been discharged from the hospital. Because the programme worked so well, the unit's occupational therapist had been invited to speak nationally on the subject to encourage other hospitals to look at ways they could deliver a similar service.
- The care being provided by staff in the critical care unit went above and beyond the day-to-day expectations. We saw staff positively interacting with all patients and visitors and evidence of staff going out of their way to help patients. Patients and visitors gave overwhelmingly positive feedback.
- There was a perinatal mental health team based in the maternity unit. This had led to consistent care for women with mental health conditions and provided multidisciplinary care to women during and following their pregnancy.
- The divisional quality manager provided 'critical incident stress debriefing'. This involved group sessions where people who had been involved in critical incidents or difficult situations were invited to talk through the process and any issues that had arisen.
- The maternity services had secured funding to have short videos produced that were available on the trust website. They were designed to build on the information given to women at the start of and during their pregnancy as it was realised that people do not take in all the information they are given by healthcare professionals. The videos could be watched at people's leisure and aim to provide women with all the information they need to make informed choices for example around screening tests and methods of delivery.
- When women called in to say they thought they were in labour instead of being asked to come into the unit to be triaged a midwife would offer to visit the woman at home to establish if they were in labour or not. Choices about how and where they would like to have

Outstanding practice and areas for improvement

their baby could then be decided upon. This had facilitated some unplanned home births which were seen as a positive outcome. The midwives found it had meant less unnecessary attendances at the maternity unit.

- One of the general theatres operating department practitioners had noticed there were sometimes communication issues between midwifery and general theatre staff. They had carried out a project to improve multidisciplinary communication. As a result of the project a caesarean section and obstetric emergencies information chart had been produced, that was laminated and displayed in the labour ward and a theatre 'do's and don'ts' also laminated and displayed for staff to follow.
- We saw a good level of involvement of children and young people in consultant interviews.
- In end of life care, bereavement officers gave out feedback cards to bereaved relatives and comments which were then discussed with the bereavement officers line manager. This had resulted in the trust introducing free parking to relatives of patients at end of life. Bereavement officers had also been able to reduce the time that death certificates took to be issued through project work. This had increased the efficiency of the process and reduced some of the emotional impact on relatives at a stressful time.
- The medical records department had consistently supplied 98-99% of records to clinics on or before the clinics, with note preparation carried out to suit consultant's individual preferences, and had plans to electronically track notes on a live system.
- The physiotherapy direct referral service, allowed patients to access physiotherapy without the need for a GP referral. Patients using this service, normally received an appointment within 72 hours of self-referral.
- In the oncology outpatient department, there was a home delivery service for some oral chemotherapy drugs. Patients received telephone consultations with their consultants for three appointments, and then came into the clinic on their fourth for a review.
- The virtual triage clinic in Fracture clinic had reduced the numbers of unnecessary fracture clinic appointments by 15%.
- The diagnostic imaging department had turned 93-99.9% of reports around within one week across all specialties and patient types. In particular, there was a dedicated inpatient-reporting radiologist for every session, which had reduced the average turnaround time for an inpatient report to six hours. The department also produced run charts to identify any outliers, and investigated the delay in their reports.
- Nursing, medical records and care plans across the eight community hospitals we visited were completed to a high standard. They were accurate, up to date with and good evidence of multidisciplinary team input. Our specialist advisors said these were some of the best care plans they had ever seen.
- Relatives spoke highly about the way in which staff involved them in the patients' care and treatment across all of the community hospitals. They felt involved in the planning of patients' care, in their goals towards goals towards discharge and for when the patient returned home.
- Therapy staff involved family and carers on admission to the hospital. They would go out to the patients' home to meet with families in order to ensure the patient had access to the most appropriate services and equipment to enable their recovery. This enabled staff to fully understand the patients' home situation and whether the family or carer was best placed to support the patient with their ongoing care and reablement. They could support families with this process and assess the level of input the patient would need from other agencies.
- The changes made to the management of diabetic patients in the community by the introduction of new care planning documentation and recording of insulin prescribed and administered. The diabetes Specialist Nurse received recognition from the Royal College of Nursing (RCN) for their work in improving the management of patients with diabetes. Their work was recognised nationally and was published by the RCN for other trusts and community nurses to follow.
- We saw a particular example of outstanding practice for end of life care in the community, in the development of a carer's course where people caring for loved ones with life limiting illnesses could access an ongoing support group. Feedback from this was positive and described by carers as helping them to feel valued and better able to cope with their situation.
- All community minor injury units (MIUs) had reduced their un-planned reattendance rates following a review.

