

Torbay and South Devon NHS Foundation Trust

Torbay Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Inadequate



Medical care (including older people's care)

Requires improvement



Surgery

Good



Critical care

Good



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Requires improvement



Patient Transport Services (PTS)

Outstanding



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 report covers the acute services provided from the Torbay hospital location. Torbay hospital has 293 beds and in 2014/15 had 70,000 inpatient admissions, 77,000 emergency department attendances and 424,000 outpatient attendances.

We inspected Torbay hospital as part of our programme of comprehensive inspections. The inspection team inspected the standard eight core services for an acute hospital. 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.

Overall we rated Torbay hospital as requires improvement.

Our key findings were as follows:

Safety

- Nurse staffing was at expected levels in most areas. However, the emergency department was not always staffed by appropriately qualified, experienced and skilled nursing staff. Nurse staffing on the Louisa Cary ward (children and young people) was often below guideline levels. The numbers of nurses on medical wards regularly fell below the established minimum number.
- 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.
- 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 the dermatology outpatient procedure rooms. Some patients without Methicillin Resistant Staphylococcus aureus (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 giving transparency on their safety.
- 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 securely stored and the safety of babies on the children's ward was compromised as breast milk was not securely stored. Cautery procedures were carried out in rooms without smoke extractors and without the use of masks.
- 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 was aware of the trust's policies and procedures.

Summary of findings

- 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.

Effective

- In most services patient's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based practice.
- 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 current 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.
- In most services there was evidence that patient outcomes were assessed. There were some areas where the trust was not meeting the national audit standard. In the emergency department patient outcomes varied, performance was mixed against national audits to benchmark performance and the results of audits were not always used to improve treatment, including management of Sepsis. Unplanned reattendances to the emergency department were not investigated to identify reasons.
- Staff were generally competent to deliver services to patients. In outpatients a nurse practitioner was performing procedures without formal qualifications.
- Multi-disciplinary working was evident in many services inspected. However some areas of multi-disciplinary working in the emergency department were not working effectively.
- Limited access for mental health services out of hours caused extended waits for patients in the emergency department.
- Staff demonstrated an understanding of their responsibilities in relation to consent, the Mental Capacity Act 2005 and the Deprivation of Liberty Standards (DoLS), although there was a mixed understanding of the Mental Capacity Act and limited knowledge of DoLS in critical care.

Caring

- Feedback about the care received was consistently positive.
- We saw examples of caring interactions between staff and patients.
- In critical care we found examples of staff going 'above and beyond' expectations to support patients and relatives during difficult times.
- Patients and their relatives were often involved in their care planning.
- 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.
- 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

- Poor patient flow across the hospital impacted on the emergency department. There was also a lack of decision makers available in the emergency department, which affected the flow of patients out of the department.
- Delays in admitting patients to a hospital bed meant the emergency department was often full, and could not immediately treat new patients. Not all patients received their initial clinical assessment in 15 minutes.

Summary of findings

- Bed pressures also impacted on 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. The trust continues to work with commissioning and partner organisations to reduce waiting times for surgery.
- 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.
- 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 were frequently not able to access services in a timely way 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. 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's and young peoples' service this included identifying trends and themes to embed learning.

Well led

- Service visions and strategies were developed in most areas but there was a disconnect between acute medicine and the emergency department. As a result patients did not always experience appropriate access and flow. There was not a coherent strategy in place to deliver the vision staff had for end of life care within the integrated organisation.
- While governance, risk management and assurance systems were in place for the services reviewed, these were not always operating effectively for example, in the emergency department, medical and critical care services.
- There was evidence of leadership supporting change in many services. However, the emergency department had been working under pressure for a considerable period without effective changes to improve the situation. In medicine there was a lack of leadership oversight in some areas and in outpatient services leaders were not always highly engaged with their teams.
- Staff generally spoke positively about the culture within services. Recurrent themes were of the openness and transparency such as in relation to raising concerns. However, staff did not always feel supported or empowered to make changes to improve services.
- There was evidence of innovation in many service areas reviewed. For example, in surgical services, there was an embedded culture of finding ways to reduce the length of stay for patients in hospital with more operations being undertaken as day cases.

We saw several areas of outstanding practice including:

- 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.

Summary of findings

- 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 their care.
- In the middle of the surgery recovery 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 innovative 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.

Summary of findings

- 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 medicines. 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.
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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 hours a day, seven days 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.

Summary of findings

- 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.

In addition the trust should:

- The trust should ensure that the privacy and dignity of patients in the resuscitation area of the emergency department is maintained and not overlooked from the adjacent corridor.
- The trust should review the security of injectable medicines on trolleys that are widely accessible in the emergency department.
- The trust should ensure that sharps bins are used correctly and are not accessible to the public.
- Staff should be aware of consistent management of paediatrics through the emergency department and ensure children's safety.
- The damaged areas of the emergency department should be repaired to ensure the safety of patients and reduce any risks of cross-infection.
- The trust should ensure staff are supported with sufficient training for the risks associated with mental health patients spending long periods of time in the emergency department.
- The trust should ensure staff are supported with sufficient training for the safeguarding of patients and protect them from avoidable harm
- The trust should ensure hand hygiene audits are completed for the emergency department.

Summary of findings

- Staff appraisal rates for staff in the emergency department were low and the trust should ensure these are completed.
- The trust should ensure information communication is known consistently by all staff. This included the alerting of patients with a learning disability to the wider hospital.
- The trust should ensure doctors complete patient records with legible signatures, designations and the use of the General Medical Council stamp.
- The trust should ensure adequate stock control policies and procedures are in place to ensure expired clinical products are disposed of in a timely manner.
- The trust should ensure clinicians are aware of infection control procedures and comply with hand-washing guidelines when assessing and treating patients.
- The trust should ensure nurses and other staff working in clinical areas are offered a robust and timely response to concerns they raise and incidents they report.
- The trust should consider the provision of practical de-escalation and breakaway training for ward-based staff, particularly on the emergency assessment units and care of the elderly wards.
- The trust should consider providing staff on medical wards with de-escalation and breakaway training to support them in caring for people who present with dementia-related violence.
- The trust should do all that is reasonably possible to reduce the numbers of patients waiting over 18 weeks for treatment.
- The trust should reduce the numbers of operations being cancelled.
- The trust should improve the completion of care planning summaries within 24 hours.
- The trust should ensure that record keeping for emergency equipment checks are done in line with trust policy and therefore in line with national guidance from the resuscitation council.
- The trust should improve access into the surgical assessment unit to allow for stretchered patients to be assessed in that facility.
- Intravenous fluid storage in the critical care unit should be improved to ensure these cannot be tampered with.
- The recording of mandatory training compliance in critical care should be improved so that this is easily accessible and reportable.
- The trust should ensure plans to relocate the antenatal and gynaecology clinics and as a result, improve the privacy and dignity issues for women attending fertility clinics and the early pregnancy clinics, continue.
- The trust should continue to consider plans around delivering the Day Assessment Unit service to ensure women receive an effective service with adequate staffing levels and reduced waiting times when using the service.
- The trust should continue to consider the best arrangements for ensuring screening blood tests taken from babies reach the external laboratory in time for the sample to be read and that staff are all trained to complete the blood spot card effectively. This would mean fewer babies are called back for a repeat test.
- The trust should work with partners to eliminate unnecessary delays in accessing the Children's and Adolescents Mental Health Services, particularly out of hours and at weekends.
- The trust should review facilities for parents on the special care baby unit to ensure sufficient chairs to enable mothers to nurse their babies appropriately.
- The trust should review access to the treatment room on the paediatric ward
- The trust should ensure clarity and consistency around care planning for children and young people on Louisa Cary ward.
- The trust should ensure the quiet room is maintained to an appropriate standard to provide a clean and pleasant environment for patients and their families.
- The trust should ensure incidents associated with end of life care are able to be collated to ensure the palliative care team are alerted and can access the incident reports.
- The trust should ensure palliative and end of life assessment of need, care planning and recording is consistent and utilises personalised end of life care planning documents available.

Summary of findings

- The trust should ensure that recording of nutrition and hydration needs is consistent and utilises the trust tools provided for example the malnutrition universal screening tool.
- The trust should ensure clarity around key strategic roles for end of life care cross the organisation
- The trust should ensure there is an appropriate level of staffing available for mortuary services.
- The trust should ensure accurate audit data is available which can be used to support delivery of end of life care across an integrated organisation.
- The trust should ensure a coherent strategy is identified, disseminated and actions in place to deliver effective end of life care across an integrated organisation.
- The trust should ensure the mortuary staff and others such as specialist palliative care team have regular training in major incident awareness to ensure the trust can respond if required.
- The trust should ensure medicine fridges in outpatient areas are kept locked at all times.
- The trust should ensure medical records remaining in clinics overnight are locked away securely.
- The trust should ensure staff undertaking procedures have appropriate skills and knowledge to do so.
- The trust should ensure staff understand their role and responsibilities when holding clinics in generic rooms, with regard to cleaning, emergency equipment and medicine storage and monitoring.
- The trust should ensure all staff adhere to the uniform policy and cross infection guidance with regard to long hair below collar length.
- The trust should ensure staff do not eat or drink in areas where blood samples and other chemicals are found.
- The trust should consider CCTV for the monitoring of isolated patients in the radiology west department.
- The trust should consider improving the environment for children in the outpatients department as the mixed environment means it is not child-friendly.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Inadequate



Why have we given this rating?

We rated urgent and emergency services as inadequate because:

- We saw at times there were not enough nurses in the resuscitation room and the children's emergency department. Safety in those areas was not a sufficient priority to be actioned with any urgency to ensure patient safety. Nurse staffing levels had improved and active recruitment was continuing. There was a qualified children's nurse on each shift but no resilience in the department for when that nurse had to transfer patients.
- There was an inadequate response to risk. The national early warning scores (NEWS) had been implemented but the scores did not always initiate the action indicated. For example, observations needed to highlight changes in condition were not consistently completed and so placed patients at risk.
- There was no designated space for assessment of patients with mental health conditions. The areas used did not have the safety recommendations made by the Psychiatric Liaison Accreditation Scheme (PLAN).
- An initial triage system had been implemented and this had improved the initial assessment of ambulance patients. This system was followed by a rapid assessment. Delays were seen for patients to receive their initial clinical assessment with not all patients being assessed within 15 minutes. Patients had to wait to access this area which extended their waiting time for triage and treatment.
- Triage of patients who brought themselves to the department was thorough and effective but long delays were caused by insufficient staffing of this area.
- There was a shortage of consultants and they were not present in the department for 16 hours a day, as recommended by the Royal College of Emergency Medicine. Mortality and morbidity

Summary of findings

reviews in the emergency department were not undertaken regularly to ensure learning and development. There was no named consultant to lead on children's care on each shift.

- Patient outcomes and the results of audits were not always used to improve treatment. Audits did not reflect a consistently good outcome for patients. These included the management of sepsis. Unplanned reattendance was not investigated for any reasoning.
- The facilities in the emergency department were not suitable or well maintained and compromised patient safety and the patient experience. This included the environment design and some fixtures and fittings.
- Access to mental health services was limited out of hours and caused extended waits for patients.
- Staff identified with us the risks in the department from mental health patients awaiting assessment. The delays encountered to see the mental health team were seen by staff to cause the patients agitation and distress and staff felt this may cause risks to other patients in the unit.
- The multi-disciplinary working practices in the emergency department did not always ensure the best outcomes for patient experience.
- Services were on occasion disorganised and did not ensure that patients received the right treatments at the right times. A lack of available beds in the hospital had resulted in poor patient flow through the 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 delayed and slow, and patients frequently and consistently could not access the hospital in a timely way, experiencing unacceptable waits.
- 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

Summary of findings

more than an hour to hand over patients had reduced significantly since the introduction of a triage system but delays were encountered when the Rapid Assessment Area was full. Patients waited for over three hours to see a doctor.

- There was no flow urgency throughout the hospital, which impacted on the emergency department. There were a lack of decision makers available in the emergency department, which impacted on the flow of patients out of the emergency department. The facilities and premises did not meet the needs of the local population.
- The percentage of patients leaving before being seen was higher than the national average for most of January 2013 to October 2015.
- The vision and the strategy were not always aligned. The arrangements for governance did not operate effectively. Assurance systems, service performance measures and action taken to improve performance were not seen to be discussed or used to ensure the safety of the service.
- The emergency department had been working under pressure for a considerable length of time with no effective changes to improve the situation. Significant issues that threatened the delivery of safe, effective and responsive care had not been identified and adequate action taken to manage them. The system used to identify, capture and manage risk was not seen to effect any change to the service. Insufficient priority was given to using audit as a tool to identify shortfalls and to improve performance.
- Staff did not always feel empowered to make the changes needed to improve the service or to feel part of the greater hospital. Clinicians did not always work cohesively to ensure the emergency department functioned as part of the wider hospital and did not always lead effectively

However:

- Access to radiology and pharmacy was available 24 hours a day, seven days a week.

Summary of findings

- We saw action being taken by senior staff to address risks and have received action plans since our inspection to demonstrate further consideration of actions needed.
- Staff treated patients with dignity and respect. Feedback from patients and those close to them was positive about the way staff treated people. There were varied results from the national emergency department patient survey.
- There were positive comments from patients who spoke about the staff as being kind, considerate and caring. Patients, their relatives and families were kept informed of on-going plans and treatment. Most told us they had been given clear information about treatment options. Their privacy and confidentiality was protected as much as was possible in the difficult environment. People's social needs were considered and staff helped patients and those close to them to cope emotionally with their care and treatment.

Medical care (including older people's care)

Requires improvement



Overall we rated medical care, including elderly care, as requires improvement because:

- The frequent and routine use of medical escalation wards and outlier beds meant patients did not always have access to timely or appropriate medical reviews from doctors.
- The numbers of registered nurses on medical wards regularly fell below the minimum number established.
- We found shortfalls in the compliance of some medical wards with fire safety guidance.
- Access and flow issues meant many patients were transferred or discharged overnight and a low discharge rate from the emergency assessment unit meant patients were often treated unnecessarily in these units.
- There was a lack of coherent working between the senior team who were responsible for 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.

Summary of findings

However;

- There was a coherent leadership structure in place in the directorate. However, we did not find evidence this had an impact on the access and flow issues we identified. This included the number of out of hours discharges and patients being treated on an extended basis in escalation wards.
- We found staff at all levels of the directorate were passionate, committed and engaged in the development and improvement of medical services through responding to feedback from patients, visitors and staff and from the results of local and national audits.
- Evidence-based care was embedded in the practice of the clinical teams we spoke with and observed. This was reflected in the hospital's performance in referral to treatment time targets and some elements of the Sentinel Stroke National Audit Programme.
- Robust and consistent multidisciplinary working was evident throughout the medical services and included daily safety briefs, cross-specialty clinical meetings and a service strategy that aimed to improve care pathways between the hospital and community services.
- Patients we spoke with were unwaveringly positive and enthusiastic about the care they had received and we observed numerous instances of staff providing individualised, highly compassionate care including when breaking bad news. Friends and Family Test results substantiated these findings as it was frequently found 100% of people who took the survey would recommend medical services.
- Clinical staff were encouraged to undertake innovative projects and implement service improvement strategies that resulted in improved patient care and treatment, particularly in oncology services. Senior managers and clinicians were aware of the pressures on the service caused by nurse staffing vacancies and had implemented strategies to address this. These included the recruitment of international nurses and the development of existing unqualified and student nurses.

Summary of findings

Surgery

Good



Overall we rated surgical services at Torbay and South Devon NHS Foundation Trust to be good because:

- There was a strong culture of incident reporting in the hospital which fed into the governance and management of risk. Managers had good oversight of the risks within the surgical division and risk assessments, action plans, and risk registers were detailed and used as an active tool to manage risk.
- There was a strong culture of evidence based practice which was reflected in patient outcomes. There were good results for national audits and they performed well nationally for surgery completed in the day surgery unit.
- Feedback about the care received was consistently positive and we saw good examples of interactions between staff and patients. Volunteers played a key role in the care of patient by completing regular questionnaires and auctioning changes to improve their experience.
- Patients living with dementia or learning difficulties had their specific care needs met. Patients we spoke with were complimentary about the staff and felt that their needs were being met.
- We found that local leadership was strong, even when under pressure from the demand of the service. Leaders led by example and were well respected by their peers.
- The use of technology, such as virtual reality headsets, to learn from never events, provided staff with an engaging experience to improve their knowledge and skills.

However:

- We found that due to capacity issues within the hospital patients were waiting too long for their operations. However, there were actions to manage the risks to these patients and that work was being done with the community teams to reduce the demand of the service.

Summary of findings

- We also found that during times of escalation, patients without MRSA confirmed status were being put on wards with MRSA negative patients. This compromised the status of all patients on this ward.
- Day to day risks to patients, such as regular assessments, was not always completed. These included venous thromboembolism assessments. We also found that there was some complacency around the checking of resuscitation trolleys.

Critical care

Good



We have judged the overall critical care service to be good. The safety, effectiveness, responsiveness and leadership of the service were all good. Caring was outstanding.

- Patients were kept safe from avoidable harm. Staff worked in an open and honest culture that encouraged incident reporting and learning. Generally good levels of nursing, medical and allied healthcare professional staffing ensured patients received care care. Staff adhered to infection prevention and control policies and protocols.
- Treatment by staff was delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment. Patients' needs were comprehensively assessed and outcomes were recorded and monitored. Staff were skilled, experienced and worked as part of an effective multidisciplinary team.
- Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been overwhelmingly positive. Staff went above and beyond their usual duties to ensure patients experienced compassionate care and that care promoted dignity. Innovative support for patients was encouraged and valued by staff, patients and visitors.
- The critical care service responded well to patients' needs. Patients were treated as individuals, and there were strong link nurse

Summary of findings

roles for all aspects of patient need. There were few complaints about the department, but where a complaint was received it was dealt with in a timely and compassionate way.

- There was a clear vision and strategy, with staff being actively involved in the development and delivery. Staff, patients and their families were actively engaged with to identify areas of good practice, as well as areas that could be improved. There was a high level of staff satisfaction in a supportive, open 'no-blame' culture. The leadership drove improvement and staff were accountable for delivering change. Innovation and improvement were celebrated and encouraged.

However:

- The unit did not meet current standards for a modern critical care unit and had been recognised by the trust as not being fit for purpose. However, staff worked well within the environment to keep patients safe from avoidable harm and the building of a brand new unit had started.
- Staff had a limited understanding of the requirements of the Mental Capacity Act 2005, and the Deprivation of Liberty Safeguards (DoLS). We could not be assured that patients who required an authorisation under DoLS were having this requested by the unit.
- Bed pressures in the rest of the hospital affected timely discharges from the unit, but the numbers of these were below (better than) the NHS national average. Elective (planned) surgery was impacted on by bed availability in critical care. There were limited facilities for visitors and the unit did not meet the modern critical care building standards. However, a new critical care unit was being built and once opened would provide much improved facilities.
- Governance arrangements required some improvement. In particular a holistic formal review of safety information on a more regular basis was needed, as was the regular review of mortality.

Summary of findings

Maternity and gynaecology

Good



We rated maternity and gynaecology services good overall;

- There were good staffing levels within the maternity and gynaecology unit. There was sufficient consultant cover of the labour ward and consultants came into the unit out of hours when requested.
- There was a positive culture around reporting and investigating incidents. Learning from incidents was shared and action plans were in place to ensure new learning was embedded in practice. Staff at all levels attended required training
- Women were risk assessed throughout their pregnancy and labour. Good communication between the integrated community and hospital midwives meant that information about risks was passed on to the right people at the right time.
- Clinical areas were clean and tidy and regular audits of infection control procedures was ongoing.
- Adult and neonatal emergency resuscitation equipment was checked regularly and a record maintained to show it had been checked. The exception was labour ward where recording the checks done had been inconsistent. This was explained by the fact a new book had been introduced and at times had been locked in the resuscitation trolley, therefore becoming unavailable to staff.
- **Guidelines, policies and procedures were reviewed regularly to incorporate updated national guidance. They were available to staff at all times.**
- Patients had access to pain control at all times.
- Data was collected to assess outcomes for women using the services.
- Supervisors of midwives were at the required numbers and available to support midwives when required. There was a preceptorship programme in place to support and develop newly qualified midwives.

Summary of findings

- We saw multidisciplinary working well internally and externally. Midwives, nurses and medical staff spoke passionately about the women and babies being at the centre of everything they did.
- Patients were encouraged and supported to be involved in making decisions about their care and treatment.
- Feedback from people who were using the service was overwhelmingly positive. We saw staff treating people with respect and dignity. Where staff felt dignity was compromised, due to the layout of the environment, every care was taken to ensure their dignity and privacy was maintained. People's choices and preferences were always a priority when planning and delivering care and support.
- Emotional support was provided via counselling services, the on-site perinatal mental health team and midwives trained in caring for women and their families who had suffered a bereavement.
- There was a positive culture around asking for and dealing with feedback from patients.
- The gynaecology service had introduced enhanced recovery to improve the flow of patients through the service. The maternity unit offered a day assessment unit facility Monday to Friday until 5pm. Women then had to go to the labour ward. To reduce the amount of women being sent to labour ward the maternity service was looking into longer opening hours for the day assessment unit. Ante natal clinics were held in GP surgeries or health centres to allow women to access services closer to where they lived.
- There was a public health midwife who worked with people who may want to stop smoking, misuse drugs and alcohol or were subject to domestic violence. There was an on-site perinatal mental health team providing support to women who had mental health conditions.
- There were systems in place to make reasonable adjustments for patients living with learning disability or physical disabilities.

Summary of findings

- The maternity and gynaecology units took a positive approach to concerns or complaints raised. Any learning was shared with the relevant teams and audits in place to ensure new learning had been embedded in practice.
- **Staff felt very supported by local and trust wide management. There was an open culture with all staff engaged in ideas about how the service could be improved. Public engagement was encouraged with opportunities to feedback through the NHS Friends and Family test and via social media pages relevant to maternity and gynaecology.**
- **Governance and audit were embedded in practice with staff reporting systems that provided feedback and as a result improvements to the service were made.**
- We were given examples of innovative practice that showed staff were always looking to improve the way they delivered the services offered.