Outstanding practice and areas for improvement

- There was an orientation programme for nurse practitioners at the MIUs, which lasted for a minimum of four weeks and practice during this time was always supervised.
- The trust been selected by NHS England to become one of eight urgent and emergency care vanguards, which are aimed at improving the coordination of urgent and emergency care services. Planning had started to expand the MIU services at Newton Abbot so that minor illnesses could also be treated.
- The majority of staff at the MIUs had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The computer system featured a flagging system for people with learning disabilities so that staff could be alerted to their special needs.
- A trauma triage system had been introduced which reduced the need for long journeys for people who had sustained fractures. Clinical notes and X-rays were viewed electronically by an orthopaedic consultant in the acute trust. Following this review many patients could continue their treatment at their local minor injury unit. Only people with more complicated fractures were asked to travel to Torquay for specialist treatment.
- Community dental staff in all the locations were passionate about working within the service and providing good quality care for patients.
- Patients reported an excellent dental service. We evidenced highly trained and experienced staff with excellent application of knowledge and skills in practice to meet the needs of this very vulnerable group in a high risk setting.
- The dentists and support staff were skilled at building and maintaining respectful and trusting relationships with patients and their carers. The dentists sought the views of patients and carers regarding the proposed treatment and communicated in a way which ensured people with learning disabilities were not discriminated against.
  - The development of the Brush and Bus scheme taking oral health prevention advice to local schools.
  - The development of a mobile dental service taking treatment to isolated areas and special schools in order to provide timely intervention in a safe manner.
  - The development of a sedation service that is not reliant on waiting list admission therefore providing care on site in a timely manner as required by the patient.
  - The provision of a bariatric chair for the treatment of obese patients.
  - The provision of a hydraulic lift for patients who use a wheelchair to be treated in their chair.
- Specialist and secondary dental staff in all the areas of service provision were passionate about working within the service and providing good quality care for patients.
- Patient's feedback demonstrated they experienced an excellent service within the specialist and secondary dental services. We evidenced highly trained and experienced staff with excellent application of knowledge and skills in practice to meet the needs of this very vulnerable group in a high risk setting.
- One of the patient transport services vehicles was able to take specialist transfer trolleys (one for surgical transfers and one for special care baby transfers). The patient transport service provided the ambulance and driver and the patient was escorted by clinical staff from the surgery ward or special care baby unit. The new fleet due later in 2016 has more vehicles that can be used to take specialist patient care trolleys to improve transfers from the hospital to other NHS units.
- A member of the control room staff from the patient transport service attended the daily bed meeting held in the trust. This was a meeting held at several times a day to look at the capacity and demand within the hospital. The patient transport service were an active part of this meeting and were able to share what resources they could make available and were able to ascertain the pressure points in the trust and where the priorities would be for discharging patients in a timely way.
- The provider had excellent communication systems which allowed them to track each of their vehicles and to get instant messages direct to individual crews or all the crews at once. The system also allowed crews to send messages back to the control room. Paper records and mobile phones were available as back-up systems.
- The patient transport service had good links with other agencies such as social services. These links extended to providing services they were not commissioned to do. The view of the managers was that if it was of

Outstanding practice and areas for improvement

benefit to patients and improved links with other agencies it was worth doing. As an example, the department was contacted by social services because a patient needed to be moved downstairs in their home. The patient transport service allocated a crew to assist the care staff in settling the patient into their new accommodation on the ground floor of their home.