However;

- **Though records seen at the time of inspection were fully completed, internal trust audits had noted that records were not always fully completed.**
- The Day Assessment Unit was run by midwives with maternity care assistants (HCA) to support them. There were two midwives twice a week with no HCA support and the other three days there was one midwife and one HCA. It was sometimes very busy meaning women sometimes had to wait for a long period of time. After the unit closed at 5pm all women who needed to be seen were asked to attend labour ward which put added pressure on staff on duty. There was no data available to show how many women had to attend the labour ward when the maternity assessment unit was closed.
- There were issues with newborn blood spot screening samples (heel prick test to test for a range of rare but serious health conditions) as a significant number were rejected when they reached the testing centre. Some were because the post had not reached the testing laboratory

Summary of findings

in the timescale and some were due to poor samples. This resulted in the baby having to undergo another heel prick test which could be distressing to the baby and the mother. The matron said work was underway to improve the rate of rejection. The trust were looking at potential ways to get the samples to the laboratory without using the normal postal system and ensuring that all midwives were competent in taking that blood samples.

Services for children and young people

Good



We rated services for children and young people as good overall.

- There was a clear vision and overall strategy for children's and young people's services. The service provided effective and responsive planned and emergency care and support to children and young people and their families. People who used the service told us they felt safe.
- We found without exception, staff at all levels were caring and supportive and keen to do the best job they could. Children and young people were placed at the heart of care and we saw many examples of where staff had gone 'the extra mile'.
- We found paediatric services were well-led at local and unit level. Staff reported they felt engaged with the senior team in paediatrics and across Child Health.
- There was a clear governance and audit framework in place and staff felt able to raise issues and concerns with their local and senior managers. Staff said they were listened to and their concerns were understood.
- There were good examples of innovative practice. For example, the short stay paediatric assessment unit and the high dependency unit, dedicated child appropriate services in outpatients, involvement of children and young people in consultant interviews and development of paediatric outpatient services who delivered children and young people's medicines to their homes.

Summary of findings

- Parents and children spoke highly of the service and we saw extensive examples of positive feedback and observed many examples of compassionate child focused care during our inspection.

However, some aspects of the service did not assure us that children and young people were always 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
- 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. Steps were being taken by the trust and clinical commissioning group to address this.
- Access to the treatment room on the paediatric ward was via the medicine storage and preparation facility. This compromised children's safety and could cause distress to children and young people in the vicinity. Staff recognised the problem and were acting on it.
- Staffing levels on Louisa Cary Ward were often below the recommended guidance (RCN 2013) particularly at night. The organisation had taken action to mitigate the risks through comprehensive skill mix reviews.

End of life care

Requires improvement



We have rated end of life care as requires improvement overall because:

Safety and well-led required improvement, and effective, caring and responsive was good.

- It was not clear how the trust learned all lessons from incidents and what improvements were made in end of life care.

Summary of findings

- We were not assured that incidents in end of life care were being monitored effectively.
- There was inconsistent completion of patients' records.
- We found there were shortfalls in the frequency of recording the monitoring of the syringe drivers for some patients. This, coupled with inconsistent staff awareness of the policy, could have put patients at risk.
- The mortuary were using temporary fridges on a permanent basis and without effective temperature monitoring.
- There was not a coherent strategy identified and in place to deliver the vision staff had for end of life care as an integrated organisation. How the next step to an integrated end of life care service would happen was not clear.
- We were told there were no risks recorded for end of life or palliative care. In addition, actual risk that existed in a number of action plans were not on a local or corporate risk register. For example, issues in the mortuary raised during the inspection.
- We saw that not all of patients' spiritual, religious, psychological and social needs were taken into account in patient records.

However:

- Staff were aware of how to report incidents and their responsibility to be open and transparent.
- Anticipatory medicines were always available and patients being discharged home had their medicines provided promptly.
- There was a good level of consultant cover for the end of life service and out of hours.
- There were processes in place to assess and respond to patient risk.
- There was no evidence that patients had had treatment against their wishes. There was good documenting of a patients ability to eat and drink in the last 24 hours of life and medicines were reviewed in the last hours of life.
- The majority of patients had a treatment escalation plan including a resuscitation decision, which had been discussed with the patient and/or family.

Summary of findings

- Compassionate care was provided to patients who were treated with respect and dignity by staff. We saw that patients and those close to them were treated with kindness, dignity, respect and compassion while they received care and treatment.
- Patients and those close to them were involved as partners in care at end of life. Staff communicated with people so that they understood their care, treatment and condition.
- Staff we spoke with had a good understanding of the impact that a person's care, treatment or condition might have on their wellbeing and on those close to them.
- The results of the national care of the dying audit published in March 2016 showed that for the quality indicators for care the trust scored significantly higher than the national average.
- The hospital specialist palliative care team monitored the numbers of patients who were at end of life on wards through a system of gold stars on ward interactive boards. In November 2015, 62 of 77 (81%) of predictable deaths were recognised and flagged with a gold star so that relevant staff were aware of end of life care needs.
- Bereavement officers had recently reduced the time needed to make death certificates available.
- Leaders in end of life care we spoke with had the skills, knowledge, experience and integrity that was needed.
- Staff we spoke with had a vision to provide quality, safe end of life care at all levels of leadership and improve upon that care.

Outpatients and diagnostic imaging

Requires improvement



Torbay and South Devon Foundation Trust outpatient and diagnostic services were over all rated as requires improvement, although there were many areas of good practice.

- The systems in place for the prevention of healthcare associated infections, including hand hygiene, were not being followed throughout the whole outpatient and diagnostic imaging department.

Summary of findings

- Systems were in place for the safe administration and storage of medicines, but recording and monitoring of fridge temperatures used for the storage of medicines was not consistent in the outpatients department and there were no records of stock rotation in some areas.
- Infection prevention and control protocols were not being followed in dermatology who carried out minor surgical procedures in rooms that were not adequately ventilated or maintained with visibly dirty air vents and dusty surfaces. We did not see evidence of any cleaning logs or records of emergency oxygen checks.
- The design, maintenance and use of facilities and premises did not keep people safe at all times. Lots of small concealed waiting areas throughout outpatients and diagnostic imaging meant staff could not observe patients waiting in their departments.
- Aging and unsafe equipment was preventing staff from providing safe and effective services in trauma and orthopaedics, ultrasound and dietetics, however, this was being addressed in the future capital funding project.
- External training courses were available to some staff, but not all, and in some departments, staff were carrying out specialist procedures without formal qualifications, and were starting to train other staff in those procedures.
- Staff were very competent in their roles, and we saw National Institute of Health and Care Excellence (NICE) guidelines were embedded in policies throughout many clinics. However, we saw patients called for follow-up mammograms at one, three and five years, which is not in line with best practice, and there was no metastatic breast care nurse in post, but there were triple assessment clinics in breast care for symptomatic breast referrals.
- Staff struggled to maintain patient privacy and confidentiality in the physiotherapy and diagnostic imaging departments, mainly due to the lack of space, and design of the departments.

Summary of findings

- Staff told us in some outpatient clinics, chaperones were only provided in some clinics if patients asked for them.
- We found that due to a follow up backlog, and the capacity of clinics, people were frequently not able to access 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.
- The hospital identified a problem with the surgical follow up outpatients booking system, which missed patients off follow up lists. The hospital investigated, and changed procedures to prevent it happening again. This was also the case in ophthalmology.
- The hospital appointment cancellation rate was 9%, and the DNA rate was 12%, which were both above the England average, however, no analysis of the reasons for this had been done.
- Service plans were reliant on increasing staffing, especially at consultant level; however, plans were in place to increase clinic facilities throughout outpatients, to help meet increasing service demands.
- There were governance processes in place, but these were inconsistent throughout outpatients and diagnostic imaging.
- Dermatology services were split over two locations, and the services based in general outpatients were confused as to who was responsible for the day-to-day running of the service. However, oncology staff had regular multi-disciplinary team (MDT) governance meetings, and we saw evidence of shared learning available in an operational policy folder.
- The dietetics department had raised the issue of the lack of an adult eating disorders service to the Clinical Commissioning group (CCG), and were monitoring its progress.
- Not all staff felt supported by their immediate managers and said some managers were not visible to their teams. Some teams did not have an overall manager, and senior staff were not

Summary of findings

very supportive or visible. However, medical records staff felt much supported by senior managers, and were very proud of their clinical engagement in their projects.

However;

- We saw detailed monitoring and analysis of patient outcomes in the Physiotherapy department.
- Seven-day services were established as part of a normal working week in some specialities, but not in others, because capacity was meeting the current demand.
- Diagnostic imaging reported the lowest report turnaround times in a recent benchmarking exercise of 78 departments in England.
- Feedback from patients and their families was very positive and described staff as helpful, efficient and polite, and we saw genuine compassionate care where patients were spoken to patiently, kindly and politely. We saw carers and relatives actively involved in decision-making.
- The Friends and Family Test produced good results, and 96% of patients who responded recommended the outpatients department at Torbay Hospital. .
- The radiology department turned 93-99.9% of around within one week for all imaging modalities, which improved inpatient report turnaround times.
- The physiotherapy service provided a direct referral system, with the majority of patients receiving appointments within 72 hours, with no need for GP involvement, and a virtual triage system in fracture clinic had reduced the number of patients called back to fracture clinic unnecessarily by 15%.
- Oncology provided a delivery service for some types of oral chemotherapy, which meant some patients did not have to attend hospital appointments regularly.
- We saw evidence that complaints were being discussed both in department and at monthly 'learning from complaints' meetings, and we saw evidence of shared learning.

Summary of findings

- The majority of staff we spoke with felt the culture was open and that staff strived to make sure the experience for the patients was outstanding in line with the trusts vision and values.
-

Torbay Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Torbay Hospital

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, plus 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 well as Teignbridge 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 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% Teignbridge and South Hams) when compared to the England figure (14%).

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

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included 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.

Facts and data about Torbay Hospital

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 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.

Detailed findings

Deprivation is varied in the geographical area that the Trust provides a service for. Torbay is lower 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.

Our ratings for this hospital







Our ratings for this hospital are:

	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
Patient transport services (PTS)	Good	Good	Outstanding	Good	Outstanding	Outstanding
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	Inadequate	
Effective	Inadequate	
Caring	Good	
Responsive	Inadequate	
Well-led	Inadequate	
Overall	Inadequate	

Information about the service

Urgent and Emergency Care is provided at Torbay Hospital by the Urgent Care division. The emergency department, also known as the accident and emergency department, operates 24 hours a day, seven days a week. There is a resident population of approximately 375,000 people, plus about 100,000 visitors at any one time during the summer holiday season. The emergency department saw approximately 77,270 patients in 2014/15, of which 19% of the total were children, between 0 and 16. There are between 200 and 250 patients seen in the emergency department daily.

Adult emergency department patients receive care and treatment in two main areas: minors and majors. Self-presenting patients with minor injuries are assessed and treated in the minors' area. Patients with serious injuries or illnesses who arrive by ambulance are seen and treated in the majors' area, which includes a resuscitation room and 18 designated bays or side rooms. The majors' area is accessed by a dedicated ambulance entrance. A helipad is available to enable urgent air ambulances to land at the department.

Paediatrics, children and young adults are treated in a dedicated paediatric area.

There is a clinical decision unit with eight seated areas. This area is for patients awaiting diagnostic test results or organisation of discharge. Patients in this area were not planned for admission.

We visited the department over two and a half days as part of the announced inspection, and also for one morning during the unannounced part of the inspection.

We spoke with 18 patients and five relatives, as well as approximately 15 staff including nurses, doctors, managers, therapists, support staff and ambulance staff. We observed care and treatment and looked at 10 care records. We reviewed performance information about the trust and other information from the trust both prior to and following our inspection.

Urgent and emergency services

Summary of findings

A lack of available beds in the hospital had resulted in poor patient flow through the 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 no flow urgency throughout the hospital, which impacted on the emergency department. There was a lack of decision makers available in the emergency department, which impacted on the flow of patients out of the 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 assessment, which placed them at risk. Patients were seen to be on corridors and waiting up to three hours to see a doctor.

The service was not consistently staffed by sufficient numbers of appropriately qualified, experienced and skilled nursing staff. This sometimes put patients at risk. The level of trained nurses in the resuscitation room did not meet the Baseline Emergency Staffing Tool guidance and placed patients at risk. There was only ever one nurse in the paediatric area and was sometimes left unstaffed whilst patients were escorted to wards. There were insufficient consultants available.

There was not an adequate response to risk. The national early warning score (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. Staff identified risks in the department with mental

health patients awaiting assessment. The delays encountered to see 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.

Premises were not always fit for purpose. The facilities in the emergency department were not suitable or well-maintained and compromised patient safety and the patient experience. This included the environment design and some fixtures and fittings.

The service participated in national audits to benchmark their practice. Performance in these audits was variable and showed room for improvement.

Patients we spoke with were complimentary about the care and treatment they received. Their privacy and confidentiality was protected as much as was possible in the difficult environment. People's social needs were considered and staff helped patients and those close to them to cope emotionally with their care and treatment.

The arrangements for governance did not operate effectively. Assurance systems, service performance measures and action taken to improve performance were not seen to be discussed as part of the governance arrangements. The emergency department had been working under pressure for a considerable length of time with no effective changes to improve the situation.

Significant issues that threatened the delivery of safe, effective and responsive care had not been identified and adequate action taken to manage them. The system used to identify, capture and manage risk was not seen to effect any change to the service. Insufficient priority was given to using audit as a tool to identify shortfalls and to improve performance.

Staff did not always feel empowered to make the changes needed to improve the service or to feel part of the hospital. Clinicians did not always work cohesively to ensure the emergency department functioned as part of the wider hospital and did not always lead effectively, with issues raised but not actioned.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate



We rated urgent and emergency services as inadequate for safe.

- We saw at times there were not enough nurses in the resuscitation room and the children's emergency department. Safety in those areas was not a sufficient priority to be actioned with any urgency to ensure patient safety. Nurse staffing levels had improved and active recruitment was continuing. There was a qualified children's nurse on each shift but no resilience in the department for when that nurse had to transfer patients.
- There was an inadequate response to risk. The national early warning scores (NEWS) had been implemented but the scores did not always initiate the action indicated. For example, observations needed to highlight changes in condition were not consistently completed and so placed patients at risk.
- There was no designated space for assessment of patients with mental health conditions. The areas used did not have the safety recommendations made by the Psychiatric Liaison Accreditation Scheme (PLAN).
- An initial triage system had been implemented and this had improved the initial assessment of ambulance patients. This system was followed by a rapid assessment. Delays were seen for patients to receive their initial clinical assessment with not all patients being assessed within 15 minutes. Patients had to wait to access this area which extended their waiting time for triage and treatment.
- Triage of patients who brought themselves to the department was thorough and effective but long delays were caused by insufficient staffing of this area.
- There was a shortage of consultants and they were not present in the department for 16 hours a day, as recommended by the Royal College of Emergency Medicine. Mortality and morbidity reviews in the emergency department were not undertaken regularly to ensure learning and development. There was no named consultant to lead on children's care on each shift. A middle grade doctor was allocated to paediatrics with an on call consultant available who may not be present in the department.

Incidents

- There had been one serious incident between October 2014 and September 2015, which was an unexpected death. The serious incident had been investigated and a root cause analysis had been completed. Staff were not aware of any shared learning from this incident.
- From 1 September to 31 October 2015 there were 78 incidents in the emergency department where patients were affected clinically. 7% of all trust wide incidents were reported from the emergency department.
- Data provided by the trust was up to December 2015 and showed there were approximately 27 clinical incidents that month. This was an increase since September 2015, but a small decrease on the previous year's figures. Between October 2013 and December 2015 the highest amount of incidents related to exceptional patient flow, the second highest reason was medicine errors and the third highest was about communication between staff.
- The audit of clinical incidents by day and time showed there were fewer clinical incidents reported at the weekends and there were greater levels of reporting of incidents overnight.
- Staff told us they were supported to report incidents and could request feedback. The types of incidents they reported did not include low staffing levels. They also told us that learning from incidents was cascaded in the daily safety brief. They were not aware of never events or near misses in other areas of the hospital to develop shared learning. We attended the daily team brief and saw areas of the emergency department safety highlighted.
- Mortality and Morbidity meetings were not consistently undertaken by the emergency department medical staff. Meetings were planned for four times a year. The last Mortality and Morbidity review by the emergency department was in April 2015. This meeting was minuted and identified areas of discussion but did not include areas for future review or development.

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, provide reasonable support to the relevant person in relation to

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the incident and offer an apology. Staff told us about an openness policy and spoke clearly about the actions they would take to be open about mistakes. The trust did not have a formal training programme for duty of candour. However, we were told that communication, openness, honesty and transparency were central themes running through many training programmes.

Cleanliness, infection control and hygiene

- The emergency department was visibly clean and tidy. We observed support staff cleaning the department throughout the day. We saw the public toilets in the emergency department were cleaned regularly but the schedules were not completed to evidence this. We saw some cleaning equipment was left unsupervised, including a mop and bucket outside cubicle 11 for an hour. This posed a risk of trips and falls.
- We saw deep cleaning taking place in bays and side rooms when a high risk of infection had been identified. The 'Annual Deep Clean' Red, Amber, Green rating for 2014/15 showed that all areas in the trust received the annual deep clean except for A&E, which was 75% complete. This had been mainly due to access restrictions because of bed pressures and not being able to always empty the bays. Outstanding areas were planned to be done 'bay by bay'.
- We saw staff followed the trust's policies and used aprons and gloves when needed. We saw staff washing their hands and being bare below the elbow. This helped to prevent the spread of infection. There was limited access to hand gel in the minors' department, with no hand gel in front or near the six patient bays. The hand gel outside the emergency department door giving access to the rest of the hospital had not been refilled.
- Infection audits of the emergency department showed that some facilities were in need of repair and improved hygiene. This included damaged walls and flooring, and sinks which did not meet the right standard. The infection control audit took place in October 2015 and not all areas reached a satisfactory level of compliance. Actions were recorded with a review date of 05 January 2016. We saw some areas of the department were in need of repair. The paediatric area had damaged furniture and areas of the emergency department

flooring were damaged. There was no hand wash sink in side room 11. This issue was known to the trust and was on the risk register as a medium risk. Staff told us plans were in place to address this issue.

- Hand hygiene audits were undertaken monthly. The trust required compliance of greater than 90% in these audits. Scores provided did not include the emergency department. The Clinical Decision Unit scored 75% in October 2015 but had reached 100% by November 2015.
- Due to the small emergency department environment cross-contamination was a risk. We saw a clean bed on a corridor with its bed linen draped on a clinical waste bin. Some curtains had no indicator of when they were due to be changed.
- 2014/15 infection control mandatory training completion was 79% for nursing staff and 77% for medical staff. This was trust-wide data because emergency department specific data was not available.
- Ebola is a rare but severe infection caused by Ebola virus and can cause fatal Viral Haemorrhagic Fever (VHF). The trust told us it had developed VHF plans and delivered VHF training (which included enhanced PPE) to over 50 staff.

Environment and equipment

- There was a dedicated ambulance entrance which allowed direct access to the major treatment and resuscitation areas. A further walk-in entrance was adjacent to this and access from the rest of the hospital was also possible. The helipad was situated close to the emergency department and all landings were escorted by security staff. The resuscitation room had four trolley areas, separated by curtains; this area was often full during our inspection. There were two main doors for the resuscitation room. One door faced directly into the area used for rapid assessment (RAA). There was a dedicated children's facility located to the rear of the main emergency department. The design and layout of the department presented challenges in respect of observing patients and ensuring sufficient capacity.
- The trust risk register had identified that the emergency department environment was not fit for purpose. There was a lack of observational space and a lack of privacy, which compromised patient safety and the patient experience.

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- We saw a sluice was not locked and chlorine cleaning tablets were accessible by members of the public and patients. We alerted senior staff and the cupboard was repaired by the next day.
- The X-ray and CT scanning department was adjacent to the emergency department to enable easy access for patients.
- The resuscitation trolleys for use in the event of a cardiac arrest in the emergency department were new, and contents were checked daily/weekly (full check) and well maintained. All contents were in date and pharmacy replaced medicines boxes if opened.
- Medical devices were seen to be checked annually and had dated stickers in place to inform when the next service was due.
- All clinical waste was disposed of in identified bins; this was managed by the cleaning staff. We found that sharps boxes were not closed after use. This meant the public could access used syringes by putting their hand in the box. This was a risk to patients and staff.
- The stock cupboard door in minors did not always close securely and we were able to access the cupboard despite a key pad lock being in place. We fed this back to the staff who reported it to the estates department.
- There was no designated room available for mental health assessment. We viewed the rooms staff confirmed were used; these were a clinic room or the relatives' room. These rooms had not been furnished to ensure there were no ligature points and that nothing that could be used as a weapon. There was no alarm system so that staff could summon help and rooms were not fitted with two doors (that open both ways) as recommended by Psychiatric Liaison Accreditation Scheme (PLAN).
- Controlled drugs were appropriately stored and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- Trust policy on refrigeration was not always followed. Whilst current maximum and minimum temperatures were usually recorded on the correct register in the majority of areas, there were deviations observed and actions not always recorded. For example, temperatures were seen at 10°C in resuscitation and 15.1°C in minors. The minor injuries fridge temperature had not been recorded for 12 days.
- Some medicines administration was required to be double signed by trained nurses. If a second trained nurse was not available due to workload a doctor or health care assistant (HCA) were used. The trust's medicine policy stated that double checking should be considered, but was not mandated. The paediatric area had its own medicine cupboard and any secondary checking required the nurse to ask the majors nurses to assist.
- Medicines were mostly stored in locked cupboards or fridges. Ten sodium chloride ampoules were left unsupervised on the top of a trolley in majors. This was unsafe practice as they could have been taken or used by mistake.
- Information about medicine allergies was checked by nursing and medical staff and recorded on the computer system. All prescribing systems were electronic and so enabled an audit trail of prescription and administration. Controlled drug records remained in paper format, as did IV fluids.
- In the minors' area the safe used to store medicines was broken. Records showed it was reported as broken on 14 January 2016. This meant medicines were stored unsecured in the nurses' desk drawer. On our unannounced inspection we saw this safe had been replaced.
- Some of the medicine PGDs were noted to be out of date. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. Of the 19 PGDs in use, three were out of date (July and September 2015). The pharmacy audited the PGDs. The PGDs were held on the computer system, but signed originals were also held in the department. Clear records were held and supply to patients was accurately recorded on patients' notes.