- We observed and heard examples of where patient transport service staff went above and beyond what they were contracted to do. One outstanding example was when a patient died on the ambulance on route to their home. The crews had been instructed to return to the hospice if the patient died, however the family present with the patient wanted to return home as planned. The staff sought advice from their control room and the hospice and followed the family's wishes and continued their journey. The crew settled the patient into their bed at home and waited with the family until the specialist palliative care nurses arrived. This was an example of where staff went above and beyond in the care they provided to their patients and their families.
- The children's and adolescent mental health service (CAMHS) worked closely with local services in health, social care and education. In-reach roles had been developed, including a team of primary mental health workers to work in schools, practitioners to work with social services and a perinatal specialist. Clinics were held in GP practices where patients could be booked in with a CAMHS practitioner instead of a doctor. This enabled patients to get the right help more quickly.
- All clinicians involved in CAMHS received safeguarding supervision every three months even if they had not needed to make a safeguarding alert. This ensured safeguarding was always high on the agenda, staff were supported and that the need to involve the local authority safeguarding team was considered for all patients.
- The CAMHS service ran a group for parents and carers to enable them to learn about mental health and consider how best to help their children. The group was effective and received good feedback from participants.
- Children, young people, their families and carers were involved in the service and its development. Children were included in interview panels and given 50% weighting in the decision process. They were involved in creating videos that were going to be used on a new website for the service. There were forums for children and young people and for parents and carers where they could give feedback about the service. There was evidence that questionnaires completed by people who used the service were making a difference to how the service was delivered.
- Staff at Walnut Lodge were caring, compassionate and motivated to help people to the best of their abilities. This was often demonstrated with staff going above and beyond what was expected of them. For example, providing additional support to people and their families to ensure that they can access appointments, assisting people with support to access voluntary support groups in the community and often taking a professional lead in co-ordinating and organising an effective multidisciplinary approach.
- There was a specialist health visitor integrated within the substance misuse team. This role involved supporting the children of people who were using the service. The role enable staff to support the person using the service and their family. This involved visits at home, comprehensive support plans for the children and family education about the risks associated with drug and alcohol use. The role provided an additional safeguard for the family and children. We received extremely positive feedback for people who had used the service about the support provided to the family as a whole and how it had enabled them to realise that recovery was possible.
- The consent to treatment form identified, for women who used the substance misuse service, the need to monitor themselves for pregnancy whilst in treatment. This is important due to the risks associated with pregnancy and opiate withdrawals.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- Make the management of the emergency department environment safe. Patients waiting on corridors to be seen must be reviewed and monitored to ensure their safety.
- Address the 24 hour a day, seven day a week consultant cover for paediatrics in the emergency department and allocate a named consultant for each shift.
- Ensure that there is consultant cover provided to all medical wards and escalation wards seven days a week.
- Ensure risks to the health and safety of patients when identified are actioned. When Early Warning Scores indicate an increased level of observation that this level is consistently maintained.
- Ensure plans in place to monitor sepsis pathways are completed.
- Ensure there is timely access to psychiatric support in the emergency department A safe room must be provided to ensure both patients and staff undertaking an assessment are safe.
- Review the process of medically expected patients having to wait in the emergency department
- Ensure senior decision makers in the hospital are involved in the movement of patients through the emergency department
- Ensure the escalation processes in place to support the emergency department during busy periods are effective to address the issues causing the escalation.
- Ensure the governance systems in place for the emergency department reflect the known issues and are used to address the concerns identified. The trust should ensure that when areas of anomaly such as the high readmission rates and rates of patients leaving before being seen are audited and investigated.
- Ensure there are sufficient numbers of suitably trained, competent and skilled staff deployed to meet the needs of patients. The trust must provide evidence of the sustainability of these increased levels and how monitoring of sufficient staffing is being maintained.
- Ensure ongoing monitoring of the initial time to initial assessment and clinical observation. Appropriate monitoring and actions must be undertaken to ensure the safety of patients.
- Ensure patients arriving at the emergency department are seen within an appropriate timescale by an appropriate doctor. The trust must ensure monitoring of this timescale to ensure the ongoing care and treatment of patients.
- Take action to ensure patients cared for on escalation wards, outlier wards and at weekends have access to medical input and review from appropriate clinicians.
- Take action to minimise the length of stay medical patients spent as outliers in surgical areas.
- Review staffing skill mix on Elizabeth and Warrington wards to ensure patients cared for there, particularly out of hours, are safe.
- Ensure patients cared for at weekends; in escalation wards or as medical outliers receive appropriate risk assessments.
- Review how staff are trained in fire safety on wards and ensure a named, competent fire warden is in place.
- Review staffing levels on Louisa Cary Ward to ensure they meet the recommended guidance (RCN 2013) particularly at night.
- Ensure the safe storage of breast milk on Louisa Cary Ward and the special care baby unit was not secure, which compromised the safety of babies. This was raised with staff at the time of the inspection.
- Ensure risks for end of life care are captured and reviewed effectively through the governance system.
- Ensure all staff that monitor and adjust syringe drivers are competent and have the skills to carry this out.
- Ensure minor surgical procedure rooms are clean and fit for their purpose and ensure these standards are maintained with regular monitoring.
- Ensure there is adequate ventilation and extraction in outpatient procedure rooms where cautery is carried out.
- Ensure emergency oxygen is checked and records kept.
- Ensure medicines stored in refrigerators are checked and to keep accurate temperature records.