Medicines

- Overall, medicines management within the emergency department was good. Patients sometimes had to wait for staff to become available to sign for medicines which required two signatures, for example controlled drugs in the resuscitation room. The majority of medicines were stored securely in locked cupboards, fridges and medicine trolleys. Intravenous (IV) fluids were stored in a secured room. No expired medicines were seen. Pre-labelled medicines were held in a secure cupboard for supply to patients against prescriptions or patient group directions (PGDs) and for out of hours.

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- We saw three oxygen cylinders insecurely stored in a cupboard with other secured upright cylinders; should they have fallen over this may have caused an injury. We made senior staff aware of the risks associated with unsecured cylinders.
- A pharmacy technician visited daily (Monday-Friday) to conduct medicine stock top up. Stock held for TTA (to take away) prescriptions for out of hours and for nurses to supply against PGDs were requested from pharmacy. There were good processes in place to enable patients to have medicines for discharge both day and night.

Records

- The emergency department was mostly paper-free and used the computer system to record assessments, care and treatment. The electronic system identified the details of admissions, length of time in the emergency department and time of decisions to admit. The reason for admission for some patients was seen to be incorrect. For example, a patient with a fractured neck of femur was recorded as 'unwell adult' despite an option being available to choose 'limb injury'.
- Security was maintained by all staff having their own access code to the computer system and we saw that staff logged out after each use. The computer system did not link with the computer systems in the rest of the hospital. If a patient was admitted their emergency department notes were printed out and transported with the patient. Paper records were used to request diagnostic tests. These were completed by nursing and medical staff and the results scanned into the patient's file.
- Staff said they found the new computer system to be an improvement on the previous paper system. We looked at patient records and saw that not all risk assessments had been completed. For example, patients in the emergency department for over six hours did not consistently have a pressure damage risk assessment. Intentional rounding to check patients were comfortable was seen to be done but not consistently recorded.
- Should previous paper medical records need to be requested, these could be accessed in a timely way. Staff told us they did not have to wait a long time for requested notes to be delivered to the emergency department.
- In the paediatric area three computer screens were left unattended for more than five minutes. These all had patient information displayed and cleaners and patients were in the vicinity, meaning confidential information was not safe.

Safeguarding

- Staff understood their responsibilities and were aware of safeguarding policies and procedures. The department had one dedicated link nurse to keep updated with developments in this area and changes in policy were communicated to the rest of the department. The link nurse also took a lead role for patients who were at risk of abuse, including specifically domestic violence. There was a process in place for identification and management of people at risk of abuse, including domestic violence.
- The electronic patient record prompted staff to consider safeguarding in their assessment of each patient. Staff were clear about the process required to make an alert.
- Arrangements were in place to protect women or children at risk of Female Genital Mutilation (FGM) but were not widely known or used. There was no lead nurse for this role and information needed would be communicated through the staff handover. We did not see this taking place but staff confirmed this was the practice.
- Children's safeguarding and child protection arrangements were in place. When any risks had been previously noted from visits to ED, those notes had been scanned into the new computer system and would appear as an alert when the child attended the emergency department. The staff were unclear if the rest of the hospital also received these alerts but staff were aware of the need for good communication.
- The Children and Adolescents Mental Health Service (CAMHS) could be accessed by the emergency department Monday to Friday in daytime hours. Additional support was set up over bank holidays. Out of hours access to support by the CAMHS team could be challenging, with delays encountered whilst the service was contacted. The emergency department staff had access to mental health training.
- When children waiting to see a doctor had had a long wait and their parents wanted to leave, this could be discussed, observations and risks reviewed and advice given about the risks of leaving. The trust had no

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protocol in place for children leaving before being seen. Staff confirmed that should they have any concerns about risks for the child they would contact the police to follow up.

- Medical staff told us they had received safeguarding training. Staff training records showed that five out of the eight consultants had completed level two or three safeguarding training. We saw that two of those consultants had only completed level one safeguarding adults and safeguarding children. Two other consultants had no training. Records showed that 89% of medical staff had completed level one training for both adults and children. 80% of medical staff had completed level two training for adults, and 82% for children. 50% of emergency medical staff had completed level three safeguarding training for children.
- Staff told us that there was no formal process in place for febrile children to be reviewed before discharge. The trust confirmed that all children with skull and long bone fractures were reviewed by a consultant before discharge.
- Two security staff were on duty 24 hours a day. The security base had cameras in the emergency department and a camera with 365 degree vision outside the emergency department. Contact with the security team was by emergency phone or pager, and in an emergency a fast pager could be used. Panic buttons were available in main reception and triage. Systems were in place in the majors' treatment area to send out an alarm and to contact the police and security. All security staff had training in restraint techniques. In the event of a major incident security could put in place a department 'lock down' to prevent unauthorised access. A similar security 'lock down' also took place each night and ensured limited access between the hospital and the emergency department and between the outside and the emergency department.

Mandatory training

- Access to online mandatory training was only possible at work. Staff could not access the systems at home and they told us that finding time during the working day to do training was very difficult. There was a mandatory study day once a year. This included fire safety, moving and handling, decontamination and resuscitation. A training update was sent to each staff member and was RAG rated for each nurse.

- The number of staff who had completed Advanced Basic Life Support within the emergency department was 86%. 56% of staff had completed Paediatric Life Support training. This had been implemented in October 2015.
- Nurses we spoke with told us that they had undertaken the Resuscitation Council's Immediate Life Support (ILS) course.
- A clinical educator was available in the emergency department and additional training requests could be made through them. Staff told us the clinical educator knew which staff needed which updates and chased them to complete this
- We looked at staff training records. The amount of staff having completed training was not available as a percentage for us to see if the amount of staff met the trust's training levels. We saw that for training for equality and diversity, health and safety and conflict resolution, most staff had completed. Other areas including fire safety, infection control, moving and handling and information governance had some staff who had not completed the training.

Assessing and responding to patient risk

- Patients arriving by ambulance as a pre-alerted priority call were taken immediately to the majors or resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient. We saw a patient who had been discharged the day before. The patient had been expected on their second visit as a priority call made by the ambulance crew. The patient went directly to resus with a suspected stroke. The emergency department doctor attended promptly.
- Patients arriving by ambulance but without a priority call were organised in a queue along a corridor outside of the major's one area to have an initial triage. This current process of triage had been in place since September 2015. The ambulance crew provided details to a trained nurse who added them to the computer. Details included name and address, when the injury or illness started and any pain management provided by ambulance staff. This process could take some time due to the volume of patients and we observed waits to initial triage of up to 40 minutes with up to five patients waiting on trolleys or wheelchairs in a corridor. The trained nurse then allocated a bay for the ambulance staff to transfer the patient to a hospital trolley. Five patients on trolleys was the maximum the corridor

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could accommodate. We saw that, dependant on the staff member, there was very little engagement by the initial triage nurse with the patient and no observations or early warning scores were completed at this time. In multiple cases the nurse did not turn around to look at the patient.

- We saw delays to initial clinical observation in excess of 15 minutes, which is the guideline for good practice. Data provided by the trust showed that for December 2015, January 2016 and February 2016, around 50% of patients had an initial clinical assessment and observations taken within 15 minutes. The remaining patients waited much longer periods. This placed patients at risk.
- After initial triage without clinical assessment, patients went to the Rapid Assessment Area (RAA). This was a pilot scheme being trialled by the department to provide further triage. There were two cubicles in the major treatment area designated for RAA and the process was used during the day but not consistently at night due to staffing constraints. A team of a nurse and a health care assistant measured vital signs and undertook diagnostic tests. This determined the action plan for the patient. Once the patient's condition had been assessed they were transferred to another treatment area within the department. If a treatment area was not available they returned to a corridor. At 2.40pm on day one of our inspection we saw three patients waiting on trolleys in a corridor having had the RAA triage but with no cubicle available for them to see a doctor. At that time there was a three hour wait to see an emergency department doctor.
- We observed the arrival of an elderly patient who had to wait in the queue to see the initial triage nurse. This patient had an evident fracture. They were then allocated to the RAA for initial clinical assessment. The RAA was in full use and so the elderly patient was queued in a corridor to wait for space in the RAA. There were four empty majors' bays at this time. This patient waited 46 minutes to be assessed in the RAA. They then had an X-ray and were transferred into a bay in the majors' department. This patient's journey could have been shortened and made more comfortable if the triage nurse had seen the patient, made an early decision and used the bays available.
- Pathways for patients having a suspected stroke or pulmonary embolism were established and clerking proformas were used to support medical staff to collate the information needed to make an initial assessment. Access to CT scanning facilities was 24 hour a day, seven days a week and within a reasonable distance of the emergency department to support quick access.
- For children coming to the emergency department there was a specific paediatric area separate to the adult area. Paediatric trained nurses were employed for that area with only occasional use of adult nurses with some additional paediatric training, when staffing was a problem. On each day of inspection only one nurse was seen working in this area. When more than one child was in this area it became a problem to move patients to the children's ward. The trained children's nurse would need to escort a child to the ward which meant they had to leave the remaining children and parents in the paediatric area unsupervised for up to 20 minutes.
- Children admitted to the emergency department had varying journeys through the department. Some went directly through the triage area to the paediatric area without any delay. At this point they were triaged by the children's nurse with a clinical assessment completed, including a pain score. However, we observed a 10 year old child waiting in the ambulance corridor queue with a family member. The emergency department was very busy with patients. This child was not moved from the ambulance queue to the paediatric area and was waiting on a trolley with the other adults.
- The paediatric department had an assessment unit on the ward which was open 8am to 8pm and medical staff from the ward would attend the emergency department if called for an urgent case. Within the adult resuscitation room one bay was allocated for children. This contained the resuscitation equipment needed for children. Any child resuscitation was undertaken by the emergency department staff. We saw that paediatric sepsis bundle documentation and feverish illness in children over three months was available to support staff.
- Patients who were able to walk into the emergency department were seen in the minors' area. A triage nurse assessed the patient and the patient may then be seen in the minors' area. An emergency nurse practitioner (ENP) coordinated the minors' area and, together with another ENP, ENP staff work 08:30 to 22:00 each day, seven days a week service. After 10.30am one minors' ENP or HCA was shared with the rest of the

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department. We saw the minors' HCA being used in resuscitation when needed. We also observed two of the minors' bays being used when majors was full, to support patients needing to be seen.

- At 8.50am on day two of our inspection there were five patients waiting to be seen in the minors' department, the longest having been waiting for one hour 49 minutes. These patients had not been assessed by a clinician within 15 minutes. Staff told us the delays had been caused by staffing issues overnight. We saw that as part of the triage process the nurse needed to leave the triage area to test urine, leaving the area unattended. We noted the telephone rang but no staff were available in triage to answer it.
- The triage room had a CCTV screen showing the waiting area but did not give a full view and so the triage nurse was not able to see if there were patients deteriorating.
- The hospital used an adult sepsis screening bundle with an essential first hour management guide. Sepsis is a common and potentially life threatening condition triggered by infection. The sepsis bundle was used with the national early warning score (NEWS). Staff told us that to identify sepsis patients on arrival they were relying on a pre-alert, skills of the ambulance crew or recognition by the initial triage nurse, who we had observed to have minimal interaction with patients. They considered there to be further risks caused by patients sitting on trolleys in corridors waiting for the RAA process. These patients were not monitored by the emergency department staff and were there because there was nowhere else to put them.
- The early warning score (EWS) was used to identify patients whose condition was at risk of deterioration. A points system was allocated to a patient's vital signs such as heart rate, temperature and blood pressure. The points were added up to achieve a total score which then determined further action. If the EWS achieved a score higher than five, the level of observation would increase to hourly. We saw these observations were not consistently completed and placed the patient at risk of deteriorating without being noticed. For example:
 - One patient was noted to have an EWS of six at 10.27pm with a potential diagnosis of sepsis. This required an increased frequency of observations to hourly. This patient's EWS was not checked again until 4.05am, a gap of four hours and 38 minutes, when it had changed to score five. It was then checked one hour later, and again two hours later, on both occasions scoring five.
 - We saw three patients in resuscitation; one had an EWS of 11 and had in one instance a gap in documented observations of three hours.
 - Another resuscitation patient had an EWS of five and gaps in recorded observations of five hours.
 - A further patient had an EWS of six and had a gap of two hours and 39 minutes between documented observations.
- The Severe Sepsis and Septic Shock Audit 2013/14 showed the recording of vital signs and two further investigations had low completion scores. There was a sepsis lead nurse within the emergency department but there was no sepsis led nurse team in the hospital to ensure that audit and actions were monitored to develop learning and practice. We were advised that the director of patient safety was the hospital clinical champion for sepsis and the paediatric lead was the lead for paediatric sepsis. The emergency department staff were not aware of this.
- The early warning scores for paediatrics (PEWS) was last audited in January 2015 to ensure they had been completed appropriately. This re audit was planned.
- The assessing for cognitive impairment in older people audit 2014/15 showed that the documentation of early warning scores did not meet the fundamental standard. We did not see any monitoring taking place to ensure that EWS had been completed.
- We saw that whilst each cubicle and bay area had a call bell for patients on trolleys to alert staff, these call bell leads were not routinely given to patients. We observed several bays when patients had curtains pulled around them, no staff in attendance and no means of alerting staff.
- There had not been any training about the risk of ligature injury. Staff said that during assessment if this was considered a risk, the patient would be admitted to a cubicle and all risks such as tubing would be removed. No environmental risk assessment was in place to support staff. Supervision of those patients would be put in place and if needed security would be called to support patient safety.

Nursing Staffing

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- Nursing staff were allocated to three areas of the emergency department. Majors' one and majors' two were looked after by team one and team two. Each team had a trained nurse and a HCA. The resuscitation room was allocated one trained nurse.
- The emergency department current nursing staffing levels and allocation were:
 - Team 1 cubicles 1-6 +side room +corridor 1 RN and 1 HCA
 - Team 2 cubicles 12-18+corridor outside 1 RN and 1 HCA
 - RAA 1 RN and 1 HCA
 - Resus 1 RN
 - Band 7 staff member used in all areas as needed.
 - One nurse for paediatric area
- The minors' area was staffed by one or two trained nurses who were specialist practitioners. If only one trained nurse was available then they were supported by a HCA.
- Staff varied on their understanding of management of patients on the corridors. Some staff told us this was managed by team three. Other staff told us it was flexible and when the department was busy this third team was implemented to ensure staffing ratios were appropriate to meet patients' needs. We looked at staff allocation and saw that sometimes team three was staffed and at other times it was not.
- The senior staff had identified that more band seven nurses were needed and three had been included in the emergency department rota. This was intended to be a supernumerary role with one extra band seven on duty each day to support staff. However, due to staff shortages during the inspection, the band seven on duty was included in the staff allocation each day. This meant there was no resilience within the emergency department staffing for an increased demand or for staff to be supported in the resuscitation room by a second trained nurse.
- The BEST nurse staffing tool was developed by the Royal College of Nursing (RCN) Emergency Care Association (ECA) and Faculty of Emergency Nursing (FEN) to calculate the staff and skills needed to provide nursing care in an emergency department. The tool indicates that for patients with moderate dependency a staff ratio of one nurse to two patients is required and for high dependency a ratio of one nurse to one patient is required.
- We observed on each day of inspection that the four-bedded resuscitation room had only one trained nurse allocated and when extra staff were needed they were pulled from other areas of the ED, so leaving those areas short of nurses. We were advised a business case had been submitted to request further staffing for the resuscitation room. No response had been received and whilst a need had been identified, no interim action had been taken to ensure patient safety. We did not see this recorded on the risk register.
- On day one of our inspection two patients were in resuscitation with one trained nurse. A third patient then arrived. The initial two patients were left without a nurse whilst the nurse attended the new patient. Cardiac monitors were continually alarming for the two patients left unattended, which nobody was available to check.
- At this time the third patient then required a CT scan. The nurse was trying to look after three patients and organise the CT scan. The third patient was then escorted to the CT scan by an HCA, without any resuscitation equipment or other support should the patient deteriorate. The trust advised that CT scan patients did go with a HCA and cardiac and unstable patients would be escorted by a trained nurse. We expressed our concerns about these staffing levels to the trust that evening.
- If a second nurse was needed in resuscitation to get medicines or to sign for controlled drugs a nurse was pulled from another area of the emergency department. For example, on days one and two, a second nurse was needed and so a HCA was pulled from the emergency department. This meant that patients in other areas of the emergency department had to wait for the nurse to return. We saw that the one trained nurse would occasionally have to leave the resuscitation room to get medicines. We saw in one instance a doctor was in with one patient but there was no nurse presence, and on another occasion a physiotherapist was in resuscitation but there was no nurse presence.
- On day two of our inspection in the resuscitation room, two patients had an EWS of five/six and two had an EWS of 11. We checked with the nurse on duty who said they were all considered to have high level needs. The BEST tool indicated a 1:1 staff ratio but the patients were cared for by two nurses. This meant that when the resuscitation department was full the trained nurse levels did not provide a safe staffing level.
- We revisited the emergency department unannounced a week after the main inspection. At 8am there were three patients in the resuscitation room with one

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trained nurse. The patients had a high dependency and a further trained nurse was needed. There was no resilience in the staffing to accommodate this and so a decision was made to move the two patients in Majors to one area and take the trained nurse from the majors two area and move them to the resuscitation area. This reduced the capacity of the majors' area by seven cubicles.

- The paediatric area within the emergency department had six spaces which included two chairs, two trolleys and two cubicles. Only one paediatric nurse was available at any given time. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identifies that there should always be registered children's nurses in an ED, or trusts should be working towards this. Staff confirmed this was mostly the case. The use of adult nurses in paediatrics was only undertaken when there were staffing problems.
- The emergency department sickness rate for December 2015 was 4.4% which was the highest it had been in the previous four months. Work pressure felt by staff in the trust overall had increased in the 2014 staff survey compared to 2013, though scores were still better than the England average.
- ED had an 11% nursing staff shortfall, which was higher than the trust's overall nursing shortfall of 9%. There were currently vacancies for one band six, and five band five nurses. There were not enough staff employed directly by the trust to meet the nurse levels calculated using the BEST tool. To make up the nurse staff numbers to the identified level bank and agency staff were used. The amount of bank and agency staff needed varied from month to month. In the emergency department the average agency use was 2%, lower than the trust average of 4%. The average bank use was 15%, which was higher than the trust average of 12%.
- The emergency service had a staff turnover rate of 10%, which was 15 staff. This was lower than the England average.

Medical staffing

- Consultants provided department cover for 14 hours a day during the week and for six hours a day at the weekend. There was a shortage of consultants and they

were not present in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine. Recruitment of more consultants was ongoing.

- There were up to four emergency department consultants on duty working a variety of shifts each day. The consultant working 2pm to 10pm then became the on call consultant overnight. There was a continuity of on call consultants as the on call consultant worked the next day. One consultant confirmed that they generally got enough sleep to be able to work the next day. One full time locum consultant was in place and had been there for an established amount of time to have a good understanding of how the trust and department functioned. The trust recognised 24 hour clinical cover was a workforce issue and had included it on the risk register as a medium risk. The lack of senior decision making was noted as increasing the risk of unnecessary investigations, admissions and incorrect diagnoses.
- Overnight the emergency department was covered by one middle grade doctor 12 midnight to 8am, and two foundation level two doctors. At weekends there was a consultant in the emergency department 9am to 3pm and then on call.
- There were six middle grade doctors on a rota covering midweek, weekends and nights. The Clinical lead consultant explained that management of the rota to ensure suitable coverage was a challenge but was managed by middle grade doctors working extra hours. Only SAS (Speciality and Associate Specialist) level doctors could be in charge of the department. Medical staff told us the current level of staffing negatively impacted on their opportunities to attend departmental meetings and training.
- There were four GP trainees working in the emergency department and the trust provided training to medical students in collaboration with local partners.
- The trust employed a greater proportion of junior doctors (43%) than the national average (24%). The trust employed a lower percent of consultants (15%) compared to the national average (23%).
- Handovers took place each morning and evening and were verbal only. Board rounds took place twice each day and more if needed. At this time all medical staff gathered at the electronic board and the patients were discussed. No minutes or records were maintained of decisions made.

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- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) states that departments seeing 16,000 children a year must have a consultant with sub specialist training in paediatric emergency medicine. There must be a nominated paediatrics lead consultant. Whilst the emergency department had a nominated paediatric lead who dealt with any paediatric issues overall, there was no identified paediatric lead consultant for each shift. A middle grade doctor was allocated to paediatrics with an on call consultant and registrar available who may not be present in the department. All paediatric consultants had received Advanced Paediatric Life Support training and would be involved in any urgent and emergency care for children. The paediatric emergency department sometimes had to wait to see a paediatrician as they were busy on the wards.

Major incident awareness and training

- A Major Incident plan (MIP) was in place. The MIP provided clinical guidance and support to staff on treating patients caused by burns, blasts or chemical contamination.
- The trust had an incident plan which included what action was to be taken should there be a chemical, biological, radioactive, nuclear or explosive (CBRNE) or hazardous material (HAZMAT) incident. The plan included instructions for staff, including photographs on the procedures to follow for decontamination. Senior staff confirmed with clear descriptions what actions had to be taken in such an incident. There was a decontamination protocol available at main reception, which advised administrative staff of the actions to take should they have any concerns.
- The department had a major incident cupboard which contained packs to enable staff to access what they needed quickly. The cupboard used was obstructed by seven wheelchairs. Major incident training was ongoing and the medical clinical lead was the emergency department lead on trauma who maintained links with the local trauma network.
- Not all training had been completed by on call managers and executive directors. An action plan was in place for the training to be complete by December 2015.
- 34 emergency department staff out of 122 had attended Level two major incident training. The training consisted of a 90 minute PowerPoint and practical sessions, and

was mandatory every two years. Fourteen out of 19 emergency department receptionists had attended the required Hazardous Materials training in 2015. This consisted of a 15 minute video and read through of the decontamination action card.

- A mandatory table top exercise had been attended by 10 emergency department staff. This was a one day major incident table top exercise made up of 40 staff and managers.
- Nursing staff told us that security staff responded promptly when called. Security staff confirmed they had been trained in conflict resolution and the safe restraint of violent individuals.