Outstanding practice and areas for improvement

- Take action to capture record and investigate post procedure infection rates in the dermatology general outpatients department.
- Ensure departments carry out regular hand hygiene audits in all outpatient areas and display the results for staff and patients.
- Ensure the systems and processes at community hospitals ensure information in relation to safety, particularly regarding staffing levels and skill mix, was shared and understood between ward and board level.
- Ensure where information is held on paper and electronic systems, staff are able to access information required.
- Ensure initial health assessments for 'looked after' children meet the statutory timescales.
- Ensure there are sufficient staff to meet people's needs and cover caseloads of health visitors and school nurses.
- Ensure treatment escalation plans and do not attempt resuscitation decisions are appropriately completed and recorded in line with trust policy and that audits of these lead to measurable action plans used to improve performance.
- Ensure healthcare assistants checking controlled drugs and syringe drivers is risk assessed and training is provided and are competency assessed.
- Ensure patients who do not have capacity to be involved in decisions about resuscitation have a clearly recorded capacity assessment along with clearly documented best interest decisions and a detailed record of all discussions with the patient and family members.
- Ensure the clinic room at Walnut Lodge is locked and keys to obtain access to the medicine cupboard and fridge are stored securely.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11 (1) Care and treatment of service users must only be provided with the consent of the relevant person. **Community end of life care** The provider had failed to ensure that the requirements of the Mental Capacity Act 2005 were adhered to in situations where a person lacks mental capacity to be involved in discussions about do not attempt resuscitation decisions.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users 12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (a) assessing the risks to the health and safety of service users of receiving the care or treatment (b) doing all that is reasonably practicable to mitigate any such risks (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs.

Requirement notices

(g) the proper and safe management of medicines.

(h) assessing the risk of, preventing, detecting and controlling the spread of infections, including those that are healthcare associated.

(i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

Urgent and emergency care

Patients on corridors waiting to be seen needed to be reviewed and monitored to ensure their safety.

The trust did not have consultant cover for paediatrics 24 hour a day, seven days a week in the emergency department or a named consultant allocated for each shift.

The trust did not have timely access to psychiatric support in the emergency department. A safe room needed to be provided to ensure that both patients and staff undertaking an assessment are safe.

The trust did not have an adequate process for reviewing medically expected patients in the emergency department leading to unnecessary waits.

There was a lack of senior manager and clinician oversight when the emergency department was under pressure. This led to a delay in escalating the need to move patients to wards.

The trust did not have adequate arrangements in the emergency department to assess risks to the health and safety of patients. When Early Warning Scores indicated an increased level of observation it was not evident this level of observation was consistently maintained.

The trust had not completed plans to monitor sepsis pathways.

The trust did not have sufficient arrangements in place to ensure there was ongoing monitoring of the initial

Requirement notices

time to initial assessment and clinical observation in the emergency department Appropriate monitoring and actions need to be undertaken to ensure the safety of patients.

The trust did not have arrangements in place to ensure patients arriving at the emergency department were seen within an appropriate timescale by an appropriate doctor. The trust needed to monitor this timescale to ensure the ongoing care and treatment of patients.

Medicine

The Trust was not doing all practicable to mitigate risks to patients. This was because patients in the hospital at weekends did not always have appropriate or up to date risk assessments to reflect reduced staffing levels at weekends.

Patients being cared for on outlier wards or escalation wards did not have risk assessments or care and treatment plans to mitigate the risks associated with less frequent medical oversight or specialist management.

The trust needed to review how staff were trained in fire safety on wards and ensuring a named competent fire warden was in place.

Outpatients and diagnostic services

Emergency oxygen in the dermatology outpatient procedure rooms had not been regularly checked and there were no written records of any checks.