Are urgent and emergency services effective?

(for example, treatment is effective)

Inadequate



We rated urgent and emergency services as inadequate for effective.

- Patient outcomes and the results of audits were not always used to improve treatment. Audits did not reflect a consistently good outcome for patients. These included the management of sepsis. Unplanned reattendance was not investigated for any reasoning.
- The facilities in the emergency department were not suitable or well maintained and compromised patient safety and the patient experience. This included the environment design and some fixtures and fittings.
- Staff identified with us the risks in the department from mental health patients awaiting assessment. The delays encountered to see the mental health team were seen by staff to cause the patients agitation and distress and staff felt this may cause risks to other patients in the unit.
- The multi-disciplinary working practices in the emergency department did not always ensure the best outcomes for patient experience.
- Access to radiology and pharmacy was available 24 hours a day, seven days a week. Access to mental health services was limited out of hours and caused extended waits for patients.

Evidence-based care and treatment

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- Care and treatment was sometimes delivered using clinical guidelines, including National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM's) Clinical Standards for Emergency Departments. For example, NICE QS3 was used for patients assessed for venous thromboembolism (VTE). All patients on admission received an assessment of VTE and bleeding risk using the clinical risk assessments criteria. Intravenous (IV) fluid therapy was undertaken, and patients were looked after by, healthcare professionals competent to assess and administer and monitor IV fluids, in accordance with NICE QS66.
- Policies used were easily accessible via the department's computer system. They included fractured neck of femur (broken hip), sepsis and head injuries.
- There was an effective clinical pathway for patients who had suffered a heart attack (myocardial infarction) or a stroke. We observed these pathways for patients and saw the documentation used to ensure the correct information was gathered.
- The score card for peripheral vascular access, hand hygiene, urinary catheter care & antibiotic audits were seen for most departments of the hospital to be done quarterly. These scores were not evident for the emergency department or for the Clinical Decision Unit (CDU).
- A major haemorrhage protocol was in place which identified a plan for the urgent delivery of blood to the emergency department. The blood bank was not near the emergency department so if a patient needed a transfusion a porter would be used to collect the blood products and deliver them to the emergency department.
- The NHS Emergency Care Intensive Support Team (ECIST) had visited the hospital. They looked at information available between April 2014 to March 2015. As a result of their visit an action plan was implemented, which involved five main areas. These included improving patient flow and developing clinical pathways. All actions had a planned completion date of 10 February 2015. The data available did not demonstrate significant improvement to date as a result of these actions.

Pain relief

- Patients who went through the rapid assessment area were asked about pain relief: what had been taken, how effective it had been and if further pain relief was needed. A scoring system was used to indicate the severity of the pain, with zero being no pain and ten being severe pain.
- The 2014 A&E survey showed that for the question 'How many minutes after you requested pain relief medication did it take before you got it?' the department performed worse than the national average.
- We saw pain relief for children was provided within the appropriate parameters and staff monitored its effectiveness.

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed, administered, recorded and monitored when clinically indicated.
- Housekeeping/cleaning staff were seen providing food and drink to patients and hot drinks to relatives. They explained that prior to mealtimes they spoke with the nurses in charge of each area to check which patients could eat and any limitations or special requirements they may have. They then spoke with each patient and took a food order. A hot meal was available for those patients who had been in the emergency department for a longer period of time. Specialist diets were accessible. They could also request food and drinks outside of mealtimes if needed. Four patients confirmed they had been offered refreshments by the staff.
- The Voluntary Services Organisation visited the emergency department with a trolley of snacks for staff and relatives to purchase.

Patient outcomes

- The department took part in national audits in order to compare patient outcomes with other hospitals in England. The results varied compared to other hospitals.
- The trust was in the lower quartile for several measures in severe sepsis and asthma in children, and performed similar to other trusts for fitting children and overdoses.
- The trust undertook a sepsis audit in 2013/14 which showed that for most of the outcome measures used

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they were in the lower quartile nationally. This meant the percentage of actions identified to be done to treat sepsis were not always completed. The exceptions were the administration of oxygen and antibiotics. We observed staff following the trust sepsis protocols with the exception of consistently completing the early warning score (EWS) when the documented scores indicated this.

- The Asthma in Children Audit 2013/14 showed five areas where observations and treatment were worse than the timescale for the England average.
- We saw treatment audits of patients with a fractured neck of femur. Pain scoring had deteriorated from previous years and was below average nationally. Analgesia offered within 60 minutes had deteriorated and was in the lower quartile nationally. Analgesia was offered within the trust guidelines in 70% cases. This was an improvement and was above average nationally.
- We observed the treatment of a patient with a fractured neck of femur and saw it took almost two hours for the patient to be seen by a doctor. Pain relief had been provided in the ambulance.
- The rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. The rates of unplanned reattendance for the trust were lower than the national average for most of 2013 to 2015 but were higher for February 2015. We asked what had been identified as the reason for the increase but the management of the emergency department could not offer any specific reason and the increase had not been investigated.
- Consultant sign off data was not available. We spoke with the emergency department doctors who said they would see all of their patients with any concerns before discharge.
- The Royal College of Emergency Medicine 2014/15 audit showed the trust fell short of standards in mental health and fundamental cognitive impairment. This was around results not being recorded in patients' records.
- There are seven standards laid down by the College of Emergency Medicine pertaining to patients who present to the emergency department with a mental health issue. Following a review of the service offered in the Torbay emergency department during 2015, it was

identified that not all of these standards were met satisfactorily. An action plan was agreed in collaboration with acute sector colleagues, which included a mental health risk assessment tool to enhance the identification and awareness of mental health conditions and their presentation. This tool should be used as part of the initial assessment process and we saw that staff had a clear understanding of its use. Staff identified with us the risks in the department from mental health patients awaiting assessment. The delays encountered to see the mental health team were seen by staff to cause the patients agitation and distress and staff felt this may cause risks to other patients in the unit. We were told about a patient who waited from 5.30pm to 2am before a mental health or acute bed as required was available.

Competent staff

- Appraisal completion percentages trust-wide were low but had improved from 45% in 2012/13 to 51% in April to July 2015. In the emergency department from April 2014 to June 2015 there was an average completion of appraisals of 47%.
- Staff told us they had annual appraisals and extra learning could be identified at this time.
- Medical staff including consultants and associate specialists engaged in annual appraisals within the trust, as well as a re-validation process with the responsible medical officer. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by the trust and the General Medical Council. Trust data on appraisal rates in the emergency department showed that all doctors who were permanently employed in the emergency department had been apprised within the appropriate timescale.

Multidisciplinary working

- Generally, there was effective multidisciplinary working within the emergency department. Medical and nursing staff and support workers worked well together as a team. However, there were some areas of multidisciplinary working that were not effective.

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- 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.
 - Emergency department consultants and staff grade doctors were not permitted to admit directly to medical wards but could admit to the EAU's. The medical consultants from the wards did not see patients that had not yet been seen in the emergency department by more junior doctors. There was no senior or consultant early assessment of medical patients in the emergency department and senior decision makers did not attend the emergency department in a timely manner. Should a patient in the emergency department not be seen and clerked in by 6pm, the medical consultants would have finished and the patient would then not be seen by a medical consultant until the next day. This meant they may have to remain in the emergency department until that time or be unnecessarily admitted because the junior staff did not have senior advice. If patients were particularly sick, the trust told us the physician would see them regardless of the state of readiness. We observed two occasions when the delays in admission could have been avoided by the input of the medical consultant. The appropriate consultant was not called to attend by either the medical team or the emergency department team.
 - Access to the critical care outreach team was in place. The emergency department staff were able to contact the outreach teams for critical care and stroke nurses when extra support was needed. The critical care outreach team would attend the emergency department at their request and provide support and advice for patients who were critically ill. The stroke specialist nurse was available 9am to 9pm to attend the emergency department. The stroke team would undertake thrombolysis in the emergency department and stay with the patient to transfer. Thrombolysis is the process of breaking down blood clots using medicines and requires patient supervision. Outside of those hours the emergency department staff would thrombolysed any stroke patients. In April to June 2015 the SSNAP) audit scored thrombolysis as a D, with A being the highest score and E being the lowest.
 - The alcohol and substance misuse liaison team were located in the hospital and had links with the emergency department; they told us that communication and advice were sought by the emergency department when needed.
 - For mental health patients in the emergency department, staff completed an assessment of risk. Once completed and the mental health team were contacted patients had to wait for the psychiatric team review. Staff explained this could take up to 12 hours and both patients and staff found this to be stressful.
 - The occupational therapy cover on the emergency department was one band seven with management responsibilities, one band six, and one rotational band five therapist. We saw therapy support being provided in the emergency department and also in the CDU.
 - The emergency department had a frailty nurse based in the department who was accessible to provide advice and support to patients and staff. The pathways for frail elderly patients were less clear through the emergency department as there were insufficient beds available to move them through the emergency department.
 - Should a cardiac arrest take place in the emergency department, the emergency department staff attended and did not call for the hospital cardiac arrest team. They would call an anaesthetist if needed. Medical staff were confident to manage this situation.
 - The emergency department had a discharge team in the department. They met each morning prior to the operations team bed meeting to identify any potential discharges, but did not attend the operations meeting. They worked with other wards and departments in the hospital and in the wider community to ensure safe discharge.
- ## Seven-day services
- The emergency department consultants were not present in the department 24 hours a day. However, they did provide senior clinical advice 24 hours per day, seven days per week, either directly within the

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department or on-call from home. Junior and middle grade doctors in the emergency department were confident to contact the consultant when advice and help was needed.

- The department had access to X-ray and radiology support 24 hours each day, with rapid access to CT scanning when indicated.
- There was an effective pharmacy on-call service. Staff confirmed they rarely had to wait for pharmacy services.
- There was access to ECG between 9am and 5pm and phlebotomy services between 12 noon and 10pm. Staff confirmed out of hours they undertook these diagnostic tests.

Access to information

- The computer system used in the emergency department enabled any paper records to be scanned in so a complete record was available. When the computer system was not working, temporarily a paper system returned to ensure records were maintained. When patients transferred from the emergency department, all records needed were printed out and sent with the patient. This was because the computer system in the emergency department was not linked with the computer system used in the rest of the hospital.
- The Royal College of Emergency Medicine (RCEM) Developmental Standards showed the proportion of discharged children whose parents or carers were provided with written safety information (all audited patients) was below the England average for the management of the fitting child. This meant in this instance, not all parents and carers received sufficient information.
- We saw that information was available in some areas of the emergency department, including cancer awareness, diabetes and safeguarding information. We did not see any literature relating to alcohol or substance misuse.
- Letters were generated electronically for every patient to be sent to their GP after their visit to the emergency department. For children, additional liaison letters were sent to health visitors and school nurses and when appropriate Children and Adolescent Mental Health

Services. The trust risk register had a medium risk identified for patient safety not being put on the computer and letters being sent to GPs with information missing.

- The emergency department had free Wi-Fi although this was not advertised anywhere. This enabled relatives and patients to stay in touch.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained before any procedures were undertaken by the medical and nursing staff. This included both written and verbal consent. The staff we spoke with had sound knowledge about consent and the Mental Capacity Act (2005) and confirmed training had been provided. When patients did not have the capacity to make a decision immediate and urgent treatment was considered in the patient's best interest.
- When needed, a mental capacity assessment was completed by medical staff. Issues about capacity were generally identified by the nursing staff but the final decision was made by medical staff. Nursing staff told us that the management of consent was continuous. If a patient's condition improved or deteriorated, capacity was reviewed. Staff told us that if a person's mental capacity was a difficult issue they would request senior staff advice and request the input of the safeguarding team.
- Consent forms were available for people with parental responsibility to consent on behalf of children they were responsible for.
- Staff spoken with were not confident about the procedure to follow to make a Deprivation of Liberty Safeguard application, should this be needed. Training had been provided but staff rarely undertook these safeguards and so they were not confident about the process.

Are urgent and emergency services caring?

Good



We rated urgent and emergency services as good for caring.

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- Staff treated patients with dignity and respect. Feedback from patients and those close to them was positive about the way staff treated people. There were varied results from the national emergency department patient survey.
- There were positive comments from patients who spoke about the staff as being kind, considerate and caring. Patients, their relatives and families were kept informed of on-going plans and treatment. Most told us they had been given clear information about treatment options. Their privacy and confidentiality was protected as much as was possible in the difficult environment. People's social needs were considered and staff helped patients and those close to them to cope emotionally with their care and treatment.
- All patients entering the emergency department through the minors' entrance were given a Friends and Family Test form to request feedback about the service they had received. This was used to inform staff of any ways to improve or develop the emergency department.
- Friends and Family Test scores had been higher than the national average, except between August 2014 and March 2015 when they were lower.
- There had been a system where people used a token to give feedback. This was stopped six months previously but the token boxes had not been removed from the reception area.

Understanding and involvement of patients and those close to them

Compassionate care

- In the 'caring' questions of the 2014 A&E Survey, the trust performed 'about the same' as other trusts for all questions.
- We saw one nurse spending time explaining X-ray results to a patient and providing information leaflets and explaining them to the patient. We saw another nurse notice a patient was cold so found extra blankets for them.
- We saw that for one patient in particular staff were very considerate. They received news whilst in the emergency department of another family member being unwell in another part of the hospital. Staff provided constant updates throughout the day to reduce the patient's distress as much as possible.
- The A&E survey 2014 showed the department performed worse when compared nationally for the question 'Were you given enough privacy when being examined or treated?'. We saw that whilst records were maintained as confidentially as possible, some conversations were overheard. This compromised the patient's dignity and privacy. We also saw that some patient's curtains, because of the way they were made, did not fully close and this enabled other people in the emergency department to see into closed areas.
- We saw that patients on trolleys in the corridor outside the resuscitation room doors could have a direct line of sight into the resuscitation room. This happened when the automatic doors were opened and for the timed duration they remained open. If curtains were not closed in the resuscitation room, it was very difficult to maintain any privacy for these very unwell patients.

- We spoke with patients who all told us they had been treated with dignity and respect. They said staff were caring, patient and their privacy had been respected. They were aware of what was happening with their care.
- We observed a patient with dementia being escorted up and down the department by a staff member. The patient was unsettled and needed staff support to ensure they could walk safely. Staff were kind and caring and ensured the patients' need to walk was met.
- Current waiting times were not displayed in the waiting room. Receptionists said that they would tell people about any delays if asked. We observed this to be the case.

Emotional support

- The hospital chaplain would attend the emergency department when requested and staff told us they had seen them attend, especially in the resuscitation room. We were told that in the event of a child death there was a child death coordinator available to attend the department and support the parents and staff.
- There were no specific counselling services available for patients and relatives in the emergency department. However, in some cases extra staff were used to support patients and families with extra needs.

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

Inadequate



We rated urgent and emergency services as inadequate for responsive.

- Services were on occasion disorganised and did not ensure that patients received the right treatments at the right times. A lack of available beds in the hospital had resulted in poor patient flow through the 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 delayed and slow, and patients frequently and consistently could not access the hospital in a timely way, experiencing unacceptable waits.
- 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 significantly since the introduction of a triage system but delays were encountered when the Rapid Assessment Area was full. Patients waited for over three hours to see a doctor.
- There was no flow urgency throughout the hospital, which impacted on the emergency department. There were a lack of decision makers available in the emergency department, which impacted on the flow of patients out of the emergency department. The facilities and premises did not meet the needs of the local population.
- The percentage of patients leaving before being seen was higher than the national average for most of January 2013 to October 2015.

Service planning and delivery to meet the needs of local people

- The emergency department was well signposted and accessible. There was parking available close to the departments.

- The waiting room area for patients attending the emergency department on foot had sufficient chairs and a children's play area. People were seen at all times in the waiting room. There was a good line of sight by the receptionist to most parts of the waiting room and CCTV coverage available behind reception. There were toilets suitable for adults and children and nappy changing facilities. Sometimes the patients had all been seen by the triage nurse and were waiting for treatment in the minors' department.
- There was a separate waiting area for children which was suitably decorated, furnished and equipped. In the emergency department the paediatric area waiting room had restricted access and was not overlooked by the adults' waiting area. An area was available in resuscitation for paediatrics.
- The receptionist staff in the emergency department reception did not receive any formal or supportive training for their role. They would use their experience and common sense to escalate any concerns about patients attending reception. The electronic computer system was updated with the patient's details at reception and so staff could review any concerns and enable patients to be seen quicker if needed.
- The percentage of patients leaving before being seen was higher than the national average for most of January 2013 to October 2015. This had not been investigated by the trust to establish why this was.
- A clinical decision area had been designated on the nearby acute medical unit (EAU3). This area had eight seated bays and was staffed by the EAU3 staff. We visited and found it was not always fully utilised, with between one and four patients being in the unit at any given time.

Meeting people's individual needs

- The department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available in the department.
- The design of the department and external ambulance and patient drop-off facilities did not always ensure access into or out of the department. Ambulance staff experienced difficulties with relatives and taxis parking outside of the ambulance bays. This caused difficulty in turning the ambulances and so delays in getting the patients in. Further difficulties were experienced when cars were parked after the ambulances were in, so obstructing their route out.

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- We saw the bereavement room was being used as a storage facility and housed a bed, trolley, mattresses, an anaesthetic machine and various pieces of furniture. Staff told us they emptied this room when it was needed. The room was clinical with no furnishings which would soften the experience of viewing.
- The relatives' room was pleasant and the facilities included the means to heat a meal and make a hot drink.
- A flagging system was in place to alert staff to patients who had a known learning disability. For patients already noted on the system, any admissions were seen to have a 'special case' alert. This system did not automatically alert the learning disability liaison staff and so any alert to staff or services was dependant on the communication of staff from the emergency department to the ward. This was varied depending on staff knowledge and experience of this system. We spoke to some staff who were very clear of their responsibilities and some staff who did not know this part of the process.
- There was only one learning disability liaison staff employed. A document called 'Recognition of specific requirements' was available for staff to complete. We were told this was rarely completed.
- We spoke with the discharge and the emergency department staff about the options available when discharging anybody who was homeless. They explained a local hostel would be contacted to find suitable accommodation at short notice. For longer term discharges, the discharge team would liaise with social services.
- We asked staff about access to the drug and alcohol team. Staff were not consistent in knowing how to access this team; however, we visited the team who provided evidence of links between the emergency department and the substance misuse services.
- The minors area waiting room had a television, which included subtitles for the hard of hearing. Tea and coffee purchasing facilities and a vending machine were available for relatives.
- Information in alternative formats was available to support patients and relatives to understand and communicate with staff. The trust's website stated they offered interpreters by telephone and document

translation. Sign language services were available, and easy-read format information available. Other formats available included braille, audio and large print information.

- The emergency department had access to a service which enabled specialist support for deaf patients or parents. An interpreter could be contacted and staff said this was a very quick and responsive service.

Access and flow

- Patients did not always receive care and treatment in a timely way. The trust recognised that national emergency standards had not been met. NHS England has set a national standard which requires that 95% of patients in emergency departments wait less than four hours to be admitted, transferred or discharged. The percentage of patients seen within the national emergency target of four hours had consistently not been met since 2014. The trust's risk register for the emergency department recognised this non-achievement as a medium risk and noted a lack of capacity creating delays for patient assessment, diagnostic tests and treatment.
- Between 1 September 2014 and 31 August 2015, 356 people waited four to 12 hours between the time a decision was made for them to be admitted, to the time they were actually admitted. Nobody waited over 12 hours. From August 2015 there had been an increase in patients waiting over 12 hours from the decision to admit being made and the actual admission taking place. Senior staff told us this change in data may have been related to a change in computer systems gathering more accurate data. We spoke with patients who had been waiting a long time for admission to hospital from the emergency department. They told us staff had kept them updated about the delays.
- Black breaches occur when an ambulance has arrived with a patient but it is not possible to handover care to the emergency department staff for over an hour. Ambulance median waiting times to initial assessment were recorded as being roughly ten times the national average from January 2013 to July 2015. This fell to zero in July and August 2015. The trust told us this was due to a change in recording system and that they were reviewing how this was being recorded. We saw ambulance staff bringing patients through the doors and then having to queue to be seen by the initial triage nurse. On three occasions we saw a queue of five

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patients on trolleys waiting for initial triage. One patient waited 34 minutes and was then admitted to the resuscitation room. This was not responsive to this patient's needs.

- Another important indicator is how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. The median time to treatment was similar to the national average for most of January 2013 to July 2015. However, from July onwards the trust reported nearly double this. Waiting times to see a doctor were seen to exceed three hours on day two of our inspection. Delays in being seen by a doctor exceeding an hour were seen consistently over the week. Medical staff told us the delays were caused by the lack of available space to examine patients.
- The 2014 A&E survey reported the trust performed worse than other trusts for two out of five questions in the 'safe' category. These included 'How long did you wait before you first spoke to a nurse or doctor?' and 'From the time you first arrived at the A&E Department, how long did you wait before being examined by a doctor or nurse?'
- Patient flow between the emergency department and the rest of the hospital was not adequate to ensure patients were admitted in a timely way. At the time of our inspection bed occupancy within the hospital was high with very few available beds. Beds were being found on outlying wards to enable medical bed availability. As a result of this high occupancy patients in the emergency department awaiting admission could not be moved.
- An escalation process was in place within the emergency department to advise the operations team who manage bed flow of the current situation in the emergency department. The escalation plan stated the criteria for escalation, for example delays, transfers and surges in demand. The operations team met three times each day, or more often if the bed situation was identified as problematic. The first meeting of the day was at 10am. At this point the operations team would review bed occupancy in the wider hospital to try and enable flow of patients. The emergency department staff told us escalation of a full resuscitation room was also made to the operations team. When the resuscitation room was full contingency plans were needed should a further patient requiring a resuscitation bed be admitted. The contingency plan was to move patients as quickly as possible out of the department to enable a greater capacity. The clinical lead consultant told us they always managed this.
- The avoidance of admission or breach of target was not seen to be a priority. When patients approached the four hour breach time staff did not promote avoidance and accepted as normal that a breach would take place. We observed patients needing review by the medical team experiencing delays caused by the system in place.
- On day two of our inspection the emergency department was crowded. At midday resuscitation was full with limited options of movement should a further trauma or resuscitation patient need access. All of the cubicles in majors were full, 10 patients had been in the emergency department over 10 hours and one patient had been in the emergency department for 11 hours and 36 minutes. The computer system showed there were 14 patients waiting to be seen by a doctor with the longest wait being two hours and 39 minutes.
- On the third day of our inspection there were nine patients who had been in the department over four hours, and the four hour breach increased to 12 patients by early afternoon.
- From August 2015 the numbers of patients exceeding 12 hours from the time a decision was made to admit them to the time they were actually admitted had increased, with five patients recorded in September 2015. The emergency department senior staff explained this change in data was due to an improvement in record keeping since the implementation of the new computer system in the emergency department, which automatically recorded this data.
- On the first day of our inspection at 8.30am there were three patients who had been in the emergency department over four hours. One patient had been in the emergency department almost eight hours and another for almost 10 hours.
- On the second day of our inspection at 8.30am there were 15 patients who had been in the department over four hours and one patient who had been in the department 11 hours and eight minutes. A decision had been made to admit all of those patients but no beds were available. In a 24 hour period 202 patients had been through the department. This was about the average number but there was no flow out of the department. By 4pm that day there were seven four hour breaches with 10 patients approaching a breach. At

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that point an escalation call was made because the department was crowded with 37 patients, but only capacity for 18 in majors. At the 4pm bed meeting a comment was made that “the wheels are not moving fast enough to free the assessment medical unit and move the emergency department patients”.