The processes and systems in place to monitor refrigerator temperatures were not being followed.

In the dermatology and urology outpatient departments. There were missing temperature registers and other temperature registers were incomplete.

The processes and systems in place to monitor hand hygiene in the outpatient and diagnostic imaging departments were not being followed.

Community end of life care

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. (5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. **Critical care** Staff in critical care had a limited understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). The unit did not have any useful guidance or support tools readily available for staff and training compliance data specifically for critical care was not available.
	The provider had failed to comply with the proper and safe management of medicines as not all staff checking the administration of controlled drugs and the use of syringe drivers had been trained or competency assessed to do so. **Community children's and young people** Initial health assessments for 'looked after' children were not meeting the statutory timescales. There was a long waiting list for an assessment to diagnose an autistic spectrum disorder at the CDC. At the time of our inspection for those aged five to 18 years documentation showed there was a 17 month wait time. **Substance misuse** The clinic room was not locked and the keys to obtain access to the medicine cupboard and fridge were stored on a shelf in the clinic room.

This section is primarily information for the provider

Requirement notices

There was a lack of assurance that a patient requiring an authorisation for the deprivation of their liberty would have this appropriately applied for.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15(1) All premises and equipment used by the service provider must be – (a) clean (b) secure (c) suitable for the purpose for which they are being used **Children and young people** The trust had not ensured the secure storage of breast milk on Louisa Cary Ward and the special care baby unit, which compromised the safety of babies. **Outpatients and diagnostic services** The premises used for the delivery of minor surgical procedures in dermatology general outpatients were visibly not clean, with unclear guidance on responsibility for cleaning, and no records of cleaning could be produced. The premises used for the delivery of minor surgical procedures in dermatology general outpatients did not have adequate ventilation or extraction.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part 17(2) Such systems or processes must enable the registered person, in particular to:

This section is primarily information for the provider

Requirement notices

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

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e)

Urgent and emergency care

The trust did not have adequate escalation processes in place to support the emergency department during busy periods.

The trust did not have adequate governance systems in place for the emergency department to address the known issues. The trust should have ensured areas of anomaly such as the high readmission rates and rates of patients leaving before being seen were audited and investigated.

End of life care

Risk registers did not reflect current risks or contain clear action plans for addressing risks relating to end of life care. End of life risks were not captured on a single risk register to ensure monitoring of these across the trust.

Not all staff were suitably competent to monitor and adjust syringe drivers and some staff were unable to demonstrate understanding of policy regarding syringe drivers.

Outpatients and diagnostic services

This section is primarily information for the provider

Requirement notices

The dermatology department had no system in place to assess post infection rates of patients undergoing minor surgical procedures in the general outpatient department. When an infection was identified, it was not recorded or investigated. This placed patients at risk of harm due to an increased infection risk after the procedure.

Community end of life care

The provider did not ensure that patients were protected against the risks of unsafe or inappropriate treatment arising from the lack of proper information about them by means of maintenance of an accurate record including appropriate information and documents in relation to Do Not Attempt Resuscitation decisions.

Community inpatients

The systems and processes in place did not ensure information in relation to safety, particularly regarding staffing levels and skill mix, was shared and understood between ward and board level.

The audit and governance system in place was not effective as concerns identified in the management and staffing of escalation wards in early 2015 had not been addressed.

Community children's and young people

Records must be accessible to authorised people as necessary.

Not all staff were able to access the electronic and paper records when required to access information.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part

This section is primarily information for the provider

Requirement notices

(2) Persons employed by the service provider in the provision of a regulated activity must-

(c) be enabled where appropriate to obtain further qualifications appropriate to the work they perform.

Urgent and emergency care

The trust had not ensured there were sufficient numbers of suitably trained, competent and skilled staff deployed to meet the needs of patients.

The trust also needed to provide evidence of the sustainability of increased staffing levels and how monitoring of sufficient staffing was being maintained.

Medical care (including older people's care)

The trust had not ensured there were sufficient numbers of suitably trained, competent and skilled staff deployed to meet the needs of patients at weekends.

Children and young people

The trust did not have adequate staffing levels on Louisa Cary Ward to ensure it met the recommended guidance (RCN 2013) particularly at night.

Community children's and young people

A lack of capacity in the looked after children (LAC) nurse role had been identified as had a shortage of middle grade doctors.