- The trust used a recently implemented ALAMAC Kitbag. This is a tool to enable staff to gather data and identify the level of risk in the department. The score on the second day at 2.30pm showed the emergency department to have a Red rating. This system was not linked with the control room and so once the calculation was complete an email was sent to the appropriate clinical staff and attendees of the control meeting. The trust told us that during escalation periods additional control meetings were held. As part of that red alert the Director of Nursing managed the 12.30pm and 4pm operations meetings. However, insufficient actions were possible to prevent ongoing difficulties with flow.
- On the morning of day three of our inspection the trust called an internal significant incident to address the issues around lack of patient flow. At this time the emergency department had exceeded capacity with 31 majors and resuscitation patients and the longest wait for admission being over 11 hours. By 12.30pm there were 41 patients in the emergency department with 36 beds to find. The total number of patients passing through the emergency department in the previous 24 hours had been 205. Staff told us this was not unusual, however the current risks were caused by the lack of flow out of the emergency department and the department having to hold a greater volume of patients. Staff were seen to be professional under pressure but were struggling to manage the continuing pressure.
- Actions taken at the operations meeting included a member of medical staff attending the acute medical unit to establish any possible discharges. By midday every medical patient, including outliers, had been reviewed by a member of medical staff to establish any potential discharges. Reviews of non-urgent day case activity for the following week took place to consider cancellations and staff from the hospital attended the emergency department to collect their patients. Access to community beds was increased and further staffing for the emergency department was also planned. It was

identified at that time that there were 92 patients with a length of stay exceeding 10 days in the hospital and efforts were made to identify more creative ways to enable some of them to be discharged.

- We visited the emergency department as part of our unannounced inspection and asked how the escalation procedures had worked following that time. Staff confirmed the measures taken had eventually restored flow to the emergency department but it had taken over a week to return to an acceptable flow through the emergency department.
- The numbers of patients leaving without being seen were higher than the national average for most of the period January 2013 to October 2015. We asked the senior emergency department staff for any explanation but they were not able to supply one. No investigation had been undertaken to see why this situation was happening.
- We spoke with staff about the difficulties with flow through the emergency department. They explained this situation was consistent and often the emergency department felt unsafe. This was because there were too many patients in the emergency department with nowhere to move them.
- The hospital had developed an ambulatory care unit which aimed to treat people without them being admitted to a ward. This unit was used to assess and treat patients referred to the hospital by GPs. The unit was not located in the emergency department but was used to prevent, when possible, admission to hospital.
- A clinical decisions unit was located close to the emergency department. This area had eight chairs and was used by patients awaiting diagnostic results or discharge arrangements. This area was staffed by the adjoining ward and was seen to be used by the emergency department patients.
- Patients awaiting admission for long periods in the emergency department were made comfortable. Patients were transferred from a trolley to a bed and when appropriate provided with food and drink. Staff members visited them as part of comfort rounds, however the emergency department was very busy during our inspection and we did not see comfort rounding taking place.

Learning from complaints and concerns

- In the emergency department 98 complaints were received over the previous 12 month period, of which 14

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received responses within 30 days and 66 received responses between 32 and 60 days. A further 15 received responses between 61 and 90 days and two received responses over 91 days.

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), which would formally log their complaint and attempt to resolve their issue within a set period of time. PALS information was displayed on noticeboards throughout the department.
- Staff we spoke with were familiar with the complaints procedure and they felt confident to deal with complaints, escalating to more senior staff if appropriate.
- Staff received feedback from complaints investigation as part of the morning handover of information. This included any learning outcomes.

Are urgent and emergency services well-led?

Inadequate



We rated urgent and emergency services as inadequate for well-led.

- The vision and the strategy were not always aligned. The arrangements for governance did not operate effectively. Assurance systems, service performance measures and action taken to improve performance were not seen to be used to ensure the safety of the service.
- The emergency department had been working under pressure for a considerable length of time with no effective changes to improve the situation. Significant issues that threatened the delivery of safe, effective and responsive care had not been identified and adequate action taken to manage them. The system used to identify, capture and manage risk was not seen to effect any change to the service. Insufficient priority was given to using audit as a tool to identify shortfalls and to improve performance.
- Staff did not always feel empowered to make the changes needed to improve the service or to feel part of

the greater hospital. Clinicians did not always work cohesively to ensure the emergency department functioned as part of the wider hospital and did not always lead effectively.

Vision and strategy for this service

- The trust's values were the NHS values, described in the NHS Constitution, which the trust had adopted and strived to fulfil. These included respect and dignity, commitment to quality of care, compassion, improving lives, working together for people and everyone counts. The trust's purpose was to provide safe, high-quality health and social care at the right time and in the right place to support the people of Torbay and South Devon to live their lives to the full. Staff confirmed they had been included in the development of these values and the standard 'Working with you, for you'. Staff knew what the values were and told us they agreed with them.
- The Emergency Care Intensive Support Team (ECIST), an external auditing body, visited the emergency department and looked at data from April 2013 to March 2015. The trust had an action plan in place with completion targets of 10 February 2016. We saw the action plans had not impacted positively on the emergency department's current performance or patient outcomes.
- There was a strategy for the emergency department which included emergency patients and other areas of medicine, including a frailty service and multi-condition pathways. The strategy included areas for service delivery. Staff we spoke with were not clear what the emergency department strategy was.

Governance, risk management and quality measurement

- A risk register was in place and identified the trust's areas of concern for the emergency department. The risk register issues were graded and were all seen as medium risk. These risks were not raised and discussed at the clinical governance meetings.
- The governance systems were not effective. There were medical and emergency directorate meetings and these, along with divisional board meetings, were used as an opportunity to review and discuss data and risks. Clinical governance meetings were held monthly and brief minutes recorded. Assurance systems and actions taken to improve performance were not all seen to be discussed. Clinical governance provided information

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into divisional board meetings. The governance systems included the ED Directorate Meeting, four hour meeting and review the issues on a SMART action sheet with local commissioning group every week.

- As of October 2015 psychiatric liaison attended the meeting to provide updates and feedback about support provided in the emergency department.
- There was a programme of audit which was included in patient flow board minutes. The minutes in January 2016 noted the trust's poor performance and identified action was needed at a pace. Insufficient attention and priority was given to using audit as a tool to identify shortfalls and to improve performance.
- An emergency department target breach report was produced every day. Breach meetings were held weekly with the performance team, operations manager and the emergency department senior team to look at trends and incidents. As a result staffing was being tailored to busier times of the day, with later consultant cover planned.

Leadership of service

- Local leadership was managed by three lead roles. The emergency department operations manager, the emergency department clinical lead and the emergency department matron. The clinical lead tried to meet regularly with the medical director but this was not a formalised process to provide a routine overview.
- Divisional leadership was evident when the escalation process was activated and staff confirmed their input was regular.
- We were told about a safety walk-around by management with the on-call director spending four hours each weekend in the hospital. We asked the emergency department staff and they were not aware of this. Staff were unaware of the executive board visiting the emergency department but had appreciated a visit from the Chairman on Christmas Day.
- We observed an enthusiastic service but because of the ongoing pressures in the emergency department staff felt the changes needed were beyond their control. This had a poor effect on staff, with many staff feeling the department was unsafe and unable to effect change. Staff told us these issues had been raised for several years without any improvement action.

- Staff spoke in positive terms about the changes implemented by the recently appointed matron. Staff felt listened to and were keen to embrace a development in the service.

Culture within the service

- The trust told us their staff aimed to deliver a first class service to everyone they met. The WOW Awards were a way of recognising hard work, staff 'going the extra mile' and the commitment staff provided. They provided an opportunity to publically say thank you to staff in the workplace, and then share that recognition with patients and on the internal and external websites so that everyone knew they were always striving to be the best in whatever they did.
- Staff told us the support they provided and received from their colleagues in the department helped them cope with the pressure which resulted when the department was very crowded. They felt the stress in the emergency department was not being recognised in the wider hospital.
- Staff told us the culture of the department was open and they felt able to raise any issues or concerns they had.

Public engagement

- The Blue Shield awards were designed to give public recognition to the hard work and dedication of people in Torbay and Southern Devon, whose work helped to improve the lives of users of health and social care services. Nominations could be submitted by staff, service users, carers, patients and their families for those teams and individuals who they felt had made a real difference in health and social care in Torbay and Southern Devon.
- Volunteers were seen in the emergency department both mornings and afternoons but not in the evenings. They went around the department periodically offering tea and coffee and talking to visitors. They checked with staff that this was appropriate to do so.

Staff engagement

- Staff understood the trust's whistleblowing policy. They told us that they felt able to raise concerns within the trust and were confident that action would be taken.
- Staff felt they could raise any good ideas or ideas for development of the service. They said that Matron was open and appreciative of input.







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- 'See something, say something' was an initiative staff were aware of. They told us they felt able to see something both positive and negative and speak up about it.

Innovation, improvement and sustainability

- 'What is The BUZZ?' was an education channel using innovative WebTV technology to deliver anytime, anyplace training. The education team were at the forefront of digital learning; the WebTV channel, was delivering new experiences for staff in the acquisition of knowledge and skills development.
- Hiblio was a WebTV channel from the innovators at Torbay and South Devon NHS Foundation Trust. It was the first of its kind in the United Kingdom using this type of technology. The service was simple to access and presented viewers with credible information about health, wellbeing and lifestyle - with an emphasis on living well.
- The implementation of a nurse-led rapid assessment and treatment system had reduced delays in the handover of ambulance patients.

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Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

The Medical Directorate provides medical care services at Torbay Hospital.

Acute medical services include five inpatient wards, two cardiac catheterisation laboratories, one stroke unit, an acute respiratory unit, a bronchoscopy service, a 24 hour a day, seven day a week percutaneous coronary intervention and diabetes services and a fully integrated heart failure and arrhythmic team. The directorate also manages an endoscopy unit, an oncology day unit and the Torbay Assessment Investigation and Rehabilitation Unit. Two wards are dedicated to healthcare for older people and there are two wards available for capacity escalation. A surgical ward also has beds available for medical patients. There are two emergency assessment units (EAU) and an acute medical unit, which is used for ambulatory care.

Medical services treated 35,300 patients between July 2014 and June 2015. 55% of these were day cases, 43% were emergency admissions and 2% were elective admissions. The majority, 42%, of patients were seen in general medicine with 22% seen in gastroenterology and 12% in clinical oncology.

During our inspection we visited all of the medical care areas, including two wards used for medical outliers and two escalation wards. To help us understand the quality and safety of medical care services, we spoke with the senior executive and leadership team responsible for this directorate as well as 15 doctors, three matrons, 21 nurses and healthcare assistants and 12 other healthcare

professionals. We also spoke with 33 patients, observed care in all clinical areas and looked at over 85 individual pieces of evidence including 27 prescription records and 30 care and treatment plans.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care, including elderly care, as requires improvement because:

- The frequent and routine use of medical escalation wards and outlier beds meant patients did not always have access to timely or appropriate medical reviews from doctors.
- The numbers of registered nurses on medical wards regularly fell below the safe minimum number established.
- We found shortfalls in the compliance of some medical wards with fire safety guidance.
- Access and flow issues meant a number of patients were transferred or discharged overnight and a low discharge rate from the emergency assessment unit meant patients were often treated unnecessarily in these units.
- There was a lack of coherent working between the senior team who were responsible for 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.
- There was a coherent leadership structure in place in the directorate. However, we did not find evidence this had an impact on the access and flow issues we identified. This included the number of out of hours discharges and patients being treated on an extended basis in escalation wards.

However:

- We found staff at all levels of the directorate were passionate, committed and engaged in the development and improvement of medical services through responding to feedback from patients, visitors and staff and from the results of local and national audits.
- Evidence-based care was embedded in the practice of the clinical teams we spoke with and observed. This was reflected in the hospital's performance in referral to treatment time targets and some elements of the Sentinel Stroke National Audit Programme.
- Robust and consistent multidisciplinary working was evident throughout the medical services and

included daily safety briefs, cross-specialty clinical meetings and a service strategy that aimed to improve care pathways between the hospital and community services.

- Patients we spoke with were unwaveringly positive and enthusiastic about the care they had received and we observed numerous instances of staff providing individualised, highly compassionate care including when breaking bad news. Friends and Family Test results substantiated these findings as it was frequently found 100% of people who took the survey would recommend medical services.
- Clinical staff were encouraged to undertake innovative projects and implement service improvement strategies that resulted in improved patient care and treatment, particularly in oncology services. Senior managers and clinicians were aware of the pressures on the service caused by nurse staffing vacancies and had implemented strategies to address this. These included the recruitment of international nurses and the development of existing unqualified and student nurses.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We rated the medical services including elderly care at Torbay Hospital as requires improvement for safe because:

- Nurse and medical staffing of 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
- Training of nurses in safeguarding was below the trust standard in all wards we checked
- There was a lack of consistency in the completion of patient notes in relation to illegible staff signatures and missing staff designations
- Staff did not always adhere to guidance from fire risk assessments that exits should remain free from obstructions and not all staff could explain how they would evacuate effectively.
- There was inconsistent compliance with trust hand hygiene and infection control policies, including by junior doctors during a ward round

However, we found a number of areas of good practice during our inspection.

- There was a well-established incident reporting system, which most staff told us worked well to inform the improvement of practice.
- Staff we spoke with had a good understanding of the Duty of Candour and were able to explain how this applied to their work.
- A daily safety briefing on medical wards included identification of key assessed risks, including those relating to safeguarding. A multidisciplinary team attended the briefings and we saw they worked in practice to ensure patient risk assessments were up to date and acted upon. Medicines were stored according to national guidance and staff demonstrated a good working knowledge of requirements around this.
- Nurses and doctors described a positive and collaborative working environment that contributed

actively to safe patient care. Nurses had access to specialist training on request and were able to adapt their professional development to their specific area of work, such as in non-invasive ventilation.

Incidents

- Staff used an electronic incident reporting system to complete and submit incidents. Between November 2014 and October 2015, Torbay Hospital reported 1512 clinical incidents in the medical division. This was 263 fewer incidents than in the year prior to this.
- There had been 18 serious incidents reported in the directorate between October 2014 and September 2015. We looked at the investigations of a sample of serious incidents and found staff used the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation to improve practice. Senior clinical and operational staff formed a root cause analysis team for each incident and conducted a systematic and robust investigation of the incident. Seven serious incidents were related to slips, trips and falls, five were related to pressure ulcers, three were related to infection control, one related to venous thromboembolism and one was a medicine error. One serious incident was yet to be allocated to a category.
- Staff understood their responsibilities to raise concerns, record safety incidents and near misses and to report them internally and externally. However, learning from clinical incidents was not always consistently disseminated.
- All nurses we spoke with described an open culture of incident reporting, which meant staff felt confident and supported to report practice they felt could be improved or posed a risk to patient safety. For example, a nurse on Simpson ward told us because of the nature of the care provided on this ward, there was usually a large number of patients at risk of falls. This was always reflected in care plan risk assessments and staff used information from incident reports to try and prevent future falls. A physiotherapist told us they had been encouraged to complete incident reports when necessary and told us they felt involved in the investigation of incidents relating to mobility and falls. Although staff told us they felt confident in reporting incidents, not all staff felt they were listened to. For example, one nurse told us they submitted an incident report after a violent patient was admitted to their ward from the emergency department

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without a handover taking place about known risks regarding the patient's behaviour. They said the incident report was read by the senior team but they felt it was not investigated or acted upon. One patient on Elizabeth ward had raised concerns about how many times they had been moved between wards. Staff raised this as an incident, which resulted in a flag being placed on the electronic patient tracking system to prevent the patient being moved again unless it was clinically urgent.

- Staff told us the open reporting culture included medicines errors. We saw staff on Dunlop ward maintained a safety briefing folder relating to this. We found an example of a medicine error made by a newly qualified nurse. We saw the individual had been supported by the matron, retrained and a reflective exercise completed to look at contributing factors to the mistake. Despite this three nurses we spoke with told us feedback from incidents regarding medicine errors was poor. They said they did not feel included in any learning that had taken place.
- Staff on an escalation ward told us they had previously submitted an incident report relating to a delay in obtaining a medical review from a registrar during a weekend. They told us they tried to submit an incident report whenever this happened but they were so busy sometimes they did not have time.
- A nurse had identified a trend relating to the number of incidents with heparin injections. Along with a junior doctor, they designed a heparin nomogram for use across the trust. A heparin nomogram is a method of monitoring infusions that improves anticoagulation measures. This enabled staff to use a more robust way of maintaining heparin infusions and anticoagulation measures.
- An advanced nurse practitioner on the Ricky Grant oncology day unit showed us how learning from a prescribing error had taken place. A pharmacist issued expensive chemotherapy for a patient whose consultant had decided to stop treatment on the same day. This meant the chemotherapy was wasted. The incident was reported appropriately and staff discussed this at a monthly chemotherapy and cancer meeting. As a result, a letter was sent to all oncologists reminding them of the importance of effective communication with pharmacy. The problem had not recurred.
- We saw staff conducted a root cause analysis following an incident that resulted in harm. They disseminated learning through staff meetings, daily safety briefs and clinical education sessions.
- The electronic incident reporting system included guidance for staff in the use of the 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 be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. We found in cases where this needed to be used, the matron and senior nurse responsible for the area in which the incident took place would gather information and contact patients and relatives.
- An acute medical consultant attended a monthly mortality and morbidity meeting. A consultant and a junior doctor told us medical cases were frequently discussed and they felt learning was identified and implemented into daily practice. We spoke with a matron about this and found they attended M&M meetings if an investigation had involved one of their wards or units of responsibility. Ward staff were also invited if they had been involved in the treatment of a patient who had died. A meeting took place for the death of every patient with diabetes who had died to review how staff put their specialist training in relation to diabetes care into practice. However, we were not able to identify who attended these meetings or how information was disseminated because meetings were evidenced using PowerPoint slides rather than with traceable, documented minutes. We asked for this information after our inspection. Mortality and morbidity meetings since October 2015 had been conducted as presentations or education sessions and attendance and outcomes were not minuted. Specialist staff who were experts on subjects such as the Duty of Candour, cancer and vascular access and mental capacity had led education sessions. However, staff had not recorded evidence of learning, discussion, multidisciplinary working or the outcomes from the meetings. This meant it was not possible to identify the improvements to practice made as a result of mortality

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and morbidity meetings. Each medical specialty performed its own M&M meeting process, but minutes and records of attendance were not consistently recorded.

Safety thermometer

- In the 2015/16 year prior to our inspection, 97% of care in medical wards had been harm free.
- All medical wards participated in safety thermometer reporting and the results were visible at the entrances of the wards on display boards, with the exception of Warrington and Elizabeth wards where this data was not displayed. We saw staff regularly collected safety data and displayed this. Where areas for improvement were identified, this was also outlined, such as in the need for improved documentation around catheter care. We asked staff on Warrington and Elizabeth wards about this. They told us because there was no consistent permanent nurse leadership in these areas, no-one led on the collection of safety thermometer data.
- From September 2014 to September 2015, staff reported 21 pressure ulcers in medical patients, 20 falls with harm and two catheter-acquired urinary tract infections. This represented a significant and sustained improvement from the previous year, during which 77 pressure ulcers, 167 falls with harm and 32 urinary tract infections had been recorded.
- Staff displayed a safety cross on Warrington ward to show the number of days of harm-free care and highlight any incidents relating to pressure ulcers, falls and short-staffing. Similarly, staff displayed a pressure ulcer collaborative working board on Dunlop ward.
- Other medical wards displayed safety thermometer information in staff-only areas; although we were told visitors could view this on request at any time.

Cleanliness, infection control and hygiene

- Ward areas were generally clean and we saw a cleaning and housekeeping team worked continually to maintain this. However, our observations showed areas in which staff could more robustly ensure prevention control measures were adhered to, particularly with hand washing. Hand washing audits were being completed and we were told compliance had improved from 87% in October 2015; however, we did not see the audits to evidence this.
- Staff used 'I'm Clean' stickers and clinical tape to indicate when an item had been cleaned and

disinfected. We saw staff used this procedure consistently, although found it did not apply to some types of equipment. For example, we saw two blood gas machines on Cheetham Hill ward were ready for use but staff told us local policy did not require 'I'm Clean' stickers on this type of equipment.

- Not all medical wards were compliant with the European Waste Framework Directive (2008/98/EC) or the HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 because sharps bins were not always stored appropriately. For example, we found a sharps bin in a sluice room on Cheetham Hill ward that was unlabelled with the aperture on the lid open and did not have an assembly date recorded.
- Antiseptic solution and lotion soap were stored in a fireproof safe in an equipment cupboard on Cheetham Hill ward. This included two bottles of surgical scrub labelled with the names of patients, one of which expired in December 2015 and another in January 2015.
- The fireproof safe was overfilled and could not be sealed. This meant there was a fire risk due to the improper storage of flammable liquids.
- We looked at the storage of cleaning chemicals on Cheetham Hill, Simpson and George Earle wards and found this to be compliant with Control of Substances Hazardous to Health (COSHH) guidelines.
- We found antibacterial hand gel at the entrance to most clinical areas, with notices displayed to remind staff and visitors to use this before entering the area. On one ward, there was no antibacterial gel at the entrance but a sink and hand-washing soap was provided with a notice instructing staff and visitors to use it. On wards with inpatient bays, we saw antibacterial hand gel was available on a per-bay basis.
- Staff adherence to the trust infection control policy regarding hand hygiene and bare below the area was inconsistent. For example, during our inspection on EAU4, we saw one member of non-clinical staff did not use the antibacterial gel when they entered the unit. During our observation of a post take ward round on EAU4, the consultant did not wash their hands before the ward round but did so between patients. During this ward round, a junior doctor demonstrated poor hand hygiene and did not wash their hands between each patient. In addition, one junior doctor on this ward round was not bare below the elbow. A doctor did not clean their stethoscope between patient examinations, including after examining a patient with a possible

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infectious condition. This practice was not challenged by the senior member of the team. These issues meant patients were not always protected from the risks associated with poor infection control because staff did not systematically follow best practice guidance.

- One nurse on George Earle ward did not take their gloves off between working in the medicine room and dealing with a patient.
- Hand hygiene audits were conducted on a monthly basis in all medical clinical areas. The results were communicated to senior staff to improve subsequent results. For example, in October 2015, Dunlop ward was found to be 75% compliant with the trust hand hygiene policy because a consultant and a physiotherapist were observed not washing their hands appropriately. The results were distributed to consultants and physiotherapists with a reminder of the guidance and standards to be followed.
- Staff displayed the latest available results of infection prevention and control audits at the entrance to each acute medical ward. Information on display at the entrance to Simpson ward indicated 67% compliance with peripheral line on-going care, 33% compliance with urinary catheter care bundles and 100% compliance with hand hygiene procedures. Where the result was found to be below 100%, causes of this were identified and displayed.
- In the 2015/16 year prior to our inspection, the trust reported nine cases of Clostridium Difficile (C.Diff) on medical wards.
- We looked at the daily cleaning schedules for toilets and showers on six medical wards and found them to be completed twice daily for the month prior to our inspection.

Environment and equipment

- We checked the resuscitation equipment on Cheetham Hill, Elizabeth, George Earle and Simpson wards and on EAU3 and EAU4. We found staff documented daily checks on the equipment and substantiated this with a weekly check. Routine checks included: a test of the ECG machine and secondary back-up power, a defibrillator test and inspection, and an inspection of cables, paddles, monitoring electrodes and charged batteries.
- The coronary care unit was spacious, well-kept and offered patients a pleasant ambience. Care of the elderly wards were cramped, with bed bays often

crowded. During our observations we saw it was difficult for people and staff to move around as a result and staff maintained extra vigilance to try and protect patients from falling or tripping. Warrington ward was in need of significant refurbishment and repair to the environment, including a lounge with a collapsed radiator cover and damaged and dirty furniture. This lounge also contained dirty equipment, including hoists but was also unlocked and available for use as a quiet day room. It was not a safe environment for patients with a mobility restriction due to the number of trip hazards and there was no clear infection control strategy for non-clinical areas.

- The Ricky Grant oncology day unit had a well thought out, patient-influenced design that supported the efficient running of the unit. Past patients had been asked about the design of the unit, which was reflected in the bright and airy environment and open layout.
- A senior nurse on Cheetham Hill ward told us the hospital's medical device service provided rapid support to staff. They said, "I can't praise them enough. If we need pumps, syringe drivers, anything...they're [staff] up here usually within 30 minutes. It's a really good service; they're especially helpful in getting air mattresses for us."
- Staff on Midgley ward, a respiratory ward, were able to provide care and treatment for patients who needed non-invasive ventilation and the use of a Bi-PAP machine.

Medicines

- We reviewed medicine storage, prescribing procedures and pharmacy cover on Warrington, Dunlop, George Earle and Cheetham Hill wards.
- Medicines were stored securely in locked cupboards, fridges and medicine trolleys. Medicines were kept in secure rooms along with intravenous fluids. All of the medicines we checked were within their expiry date and stored according to a robust stock rotation system. On George Earle ward, patients' own medicines were kept in lockers and administered by nurses as per the prescription chart.
- We observed six patients receiving medicines and found the process to be safe and comprehensive. Two members of staff administered controlled drugs. Stocks of controlled drugs were well-managed, with low, accurate stock levels that were checked regularly.
- Access to medicine storage rooms on medical wards was restricted to substantive ward staff. This was a

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safety policy designed to reduce the instances of medicine errors as well as to prevent unauthorised access to medicines. Healthcare assistants we spoke with told us this system often resulted in delays in accessing medicines, particularly when large numbers of agency or bank staff were on shift.

- Doctors we observed on all medical wards followed national guidance and best practice when prescribing intravenous antibiotics.
- However, staff did not always follow trust policy on the refrigeration of medicine. Whilst current, maximum and minimum temperatures were recorded on the correct register in the majority of areas, we observed deviations outside of the recommended temperature range (2 to 8°C) and actions were not always recorded. For example, we saw temperatures at 9.1°C, 1.3°C and 9.7°C. Staff told us they took action to correct the problems but this was not recorded. Therefore, we were not assured effective monitoring processes were in place to ensure practices for the safe storage of refrigerated medicines kept people safe.
- Staff were using thermometers incorrectly and training had taken place to ensure temperatures were recorded properly.
- An electronic prescription system was in place, which we found was comprehensive and clear. The system helped to reduce the risk of medicine errors and enabled staff to prescribe consistently and accurately.
- We found a low incidence of missed doses seen on inpatient prescription charts, with an annotated explanation in 14 of the 17 records we looked at. Medicine reconciliation and pharmacy staff advice was documented in 15 of the 17 records we looked at, which helped to ensure patients received the right medicines.
- A multidisciplinary team formed an antimicrobial stewardship team who were responsible for ensuring clinicians, pharmacists and nurses adhered to the trust antimicrobial prescribing policy. This ensured staff prescribed antimicrobial medicine according to national best practice guidance.

Records

- We looked at the care records of 30 people to see if they were managed and written in a way that kept people safe. We found inconsistencies in the use of risk assessments and care plans for use at the weekend. Staff names were frequently illegible. This meant it was not immediately clear what the name or profession of

the doctor was who had signed the records. For example, in 13 of the 17 patient records we looked at on Turner ward, staff names were illegible and nurses were not able to recognise signatures. Of these records, only seven members of staff had recorded their bleep number. This meant it was not possible to trace the member of staff and it was not possible to identify if a nurse or associated health professional had made some entries.

- We looked at three records of patients who were medical outliers in Forrest ward. A medical outlier is a medical patient being cared for outside of the main medical wards, usually due to a lack of capacity. For each person, staff had completed a food and fluid chart, a waterlow risk score, a physical assessment and risk assessments relating to falls and bed rails. Two patients had an individualised nursing care plan in place, which staff had reviewed regularly. One patient had a care plan in place following their admission to Forrest ward but this was not individualised and was based only on clinical evaluations on admission.
- We looked at three prescription sheets of patients on Midgley ward who were receiving additional oxygen therapy. In all cases the prescriptions were written correctly but the signature of the prescriber was illegible.
- Where a patient had been admitted from the emergency unit, the medical records system did not require the receiving doctor to record their name. In four examples we looked at on Warrington ward, doctors had recorded their name but not the time of their admission assessment and one name was illegible. We found this caused difficulties for GPs when patients were discharged because they could not identify the clerking doctor or the time of the patient review.
- Colour-coded weekend review sheets were available for use by doctors who reviewed patients on a Friday prior to the weekend. We saw these in use on Turner ward and found the doctor completed a summary of the patient so anyone caring for them at the weekend could identify all of the key points about their care and treatment immediately and in one place. However, we looked at the records of four patients on Forrest ward during our unannounced inspection. We found weekend treatment plans to be missing or out of date in all of these records.
- Doctors used a post take ward round recording sheet to document each patient review. We saw during a ward

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round on EAU4, page numbers were clearly labelled and the documents were signed, although not all legibly. The recording sheet included prompts for doctors to consider end of life care and venous thromboembolism assessments and we saw documentation of catheter insertions was completed accurately. During a ward round on EAU4, we saw doctors did not clearly flag the use of sepsis bundles in patient notes.

- Ward managers conducted monthly documentation audits on the completion of patient records as well as on records required by staff, such as incident reports and discharge notes.

Safeguarding

- During all of our observations of ward rounds, board rounds and multidisciplinary meetings, we found staff demonstrated a thorough understanding of safeguarding. For example, during a multidisciplinary meeting on Simpson ward, staff discussed how to ensure patient best interests after discharge, including liaising with a nutritionist where a person was at risk of malnutrition and the most appropriate way to speak to the family of a person who had become increasingly confused.
- Nurses we spoke with on medical wards were able to tell us confidently about their role in safeguarding issues. For example, a nurse on Simpson ward told us they contacted a safeguarding link nurse when they were concerned about some visitors attending the ward with children. They also showed us the safeguarding link nurse was contacted whenever a patient was admitted with pressure sores. One nurse said they thought the safeguarding training was adequate and could be improved if it included information on supporting patients who were living with dementia that manifested itself through violent behaviour.
- Where staff found a safeguarding concern during a complaint investigation, this information was added to the patient's notes. This meant staff could identify patients who had previously been at risk in the hospital.
- However, staff in medical services were not fully compliant with the trust's mandatory safeguarding training target of 90%. 81% of staff in the medical division had up to date safeguarding children training and 86% had up to date safeguarding adults training. Whilst all nursing staff on Cheetham Hill ward had undertaken adult and child safeguarding training to level one as a minimum, only 65% had up to date

safeguarding adults level two training. Training records for nursing staff on George Earle ward indicated only 30% of staff had up to date adult safeguarding level one training and 50% of nursing staff on Simpson ward had this training. We spoke with the matron and a senior sister about this. They said the lapse in some training had resulted from a prolonged period of operating at full capacity without a full complement of staff. We saw staff training schedules, which demonstrated all staff would have up to date training in the following 12 months.

Mandatory training

- Mandatory training compliance fell below the trust internal targets. The trust had a minimum staff training target of 80% in infection control, fire safety, health and safety, conflict resolution, manual handling and equality and diversity. The target had been exceeded in all areas except infection control (78%) and manual handling (78%). The minimum training target for staff in information governance was 95%. 84% of staff in the directorate had up to date training in this area.
- Mandatory training for healthcare assistants, nurses and other health professionals working permanently in the trust, such as physiotherapists, included safeguarding, moving and handling, fire safety, security and infection prevention and control.
- A band five nurse we spoke with told us e-learning was difficult to access because wards were so busy and they could not access it from home. The nurse told us they tended to come in during time off to complete this training. Another band five nurse said, "The e-learning is not good. It's difficult to use and not very understandable. I've never been shown how to use it." A band four nurse told us they had previously had to complete their training on their days off. A senior nurse told us protected time was sometimes given for training but this was not guaranteed as nurses could be reallocated at short notice in the event of short staffing.
- 80% of nurses on the respiratory ward had up to date mandatory training.
- Only 12 nurses between Cheetham Hill, Simpson and George Earle wards had 100% compliance with up to date mandatory training. We saw some staff were sick and some were on maternity leave. Low numbers of

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staff had impacted the ability of nurses to keep up to date with mandatory training requirements and we saw senior nurses and the matron were supporting them to improve this in the coming months.

Assessing and responding to patient risk

- Staff used the National Early Warning Scores (NEWS) system to identify patients who were deteriorating. This was recorded in all of the patient records we looked at. During a board round on EAU4, we saw a critical care outreach nurse was present and able to assess a deteriorating patient within 20 minutes of the decision being made. Staff routinely informed the critical care outreach team when a patient with an acute kidney injury was admitted to a medical ward.
- During a post take ward round on EAU4, we saw the consultant checked all six patients for their venous thromboembolism status and acted quickly when they noticed a patient who needed anticoagulants. In 16 of the 17 prescription records we checked, allergies and venous thromboembolism risk had been documented. 'Venous thromboembolism' refers to a blood clot in a vein.
- Staff discussed patient risk during our observation of a multidisciplinary meeting on Simpson ward. This included the risk of social isolation after discharge and staff concern about a person's change in behaviour after a planned procedure had been cancelled. We found two patients had been recorded at high risk of falls but noted this risk was not discussed during the meeting.
- Staff on Simpson ward used a risk assessment booklet to document routine mobility and bed rail assessments.
- A daily morning safety briefing took place on acute medical wards, which enabled night staff to brief day staff on any patients who had experienced a fall or who had deteriorated. We observed the safety brief on Simpson ward and found it to be thorough and well-documented. Staff included new admissions, urgent medical reviews, falls incidents, deteriorating patients, pressure ulcer risks and patients being cared for under barrier nursing practices in the discussion.
- Staff on acute medical wards used a system of 'intentional rounding'. Healthcare assistants led this process, which involved hourly or two-hourly recording of key safety checks such as if the patient could reach the nurse call bell and if they were wearing non-slip slippers. Assessments of continence, pain and comfort, hydration and positioning in bed were included. We saw

this process was designed to reduce the number of preventable incidents in ward areas but was not always documented consistently. For example, we found gaps in recording of several hours on Warrington and Dunlop wards.

- We observed a nurse handover on Cheetham Hill ward and noted medical reviews were prioritised based on assessed risk. Where a patient had been admitted without a falls risk assessment, a nurse was assigned to this immediately.
- We looked at the weekend treatment plans of four patients on Forrest ward during our unannounced inspection. The plans did not always contain information to help staff manage risk. For example, in the records of one person, a doctor indicated the weekend plan was to continue their intravenous medicines and review again on Monday. Ward staff told us they were concerned by this because the patient had been poorly and their treatment plan had not been updated. A nurse in charge on Warrington ward told us they did not use blue weekend treatment plans on this ward. However, we found one patient had a plan in situ, although this was out of date. A nurse in charge on George Earle ward told us patients did not have separate weekend risk assessments.
- We found staff on Cheetham Hill ward completed a skin care bundle and risk score for every patient within two hours of admission. This was part of a project to prevent pressure ulcers. A similar project on Dunlop ward led to a period of two years with no new pressure ulcers. There had been two recent pressure ulcers reported, which we saw staff were investigating using a root cause analysis process.
- We found medical patients were sometimes cared for on Turner ward, which was primarily for oncology patients. A junior doctor and senior nurses were able to provide care and treatment and could call a consultant from the 'buddy ward' to ask for a review if needed.
- All nurses and healthcare assistants attended a daily safety brief on Simpson, Cheetham Hill and George Earle wards. This ensured staff were aware of deteriorating patients or those who needed additional care and monitoring due to a safety risk.

Nursing staffing

- Nurse staffing levels according to the established requirement in medical wards was inconsistent and fluctuated significantly from month to month. Although

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the average staffing level during the previous 12 months indicated a low deviation from the established safe nurse requirement, some individual wards recorded much higher levels of deviation at times. Senior staff told us they had not identified an overriding cause of the shortfalls in staffing, other than local sickness absence and staff turnover.

- We looked at the planned and actual registered nurse staffing levels for nine medical wards and units. From October 2014 to October 2015, the average nurse staffing levels for all areas was consistently within a +/-5% deviation from the planned numbers. The numbers of clinical support workers, such as healthcare assistants, had been consistently greater than planned and in every month at least 18% higher than the planned number of staff. Dunlop, George Earle and Cheetham Hill wards had recorded the greatest deficit in registered nurse staffing compared to planned numbers. For example, from October 2014 to October 2015, George Earle ward had been staffed by at least the minimum planned number of registered nurses in only one month. For four months in this period, a nurse deficit of 20% had been recorded. During the same period, Cheetham Hill and Dunlop wards each recorded a 25% deficit in registered nurses against the established plan on at least one occasion. EAU3 and EAU4 had reported smaller nurse deficits and had met the established nurse required on at least three occasions each. Nurse staffing on Turner ward had been at or above the established safe minimum staffing level every month between March 2015 and October 2015, with up to 30% more nurses available than required as a minimum. The trust recognised the need to extend this work across all inpatient areas, including specialist areas and invested in a full time band 8 Associate Nurse Director for Professional Workforce and a full-time band 6 Service Improvement Lead to complete a comprehensive review of nurse staffing across all areas.
- Nurse staffing on Forrest surgical ward was impacted by two whole time equivalent vacancies and nurse staff sickness. This meant up to 25 patients, up to 10 of whom could be medical outliers, were cared for by five trained nurses and three healthcare assistants during weekday daytimes. At the weekend during the day there were four trained nurses and three healthcare assistants on shift and during the night there were three trained nurses and two healthcare assistants. A nurse with tracheostomy training was scheduled on each shift.
- The Royal College of Nursing recommends in lieu of a national standard for nurse to patient ratios in general medical wards, skill mix be reviewed regularly by senior staff to ensure patient safety is maintained. We found the skill mix of nurses on Forrest ward to be adequate but there was additional pressure associated with the mix of medical and surgical patients.
- Nurse staffing on Midgley ward had recently improved with the successful appointment of five new registered nurses, which had left only one whole time equivalent vacancy. This ward cared for up to 28 patients and was staffed by five registered nurses and four healthcare assistants during the day and three registered nurses and two healthcare assistants overnight. The ward could care for up to four patients receiving non-invasive ventilation using a Bi-PAP machine overnight. Where this had been the case, we found the ward manager had secured enough agency staff to ensure ward staffing levels were compliant with guidance issued by the British Thoracic Society, Royal College of Physicians and Intensive Care Society guidelines.
- There was a significant reliance on agency and bank nurse staff to fill vacancies on escalation wards. The ward sister for Warrington told us this ward was sometimes staffed predominantly by agency or bank staff overnight. Elizabeth ward, a discharge lounge used as a medical escalation ward, did not have any substantive registered nurses allocated on a permanent basis. During our inspection we saw this was staffed by substantive nurses who were redeployed from other areas and agency and bank staff. This ward had one permanent HCA and a nurse from another ward had been trained to act as a regular ward clerk. One nurse told us "We get moved a lot to these [escalation] wards. It's not ideal but we all chip in." Where an escalation ward was planned to be staffed solely by agency nurses, a substantive registered nurse would be redeployed from a ward. However, bank nurses working on the escalation wards were considered to be substantive hospital staff and were able to work without the supervision of a permanent nurse.
- We spoke with a band five nurse on Cheetham Hill ward who told us there was a cohesive working relationship between permanent nurses and bank nurses. They said,

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“Bank nurses want to come back and work here, we see the same people a lot. I used to be a bank nurse and came here to work permanently because I liked it so much.”

- Nurses we spoke with were positive about the training opportunities available to them. One band five nurse told us the trust had funded some undergraduate degree modules for them, which they felt had positively influenced their practice and development, particularly in their care of patients with dementia. Another nurse had been supported to complete a critical care course, which meant they could provide support to colleagues treating patients who were deteriorating.
- We looked at the nurse staffing levels on four medical wards during each day of our inspection and for the month prior to this. We found nurse staffing levels met the established need based on the acuity of patients and there was always a registered nurse coordinator on shift. On the escalation wards, established nurse staffing levels were met by agency and bank nurses with support supplemented by moving nurses from other wards. Nurse staffing levels on Cheetham Hill and Simpson wards met the identified minimum numbers established to run the wards safely. However, nurse staffing on George Earle ward did not meet the established requirement and the matron had begun to work with a safer staffing initiatives team to identify areas to improve practice whilst awaiting new nurse recruitment. As an interim measure we saw nurses were allocated overtime shifts and agency nurses supplemented the permanent team. This enabled the ward to be staffed at establishment level.
- A senior nurse on a care of the elderly ward told us low staffing levels often affected how they felt about continuity of care but it never impacted safety. This meant patients were cared for safely but did not see the same staff each day, which can be unsettling for people with short term memory loss or dementia. The senior nurse in charge of each ward was responsible for checking actual nurse staffing levels 24 hours in advance. Where a shortfall was identified, the matron would identify areas from which nurses could be redeployed.
- On Cheetham Hill ward, a band four practitioner was counted as a registered nurse in the staffing levels and we saw this individual was deployed appropriately

based on skills and competencies. We found healthcare assistants were able to provide personal care and additional one-to-one support on care of the elderly wards.

- The trust recruited nurses internationally to address shortfalls. Nurses we spoke with gave positive feedback, particularly around the good English language skills of international nurses.
- Nurses provided one-to-one care for post-thrombolysis patients on George Earle ward. These were patients who received medicine to disperse a blood clot following a stroke. Where staffing levels could not guarantee this ratio, patients were transferred to critical care or the coronary care unit to ensure they received appropriate treatment.

Medical staffing

- Torbay hospital medical services employed 151 medical staff. Of this figure, 39% were consultants, 8% middle career doctors, 30% registrars and 24% junior doctors.
- A stroke specialist consultant based their time 50% in the acute medical unit and 50% in care of the elderly wards. The consultant was supported by three stroke physicians and 4.5 geriatricians, two of whom were qualified in ortho-geriatrics. Two geriatricians operated an outreach clinic in a community hospital to help reduce the need for hospital admissions.
- Medical consultants looked after patients on Forrest ward, which was a surgical ward with the capacity to care for medical patients, called outliers. The clinical lead for medicine told us consultants caring for patients in this area used a buddy system to make sure regular reviews took place. However, the nurse in charge on Forrest ward told us this was not the case and the system stopped when a care of the elderly consultant left the hospital.
- On Forrest Ward (a general surgery ward) we found that out of the 25 beds, 13 were being used for medical patients. We were told it was difficult to manage the consultant base for the ward. During the inspection there were nine consultants managing patients on the ward from various specialities. Getting information from these consultants was sometimes difficult for nurses and we were told a theme on the ward was that the wrong consultant could be allocated in the emergency department making finding the correct doctor more time consuming.

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- The clinical lead for acute medicine described the difficulty the trust faced in recruiting doctors to acute medicine and care of the elderly services, which was also a common issue nationally. They told us recruitment processes were being reviewed to improve the trust's ability to attract new staff.
- We looked at the junior doctor duty rota for general medicine. This was staffed by one medical registrar, a senior house officer for patient take and a senior house officer to cover wards, with an additional doctor between 4pm and 2am to cover additional patient take. 'Patient take' means a doctor is assigned to the treatment of an individual patient, which is used to ensure the patient receives care from the most appropriate type of doctor. On a weekend, an additional junior doctor was available. Junior doctors told us medical cover on a weekend was problematic because of low numbers and meant they found it difficult to prioritise patients.
- A team of six cardiologists covered the cardiology care unit, four of whom were interventional, which meant they covered an on-call rota one week in four. Staff told us that in addition, each doctor had between 18 – 30 angioplasties per week, which was a significant workload. However, we did not see evidence of this being the case.
- A team of four oncologists covered Turner ward and the Ricky Grant day unit, which were used for oncology and clinical haematology patients. The workload was shared with an additional four oncologists who visited from another hospital as they also had inpatients on this ward. The lead clinician for oncology told us they were recruiting a consultant specialising in breast cancer. At the time of our inspection, the hospital had no registrars for oncology but an on-call consultant provided out of hours cover.
- We observed and asked about ward round arrangements on EAU3. We saw the consultant included patients in the post take ward round only after the acute physician had seen them. This meant at times there were two teams operating simultaneously. During the ward round we saw a physician assistant trainee and a junior doctor prepared patients for consultant review alternately. This process meant both staff developed their skills but we observed they did not always hear each other's presentation. There was some flexibility in the approach to ward rounds on EAU3 to ensure patients were seen as soon as possible.
- Medical staff on Allerton ward, a mixed gastroenterology and gastrointestinal medical and surgical ward, worked closely with surgical colleagues for patients being treated for inflammatory bowel disease. For example, consultant physicians completed a daily ward round and the consultant on call for bleeding also completed a ward round, seven days a week. The consultant surgeon completed a ward round on Mondays and Fridays, which we saw worked well in practice.
- Consultant cover on EAU3 and EAU4 was provided on-call from 8am to 6pm, with patient reviews taking place until 7pm. A second consultant was available from 2pm to 8pm.
- A consultant, a registrar and three junior doctors provided daytime medical cover for general medical wards. Overnight, three junior doctors and a registrar shared cover with additional support from the Hospital at Night team. On a weekend, medical registrars provided 1.5 whole time equivalent cover with four junior doctors. On permanent medical wards this cover was enough to provide appropriate care and treatment to patients. However, there was a lack of senior clinical input at weekends in some inpatient medical areas. Haematology, gastroenterology, cardiology and EAU had senior clinical cover during weekends.
- Warrington ward was covered by a junior doctor from 9am – 5pm Monday to Friday. Each patient on this ward was followed by their own consultant. The overall lack of medical cover on Warrington and Elizabeth wards was highlighted on the divisional risk register. The recommended action was to improve consistency in junior doctor cover to these areas and to cease the use of Elizabeth ward as an escalation area.
- There was a plan in place to establish two consultants for each sub-specialty in oncology and clinical haematology, which required an increase in recruitment to consultant posts.

Major incident awareness and training

- Fire safety knowledge and experience varied across the staff groups and wards. Not all staff we spoke with on the seven medical wards we visited were aware of the emergency procedures. The trust had a target of 85% compliance with fire training, but the medical wards were only achieving 80% compliance. We asked the nurse in charge on Warrington ward if they were the responsible person in the event of an evacuation. They said, "I suppose so." An HCA could not tell us what the

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evacuation procedure was and said they would "probably follow the nurse in charge." We were not confident staff working in this area had adequate training in the safe management of an emergency.

- Fire risk assessments and equipment checks were up to date, with records held centrally rather than locally. This led to some confusion because in some areas records were available locally, and staff were not always aware that updated records were available from a central point. We saw examples of incomplete records held locally, but the trust provided up to date records from the central database. For example, the trust's facilities team had identified several areas for immediate action following an audit in 2014, and this had been held locally. However, a further audit in 2015 was held centrally and showed improvements had been made but staff were not aware of this. This highlighted a need for improved communication and awareness of the correct process throughout the medical wards.
- A fire safety action plan from October 2015 highlighted the need for estates and facilities staff to complete the log book after each check of equipment on the ward. This action was due for review in November 2015 but had not been recorded as complete. The last dated inspection of the fire alarm panel, emergency lights, fire extinguishers and fire exits was dated June 2015.
- On Cheetham Hill ward we found one fire door was partially blocked. However, this was not a dedicated fire escape and the room had a second exit. The partial obstruction was caused by a large laundry trolley. A November 2014 fire risk assessment reported one end of the ward to be, "...extremely cluttered, evacuation in an emergency would be hindered." Although a further assessment one year later demonstrated corrective action had been taken, we observed staff did not follow this consistently. We raised concerns at the time to the ward and site managers.
- Evacuations sheets were available on Simpson, George Earle and Cheetham Hill wards. The matron for these wards told us all staff had been trained in their use and were aware of when to use them. We asked a nurse about this on Simpson ward, who told us they weren't aware the ward had evacuation sheets. A nurse we spoke with on Cheetham Hill ward was able to explain how they would use the evacuation sheets and said they had been trained to do so.
- Turner, Simpson and George Earle wards had named fire wardens with up to date specific training for this role. Midgley ward had three named fire wardens but there was no documentary evidence they had been trained in this role. The trust planned to identify and train a fire warden for each ward and to increase fire safety training to meet the trust's 85% target. Fire wardens are not mandatory roles, but are undertaken by staff on a voluntary basis to fulfil some fire safety tasks. Having fire wardens on a number of wards within the hospital is evidence of good practice.
- Nurses told us they had a good relationship with security staff. They said that out of hours there could be a delay security if the office was unmanned because they had to first contact the switchboard who would then contact the security officer. However, we were not given any specific examples and did not see any incidents of delays reported.
- The trust's major incident plan was stored on the intranet and accessible on every ward. However, some staff were not aware of how to locate this. A hard-copy major incident plan was available in all wards we visited, except for Warrington and Elizabeth wards. The hard-copy plans were not dated so it was not possible to ascertain if these were the most up-to-date versions. Staff told us they were aware of who would be in charge during a major incident but said they had not received recent training or practice in this.

Are medical care services effective?

Requires improvement



We rated the medical care, including elderly care, at Torbay Hospital as requires improvement for effective because:

- The medical wards did not meet the trust standard for nurse appraisals.
- There was not a clear and targeted management approach to caring for and treating patients on outlier wards.
- Recording of pain and the effect of pain relief was inconsistent.

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- The tool for monitoring a patient's risk of malnutrition was not always used correctly and staff sometimes found it difficult to obtain specific foods for certain patient groups.
- Results of the Sentinel Stroke National Audit Programme were variable. Some actions to achieve better results could not be achieved without a seven-day service, which we were told was not achievable in the short-term.
- Some staff had not received appropriate training to respond to violent or aggressive patients.
- Patient records did not always have a legible signature identifying the doctor responsible for the note entry.

However:

- A programme of clinical audits was organised by the directorate of education and development and a junior doctor presented weekly audit meetings.
- We found extensive evidence of cross-specialty multidisciplinary working, including with community services
- Evidence-based care was embedded into treatment pathways and staff showed us they had a good understanding of how to access policies and procedures to help guide their work
- Staff demonstrated a proactive approach to assessing mental capacity with the guidance of the Mental Capacity Act (2005) and to ensuring this was used to tailor the most appropriate treatment plan to each patient

Evidence-based care and treatment

- We observed ward rounds on EAU3 and EAU4 and found investigations were ordered promptly and appropriately, including endoscopy, computed tomography pulmonary angiography (CTPA) and ultrasounds. This is a diagnostic test used to obtain an image of pulmonary arteries. Junior doctors demonstrated how they accessed protocols and guidelines and told us they were very useful out of hours when there was fewer senior staff on site. During a ward round on EAU4, doctors did not conduct blood cultures before prescribing antibiotics for three patients. Best practice guidance indicates a blood culture enables doctors to prescribe the most appropriate medicine and

is part of the severe sepsis care bundle. The trust's antimicrobial prescribing policy requires doctors to obtain blood cultures prior to prescribing antibiotics as a prescribing standard.

- We observed a board round on EAU4 and found there was no action discussed for a patient who had undergone a CTPA the previous day. However, diagnostic results for other patients were discussed. This demonstrated an inconsistency in how diagnostic results were acted upon.
- On George Earle ward there was a thrombolysis audit folder, which included the outcomes of previous audits. Audits demonstrated thrombolysis practice was in line with NICE guidance.
- We observed numerous examples of effective, evidence-based care. For example, a multidisciplinary team of chest specialists and an ultrasound specialist delivered appropriate care to a patient being managed for a pulmonary embolism.
- The Ricky Grant oncology day unit was led by an advanced nurse practitioner. We found this unit had an efficient system for prescribing.
- Consultant physicians and consultant surgeons worked together on Allerton ward to ensure patients being treated for inflammatory bowel disease were cared for by medical and surgical physicians with evidence-based practice from their respective specialties.
- Physiotherapists on care of the elderly wards used the elderly mobility scale to assess risks associated with moving patients, which was used to plan their physiotherapy programme.
- A senior nurse on the respiratory ward showed us learning had taken place following recent audits on catheter care. This led to better documentation of safety and infection control checks.

Pain relief

- Patients we spoke with on Elizabeth and Warrington wards told us staff asked about their pain and offered them pain relief and during our inspection we saw staff routinely ask patients about levels of pain.
- Staff recorded a pain score in all 30 of the patient records we looked at. In three patient records we looked at on Forrest ward, staff assessed pain and recorded pain scores and indicated if paracetamol or analgesia had been given but had not recorded the effect of this. There was also inconsistent recording of the level of pain the patient had complained of.

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- A specialist pain team was available on call for medical staff to refer to.

Nutrition and hydration

- Staff used the Malnutrition Universal Scoring Tool (MUST) to monitor the weight of patients and implemented a food and fluid monitoring chart where there was a risk of malnutrition. However, staff did not always use this tool correctly. For example, on Dunlop ward we saw two patients had MUST risk assessments but neither had been dated. This meant staff would not know when the risk assessment had been undertaken or associated actions implemented.
- Each medical inpatient ward had a stock of supplements, snacks and puddings. Staff were able to call the kitchen for any special orders. A nurse on Simpson ward told us catering staff never refused a special request and were able to meet diverse patient needs. However, a nurse on Cheetham ward told us they struggled to order high-calorie food or food that was appropriate for patients living with dementia
- We observed breakfast on Simpson ward. Nurses and healthcare assistants offered to help patients who had difficulty feeding themselves and did so patiently and at an appropriate pace.
- Patients told us they had plenty of tea, coffee and water whenever they wanted. We confirmed this during our observations.

Patient outcomes

- The average ratio of actual readmissions to expected readmissions was better than the England average for the elective and non-elective patients from June 2014 to May 2015. This meant fewer patients than expected who were discharged were then readmitted with the same condition. This was an overall average and also applied to the readmission rates in general medicine, cardiology and gastroenterology.
- Readmission rates in clinical oncology and medical oncology were significantly lower than expected and better than the England average. In 2015/16, 7% of clinical oncology patients and 21% of medical oncology patients were readmitted within 28 days. The low figures were representative of the capacity to see patients as day cases and the support provided by a 24-hour, seven days nurse advice service.

- Patient outcomes were improved by the use of national audits to monitor and deliver care and staff sought accreditation from specialist bodies to demonstrate the high standards patients could expect.
- Medical outlier patients cared for on Forrest ward did not receive consistent medical reviews by consultants. On one day of our inspection there were 10 medical patients in Forrest ward, being cared for by seven different consultants. The nurse in charge told us medical patients on this ward were never included in morning visits or ward rounds from doctors.
- The endoscopy suite was accredited by the Joint Advisory Group on GI Endoscopy (JAG). This accreditation demonstrated the effectiveness of its endoscopy service.
- Consultants contributed to the Sentinel Stroke National Audit Programme (SSNAP). Audit data from June 2014 to July 2015 indicated Torbay Hospital received consistently poor ratings, D and E, for team-centred and patient-centred key indicators in scanning, stroke unit, thrombolysis and special assessments. However, in the same period the hospital performed consistently well, receiving ratings A – C, for key indicators in discharge processes, standards by discharge, multidisciplinary team working and speech and language therapy. At June 2015, the hospital's overall SSNAP level score was D, in line with the England average, with case ascertainment band and audit compliance band both rated as A. The trust had recognised areas for improvement and included these on the division's risk register. The highlighted risk was the loss of the stroke service due to poor performance. The risk had been assigned to a senior clinician to lead on an action plan and improvements, including the recruitment of additional consultants and a more robust escalation and decision-making pathway. It had been identified that improvement in the SSNAP programme outcomes would be limited without the provision of a seven-day service, which had been identified as not possible in the short-term. The latest available update to the action plan was in December 2015, at which stage the trust was awaiting a decision from the specialist commissioners regarding the stroke service before recruitment could be started.
- Two doctors conducted an audit of the treatment standard most often breached in SSNAP data, which had contributed to the trust's poor ratings. This standard was the admission of stroke patients to the

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stroke ward within four hours of arrival by ambulance. The audit found 40% of breaches had been avoidable. The subsequent action plan highlighted a number of areas for improvement, including a more proactive approach from the emergency department staff in contacting the stroke coordinator and a faster response from the stroke coordinator. The audit also highlighted staff were not requesting scans quickly enough out of hours and there were delays in admitting patients to George Earle ward. Staff were undertaking a number of lines of enquiry in relation to the areas highlighted by the action plan. For example, an SSNAP administrator had been appointed to ensure data was accurate and submitted in a timely manner. Additional training was also scheduled for stroke coordinators and the emergency department staff had been given education sessions on the role of the stroke coordinator. The hospital manager held the stroke bleep overnight as a strategy to reduce out of hours admission delays. Future plans to improve stroke care and treatment included the reconfiguration of the stroke coordinator on George Earle ward to ensure they would not be counted as a core member of the medical team. This would free them up to attend to stroke calls more rapidly. Staff were also undertaking a new stroke acute care pathway to incorporate the wider changes implemented as part of the action plan.

- Doctors of all grades contributed to a rolling programme of clinical audits across all medical specialties. The audits covered a wide range of topics, including blood transfusions at weekends and improvements in the heart failure service. Junior doctors presented the findings of audits at a weekly meeting and conducted re-audits to ensure learning was embedded in practice. For instance, staff used x-rays more consistently to check for sepsis in patients with liver cirrhosis.
- The latest data published from the Heart Failure Audit was from 2014/15. This audit used 11 benchmarks to assess the standard and quality of care patients with heart failure received. The trust demonstrated a significant improvement from 2012 to 2015 in this audit and performed better than the England average in a number of benchmarks. For example, 90% of heart failure patients had input from a clinical specialist, compared with 78% nationally and 100% of patients had a discharge plan, compared with 83% nationally. In the remaining nine benchmark criteria, the trust

performed worse than the national average. The trust significantly improved the number of patients referred to a heart failure liaison service between 2013 and 2015, with 66% of discharged patients referred.

- The medical division contributed to part the myocardial ischaemia national audit project (MiNAP) and the latest available information was from 2013/14. In the three benchmark criteria that refer to the care of patients with non-ST-elevation myocardial infarction (nSTEMI), the trust performed better than the national average. This included 96% of patients seen by a cardiologist, 60% of patients admitted to a cardiac unit and 84% of patients referred for angiography, including after discharge.
- In the National Diabetes Inpatient Audit (NaDIA), the trust performed better than the national average in 12 of the 20 benchmark standards and worse in eight of the 20 standards. The trust performed well in its nutritional care of patients, the comparatively low number of management errors and the number of patients seen by a multidisciplinary team within 24 hours. The trust performed worse than the national average for medicine errors, prescription errors and insulin errors. However, this may indicate a higher reporting rate rather than actually demonstrating a significant risk to patients. Diabetic patients received a foot risk assessment within 24 hours of admission in 38% of cases in England. In the trust, 19% of the same patients received a foot risk assessment in the same time period. Although there was still significant room for improvement, the trust had improved its NaDIA outcomes in 14 benchmark areas from the previous year.
- We spoke with a person on Warrington ward who was readmitted four days following their discharge. They said, "I was sent home from Simpson ward even though I told [staff] I didn't feel well. Then four days later my GP had me readmitted and this time consultants have been much more involved, I've had tests done and they've kept me up to date with my diagnosis and treatment." Another patient on Warrington ward said they were readmitted after being sent home feeling unwell. They said, "I'm over the moon with the service since I was readmitted."
- The trust contributed to the Commissioning for Quality and Innovation (CQUIN) framework with a particular focus on improving care, treatment and outcomes in

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patients with an acute kidney injury and sepsis. Staff used this framework to improve the frequency and accuracy of dementia screening and to reduce the rates of unplanned readmissions.

- The hospital performed exceptionally well against the 31 day first treatment target for cancer (96% of cases achieved this) and the 62 day first treatment target for cancer 85% of cases achieved this).

Competent staff

- Across the medical division, 84% of staff had an up to date appraisal. In the 12 months prior to our inspection, 90% of nursing staff on Midgley ward received an appraisal. A nurse on Simpson ward told us their annual appraisal was a useful process and helped them to establish objectives in their professional development. Another nurse, on Cheetham Hill ward, told us they received clinical supervision every six months and said this was a supportive process.
- Ward managers were responsible for new staff inductions. We saw there was a robust induction process in place for agency and bank staff, which included a briefing of the treatment escalation plan, infection control procedures, incident reporting, moving and handling, fire safety and the location of resuscitation equipment.
- We asked staff about support for training opportunities. A senior nurse on Midgley ward, an acute respiratory ward, told us they had received support to undertake specialist respiratory training.
- Junior doctors we spoke with told us they received support from senior doctors in preparation for their Practical Assessment of Clinical Examination Skills (PACES) examination. Successful completion of this exam with the Royal College of Physicians enables junior doctors to enter higher specialist training. Support from senior clinicians is therefore important during clinical preparation for the exam.
- We found senior staff used the previous professional experience of nursing staff to encourage their development. For example, on Cheetham Hill ward, one staff member led the care of elderly patients, having previously worked in community residential care. This member of staff had been supported to complete competencies in intravenous medicine and catheter care.
- Nurses working on care of the elderly wards told us they had not received training in de-escalation techniques or

in breakaway training for use when faced with a violent patient. De-escalation and breakaway training is used to show staff how they can protect themselves from attack by a violent patient using a method that does not present a risk to the patient. We saw conflict resolution training was provided to nurses on a three-yearly basis. Staff had submitted 16 incident reports in the 10 months prior to our inspection, which detailed violence, abuse or aggression from patients.

- Nurses working on the cardiology ward had undertaken an annual basic cardiology course and an ECG course.
- Healthcare assistants (HCAs) working in acute medical wards undertook a 12 week care certificate course and were sponsored to complete a level 2 NVQ. New band five nurses completed a preceptorship course.
- All specialist registrars working with stroke patients had undergone thrombolysis training.

Multidisciplinary working

- There was evidence of good multidisciplinary working. An acute medical consultant attended a monthly acute physician meeting and a monthly emergency department meeting. This was a strategy to improve working relationships and access and flow between the emergency department, general medical wards and specialties. Staff we spoke with told us this had been effective at improving working practices between general medical wards and specialties. We saw a consultant microbiologist was readily available and the medical consultant was able to obtain their support on one ward round. This meant patients had rapid access to appropriate specialist staff.
- We saw innovative multidisciplinary working between the nursing team and the IT department in the Ricky Grant oncology day unit had led to the implementation of a prescribing system that resulted in the most appropriate and effective timing of medicine regimens based on the results of bloods tests and the duration of treatment.
- During our observation of a board round on EAU4, we saw a multidisciplinary team of doctors, nurses; intensive care outreach, a bed manager and discharge coordinator discussed each patient. We found a positive culture of involvement, with junior doctors and nurses encouraged to present.
- A band four practitioner worked on Cheetham Hill ward and we saw this role was clearly integrated with the

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registered nursing team. For example, this member of staff worked closely with the nurse coordinator and contributed significantly to a nurse safety briefing and handover we observed.

- We observed a multidisciplinary meeting on Simpson ward. We found this to be well-attended by appropriate staff, including a discharge coordinator, two consultants, an occupational therapist, an FY2 doctor, an assistant practitioner, a band five nurse and the ward manager. Each patient was discussed in depth, with specific attention to their social situation following discharge including mental capacity and safeguarding. We saw staff were supportive of each other and shared their expertise readily, such as when one individual asked for more information on how a specific medicine worked. An F2 doctor and nurse jointly presented their patients to the consultant leading the meeting, which worked well and demonstrated a robust multidisciplinary process to assessing patients across staff roles. Staff of varying specialties contributed to daily multidisciplinary meetings as appropriate on their own wards, such as a band four practitioner on Cheetham Hill ward.
- All medical wards we inspected had access to daily input from a dietitian and the speech and language team where necessary. Staff could readily obtain the assistance of social workers when needed.
- We saw physiotherapists and occupational therapists worked closely together on Elizabeth ward to screen patients to identify possible specialist referrals for both disciplines.
- Nurses working with cardiology and respiratory patients formed a heart failure specialty team and had established working links with community heart failure nurses. Respiratory nurses had begun to review integrated care partnership working in other hospitals to plan a joint hospital/community consultant appointment.
- We observed an operational meeting with the Hospital at Night team and found medical, surgical and operational staff conducted a patient-centred handover that considered options to improve access and flow when the hospital was approaching its maximum capacity.
- A pharmacist and pharmacist technician attended each acute medical ward daily Monday to Friday and conducted medicines history and reconciliation, prescription chart reviews, stock replenishment and supervision of nurses during medicine rounds.

- However, we observed a post take ward round on EAU4 and found this was not multidisciplinary. It was led by a consultant with junior doctors in attendance but did not have a nursing presence and doctors did not routinely hand over to nurses after the ward round.

Seven-day services

- A junior doctor told us they felt medical cover at weekends made the prioritisation of patients “unbearable” because of the lack of specialty cover. For example, only doctors from cardiology, gastroenterology and clinical haematology reviewed their own patients at the weekend.
- Out of hours oncology cover on Turner ward was provided by a consultant based at a neighbouring hospital and was operated according to a service level agreement that included telephone triage.
- A seven day cardiac catheterisation facility was available.
- We found the stroke ward did not have consultant cover available 24 hours a day, seven days a week. The shortfall in consultant cover was reflected in the division's risk register. To mitigate the risk, a 24-hour thrombolysis service was provided from the emergency department. The stroke unit was able to offer a transient ischaemic attack (TIA) service five days a week and this was being delivered by two experienced consultants. An action plan was in place to avoid having to send patients elsewhere for treatment but this relied on the recruitment of a new consultant, which had been unsuccessful. Locum doctors were used as a temporary measure while senior staff continued their recruitment efforts.
- A specialist registrar told us there was minimal consultant cover of acute medical wards at weekends and medical cover was primarily led by a very junior doctor. We found the consultant body had partially addressed this concern by implementing a new 9am weekend meeting between a consultant and the registrars. A specialist registrar told us this had happened for the two weeks prior to our inspection and had greatly improved support for them.
- Physiotherapy and occupational therapy staff were available from 8.30am to 6pm seven days a week on all acute medical wards. Outside of these hours, a respiratory physiotherapist was available on call.
- On-call services for dietetics, pharmacy and microbiology were available seven days a week.

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Access to information

- The trust target for the completion of discharge summaries within 24 hours of discharge was 77%. In the eight months prior to our inspection, 67% of weekday discharges and 38% of weekend discharges were completed within 24 hours. This meant staff were not meeting the trust's target and patients were sometimes discharged without appropriate notes being available to their GP.
- Ward staff completed a health needs assessment and continuing care checklist for each patient who was discharged into a care home.
- We found it could be difficult for GPs to interpret notes written whilst patients were being treated on a ward because doctors' signatures were often illegible. For example, GPs could not always trace the doctor who had completed patient notes because they could not identify them.
- The electronic patient tracking system enabled staff to identify where a patient had previously been highlighted as at a safeguarding risk, if they had been diagnosed as living with dementia, or a learning disability.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- We found on Forrest ward, staff spoke about resuscitation with a patient who had been admitted at the request of their GP. On admission, they had a do not resuscitate (DNAR) authorisation in place. Staff established the person's level of mental capacity and then discussed the DNAR with them to confirm it was still their wish.
- A medical registrar conducted a mental capacity assessment of a patient and discussed this appropriately with a relative. This was documented accurately on a DNAR authorisation, which was countersigned by a consultant 12 hours later.
- We observed a nurse handover on Cheetham Hill ward and saw staff had a good understanding of mental capacity and the principles of consent. For example, a nurse highlighted a patient with a high waterlow risk score, which meant they were at risk of developing pressure sores. Staff offered the patient an air mattress but they refused. Staff discussed and noted the patient

had full capacity to be able to refuse this. Another patient had been booked for a chest x-ray but refused this. This patient also had mental capacity and staff discussed strategies to encourage the patient to consent to the investigation as it was in their best interest clinically.

- During our observations, staff demonstrated a compassionate and pragmatic understanding of consent. We saw a junior doctor on EAU4 demonstrate particular ability in relation to assessing the mental capacity of a patient who was very sick and discuss this openly and with respect with an appropriate family member.

Are medical care services caring?

Good



We rated the medical care, including elderly care, at Torbay Hospital good for caring because:

- We received consistently positive feedback from the patients we spoke to in all areas of medical care
- Patients gave us numerous specific examples of staff 'going the extra mile' to make them feel welcome and to help them settle in as an inpatient
- During our inspection we witnessed a commitment to compassionate, kind and respectful care from staff at all levels of the service
- Doctors and nurses ensured patients and their relatives understood their treatment and care packages
- A ward buddy system was in place to help provide emotional and social support to patients

Compassionate care

- Throughout our inspection we saw kind and compassionate care and support from staff at all levels of the organisation. For example, we observed a member of the housekeeping team help a lost and anxious relative on EAU4. Consultants and junior doctors introduced themselves by name to patients during post take ward rounds. On George Earle ward a ward clerk dealt patiently and compassionately with an upset family member. On this ward a patient said, "One of the things I remember most is my first night here

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when another patient was upset and woke me up in the middle of the night. A nurse brought me a cup of tea and apologised for the disturbance. It was a tiny gesture that made a big difference to me.”

- We spoke with twelve patients on Cheetham Hill, Warrington and Elizabeth wards, some of whom had been looked after for an extended period of time. In all cases patients said staff had been very caring in all areas and respected their dignity and privacy, and treated them with compassion and respect. One patient said, “Everyone has been so helpful and kind, they’ll chat with you.” Another patient said, “It’s the personal touch – the banter between nurses and patients; it makes life in here more enjoyable.”
- Five patients we spoke with in the Torbay Assessment Investigation and Rehabilitation Unit (TAIRU) told us they were happy with their care and treatment from nurses. One patient said, “The staff are very attentive, always check that you’ve got a drink.” Another patient said, “It’s a lovely familiar voice I hear from [nurse]. They’ve really looked after me.”
- Nursing staff on Forrest ward dealt sensitively and compassionately with a patient who wanted to go outside to smoke, which would have put them at risk due to their mental state. This resulted in the patient acknowledging the risk and agreeing to stay in the ward.
- During a ward round on EAU3 a consultant spoke with an elderly patient with great dignity and respect, promising to speak personally to their son.
- We observed a nurse on Elizabeth ward offer a patient a laxative in a way that preserved their privacy and dignity and ensured only the patient could hear, despite the very busy and quite cramped environment.
- Warrington ward was often staffed by agency nurses. We asked a patient about this. They said they had always found agency nurses to be friendly and to have a positive attitude, despite there being little consistency between shifts.
- Each medical ward except Warrington and Elizabeth had a display at the entrance on which staff had indicated changes made as a result of feedback from the Friends and Family test. This included the percentage of patients and visitors who indicated they would recommend the ward. For example, the display at the entrance to Simpson ward indicated in August 2015 100% of patients and visitors would recommend the ward. Warrington ward had a display in situ but it was not used.

- Friends and Family Test data for the 12 months prior to our inspection demonstrated medicine wards frequently scored 100% in recommendation ratings.
- However, we found there was a lack of understanding in some areas about the need to speak about patient’s conditions with appropriate language. For example, one healthcare assistant told us we could speak to a patient on a ward for dementia care because the person was ‘with it.’

Understanding and involvement of patients and those close to them

- A patient on Cheetham Hill ward told us they had a good understanding of their condition and their treatment because staff took the time to explain everything to them. We observed ward rounds on EAU3 and EAU4. We saw the consultant explained people’s condition to them as well as their treatment plan although their understanding of this was not always confirmed.
- From looking at records we found staff routinely documented their conversations with family members. For example, one doctor on Warrington ward documented how they had calmed the anxiety of a distressed family member and included them in discussions with the patient about prognosis and treatment.
- 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.
- Patients on Elizabeth ward were not always involved in their care and treatment. For example, one patient told us they had been admitted one week prior to our inspection and had not seen a doctor since admission. They said, “I’ve had no communication about my treatment or discharge. Nurses haven’t told me and I haven’t asked.” Another patient on Elizabeth ward said, “I wish someone would just talk about discharge with me, I haven’t been given any information.” However, a patient on Warrington ward said, “I have been kept fully informed about my treatment and I know what my discharge plan is.” A patient on TAIRU said, “Staff have given me plenty of advice about how to prevent a flare-up of [condition] and I know now how to avoid an

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infection." Another patient on the same unit said, "My treatment has been really exceptional. The consultant gave me a really good explanation as well as a choice of medication."

- We observed nurses on Elizabeth ward explaining to people what their medicine had been prescribed for and how they should take it. Staff also asked patients if they had any questions about their medicines.
- We observed a physiotherapist and occupational therapist on George Earle ward carrying out an initial assessment on a patient. We saw staff explained who they were and what they were doing, which immediately put the patient at ease. Staff also asked the patient what they would like to be called.
- During our observation of a nurse handover on Cheetham Hill ward, staff highlighted a patient's upcoming birthday and made plans to surprise them on the day.

Emotional support

- A patient on Cheetham Hill ward told us there were often problems with patients who were upset and unsettled overnight but they felt staff handled this very well and kept people as calm as possible.
- We saw an occupational therapist provide an anxious patient with positive techniques on managing their worry as well as methods of coping with their condition, which we saw had a demonstrably positive effect.
- Ward buddies on care of the elderly wards 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. A ward buddy said, "Quite often people are very confused. This gives them the opportunity to reflect and express themselves. It makes them happy and it's very rewarding, to see someone get to a brighter place and start smiling again."
- Staff were able to provide information and referrals to the bereavement service, which was also signposted in medical wards.
- A consultant who broke bad news to a patient did so in an exemplary manner, with obvious gentleness and at the correct pace. The consultant documented this very carefully in the notes and double-checked with the patient they understood how to access specialist nurses.

Requires improvement



We rated the medical care, including elderly care, at Torbay Hospital as requires improvement for responsive because:

- Significant numbers of patients had been transferred out of wards overnight over an extended period of time
- Delayed discharge 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 escalation beds available on Elizabeth ward whilst patients were being held as outliers on a surgical ward.
- We found staff were not always able to meet the needs of people who presented violently or with complex conditions such as alcohol-related dementia.
- However, we found a number of areas of good practice, including Extensive planning and service modification to meet the needs of patients living with dementia and learning disabilities. We saw this led to very positive person-centred care and treatment.
- Specialist teams in the hospital supported staff and patients in the care of patients living with dementia and with learning disabilities.
- Daily discharge and flow meetings were well attended and used to identify areas where access and flow could be improved, including the utilisation of community social care teams to support patients with respite care.
- There was a robust complaints handling procedure in place that we found involved staff, patients and their relatives in investigations appropriately.

Service planning and delivery to meet the needs of local people

- Staff we spoke with told us they understood the needs of the local elderly population, who represented a significant proportion of inpatients. The turnover of geriatricians and a failure to recruit new staff increased the pressure on care of the elderly medical staff. To facilitate better support for elderly patients, a 'carer's pass' system had been implemented. This entitled visitors who cared for elderly patients to a reduction on

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the cost of meals in the hospital restaurant, free car parking on site and more flexible visiting hours. Carers also had access to dedicated support workers in the hospital.

- Staff acknowledged the health needs of specific population groups in the local area, including seasonal workers and those with alcohol-related diseases. Key staff had received training in alcohol-related dementia and an alcohol liaison team was available to provide specialist support.
- A Cancer User Group was in place to provide care and support to people during and after their inpatient stay, which had good links with community support services.
- However, a patient who was frequently treated in the Torbay Assessment Investigation and Rehabilitation Unit said they found the unit difficult to access because of a mobility issue. They said, "I can drive myself but because there is no accessible parking near the unit I always rely on a friend to drop me off."

Access and flow

- Patients had timely access to care and treatment, which was demonstrated by the trust's performance against similar hospitals nationally. Daily flow meetings were used to help support the admissions and discharge processes of patients as well as how they were treated between different specialties.
- From September 2014 to September 2015 the trust consistently met or exceeded targets for referral to treatment times. In this period, 100% of patients being cared for in general medicine and the geriatric medicine, neurology, rheumatology and thoracic medicine specialties started consultant-led treatment within 18 weeks of referral. In the same period, 90% of dermatology patients and 98% of gastroenterology patients also met this target. Cardiology patients were slightly below the 90%, 18 weeks referral to treatment target, at 87%.
- The average length of stay for elective procedures was 4.4 days, which was slightly higher than the national average. For non-elective procedures the average length of stay was 4.9 days, which was slightly lower than the national average.
- A multidisciplinary flow meeting took place four times daily between 10am and 8.30pm and was attended by the on-call manager, the head of operations, the matron of the week, flow coordinators, community hospital

nurses, members of the transport team and cleaning time. The meetings were used to improve access and flow in all hospital areas and were supplemented by a clinician meeting at 9pm daily.

- Senior nurses undertook on-call support shifts with flow coordinators to assist in the appropriate movement of patients.
- Medical outliers were cared for on Forrest ward where we found a lack of consistency in medical treatment and oversight. For example, on one day of our inspection, there were nine medical outlier patients on the ward, cared for between six different consultants.
- Elizabeth ward was a discharge lounge that could be used as a medical escalation ward when there was a lack of capacity elsewhere in the hospital. Staff limited the time patients were cared for on this ward, with the recent maximum length of stay having been 35 hours.
- Planning for discharge did not always commence on admission. In the 2015/16 year prior to our inspection, there had been 2,560 delayed discharges. We found the cause of most delayed discharges were due to a lack of community social care or mental health bed, or a delay in discharge planning due to low numbers of medical staff at weekends. This meant some patients stayed in hospital longer than they needed to while patients awaiting a bed in the emergency department or emergency admissions units were delayed.
- A daily discharge handover meeting took place at 9.30am in the hospital's control room to plan the discharge of patients and to identify where discharges should be prioritised, such as from full wards and escalation wards. A referral coordinator assisted this process and liaised with specialist and external services in complex discharges. We observed this meeting and saw patients awaiting a community social care bed were identified and discussed separately and each delayed discharge was also identified and strategies discussed to facilitate their discharge.
- We found a number of patients were transferred from medical wards out of hours. The clinical lead for medicine told us in many cases this was due to patient safety overriding their experience. Between April 2015 and April 2016, 482 patients were discharged or transferred between 10pm and 6am. The quality improvement group reviewed this data and found the number of transfers to be proportionately low.

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- A senior nurse on the cardiology ward said these beds were protected from out of hours transfers and patients would only be moved in an emergency.
- We asked the clinical lead for acute medicine about the operation of the emergency assessment units and were told these units were being operated as acute medical wards. As such, the acute medical team would call in specialists when needed.
- A community respiratory consultant had been appointed to try and reduce the need for admissions in this specialist area.
- We found the matron of the week used established selection criteria when identifying patients suitable for admission to the escalation wards. This included patients who were on a community hospital waiting list and those who would be discharged imminently. The matron of the week was responsible for assisting bed managers and site managers with access and flow, admissions and discharges.
- A senior clinical nurse was involved in all decisions to transfer or discharge acute medical patients out of hours.
- Ward staff told us bed managers sometimes conducted a daily walk of each ward to assist with access and flow but said this did not happen consistently.
- A matron led a medical admissions avoidance team who could arrange scans and give results to patients to avoid an inpatient stay in hospital.
- We found a proactive approach to patient safety in the discharge procedure for patients leaving Warrington ward. For example, the charge nurse organised discharges to community hospitals by ringing them to check that medicines were available to ensure patients would be admitted there safely.
- The two emergency assessment unit wards were designed as short stay wards, to admit medical patients, assess and transfer to an appropriate ward for their stay. Between January 2015 and December 2015, the average discharge rate from EAU3 and EAU4 was 37%. This demonstrated significant delays some patients experienced in being admitted to a general medicine or specialty ward. There were delays in getting access to specialist care and treatment on the most appropriate ward due to the lack of flow, which meant patients were often kept in an emergency assessment unit for longer than was necessary.
- We observed a multi-disciplinary bed meeting on EAU4. We found this was well attended and included a bed

manager, two consultants and two sisters. Staff used the electronic patient monitoring system to discuss patient flow but we did not observe a sense of urgency or clear priority from senior staff regarding the pressures on the emergency department.

Meeting people's individual needs

- Staff worked continually to meet the individual needs of people, in the delivery of individualised care and in modifications to some ward environments. In most wards, information available to patients was good. Care of people with dementia represented good practice and the use of additional resources meant patients on care of the elderly wards had access to activities to reduce the risk of social isolation.
- An information board was displayed at the entrance to each ward that presented the planned number of nurses and healthcare assistants on shift alongside the actual numbers of staff. This display also included details of protected meal times, the results of infection control audits and the most recent feedback from the Friends and Family Test. Staff indicated the changes made to each area as a result of this feedback, such as reducing noise at night on Simpson ward.
- Staff displayed photographs of the ward team in some areas, such as at the entrance to Dunlop and Simpson wards. This included a guide to the meaning of each uniform colour and a clear visual guide to the senior team in the unit.
- A day room was available on some wards, including Cheetham Hill. We saw that these rooms were used regularly in some areas but a patient on Cheetham Hill told us they did not know there was a day room because staff hadn't told them.
- Patients we spoke with told us they were happy with the visiting hours for relatives and said staff had been flexible with these to accommodate relatives who could not visit during the set period.
- Staff on Cheetham Hill and Simpson wards had provided a reminiscence area in each day room, which included photograph books from historic events and about the local area. A cinema club was also about to be launched on Cheetham Hill ward and staff had been able to provide a stock of twiddle muffs to help people with anxiety. Twiddle muffs are knitted hand muffs that have tactile items attached to help people living with dementia to relax. The matron told us they had been very popular since being introduced.

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- Ward staff had been involved in fundraising to improve resources for patients. Funds had been raised for a fish tank for the day room, reminiscence boxes and radios, headphones and a stock of double cream to help fortify and flavour food for patients on request and where a high calorie intake was needed. Staff facilitated a daily lunch club on Simpson ward in the day room. A dementia link nurse supported this and could also use the time for reminiscence therapy on a one-to-one basis. Staff on Simpson ward had collected over 100 books for the day room, which included replicas of ration books for reminiscence sessions with patients with dementia.
- We saw staff used the 'This is me' booklet from the Alzheimer's Society when a patient with dementia was admitted, which assisted them to provide personalised care.
- Dementia link nurses had organised annual dementia workshops and healthcare assistants who worked on care of the elderly wards had attended specialist dementia training. Staff had undertaken training and workshops with the Purple Angel Dementia Awareness Campaign and had displayed the organisation's dementia-friendly stickers in key areas so patients and visitors could identify when they were in an area where staff had undergone specialist instruction.
- We spoke with the honorary Chaplain who told us they conducted a ward round of medical wards each Friday and staff were able to contact him on behalf of a patient at any time during the week.
- We found clinicians on Allerton ward tailored a patient's treatment plan following feedback from them. For example, a patient with a stoma had told their doctor that managing it was easier with a lower mirror, which staff subsequently provided.
- Nurses screened all patients over the age of 70 for dementia on admission, using an abbreviated mental test score. Where the screen result suggested the patient may have dementia, a junior doctor confirmed this and a blue 'forget me not' symbol was added to the electronic patient tracking system. This meant all staff who looked after the patient understood their dementia status and were more able to meet their needs.
- We asked 11 patients on Elizabeth and Warrington wards and EAU3 about using the nurse call bell. In all cases patients told us staff responded to this very promptly.
- Nurses had been allocated 'champion' roles, which meant they led service audits and improvements in specialist areas. For example, a band four practitioner on Cheetham Hill ward had been allocated a diabetic champion role. Other champion roles included learning difficulties, frailty, Parkinson's, multiple sclerosis and Asperger's.
- Staff had access to an alcohol liaison team based in the hospital who were also able to support ward nurses in the care of patients with alcohol-related dementia.
- Staff facilitated a game of bingo for patients on Cheetham Hill ward every Sunday afternoon. Staff had implemented an activities programme on Simpson ward as a result of patient and visitor feedback.
- Staff on Simpson ward had created an information board signposting people to community dementia support organisations, which included contact details for urgent support.
- A ward buddy system had been implemented on care of the elderly wards. Ward buddies were volunteers with an understanding of the needs of elderly patients and those with dementia and provided one-to-one support sessions with patients. We spoke with a ward buddy and found they could provide reminiscence sessions, bring books in to read to patients and accompany patients during mealtimes. All ward buddy activity was documented and we saw this was a role vital to the social wellbeing of patients and was well respected by clinical staff. We found ward buddies used a distinct attention to detail to identify patients who would benefit from individual support. For example, a ward buddy noticed a member of staff from a pastoral care team give a leaflet to a patient who was not able to read. They offered to read the leaflet to the patient discreetly and took the time to explain it.
- Staff completed a care plan for patients with a learning disability to help them understand their likes and dislikes and what they could do to make their admission calm and comfortable. We saw staff had access to independent mental capacity advocates (IMCAs).
- Nurses worked with doctors to rearrange timings for medicine doses around patient routines, to improve adherence.
- A senior nurse on a care of the elderly ward told us side rooms could be used to care for end of life patients but capacity pressure sometimes meant this was not possible. They said, "We have had end of life patients

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with their relatives in a bay with other patients, who are anxious and shouting out. It's totally inappropriate but sometimes pressure from bed managers is such that we can't avoid this."

- We asked six patients about food and drink. Most patients were positive about this. One patient on Cheetham Hill ward said, "The food is hit and miss. Some of it is okay, some of it not too good but there's plenty of it."

Learning from complaints and concerns

- In the 2015/16 year prior to our inspection, medical services received 59 complaints.
- The trust had a robust and clearly structured process in place for the handling of complaints. The associate director for nursing for the medical service delivery unit and a dedicated administrator assigned a lead investigator to each complaint based on the contents of the communication. The investigation lead would usually be the matron and ward manager responsible for the area in question, who would then include other members of staff if necessary. The clinical director was included routinely in the outcome of each investigation, which a member of the complaints team discussed at each monthly divisional meeting.
- The complaints team had access to incidents submitted by staff and were able to identify areas likely to generate a complaint. Staff investigating complaints did so on a case-by-case basis using a method tailored to the nature of the complaint. For example, where a patient raised concerns about a missed diagnosis, the investigation would focus on medical records. Complaint investigations and outcomes were discussed and shared with matrons during weekly governance meetings and on a monthly one-to-one basis with each matron. A divisional consultant led the investigations and outcomes of complaints about doctors.
- We found there was a separate process in place for complaints received involving agency nurses and locum doctors.
- We saw people who submitted complaints were invited to the hospital to meet with appropriate staff to discuss the issues raised. This was used as an interactive tool to improve the outcome that would otherwise be communicated by a letter.

- Staff were able to share the outcomes of complaints with the Patient Advice and Liaison Service, who were also able to attend complaints meetings with people and patients.
- Matrons had received complaints management training and were able to offer this to other nurses based on identified need on an individual basis.

Are medical care services well-led?

Requires improvement



We rated the medical care, including elderly care, at Torbay Hospital requires improvement for well-led because:

- We found a lack of leadership and oversight in problems with safety in ward areas relating to fire risk management as well as in the oversight of patients being treated on outlier wards
- A disconnect between acute medicine and the emergency department meant patients did not always experience appropriate access and flow
- Feedback from some nursing staff indicated a lack of management support in some areas relating to the raising of concerns and risks
- Information governance in relation to the protection of patient data was not always adhered to because the patient information screens in ward areas were publically visible and included personal information

However, we found numerous examples of areas of good work.

- There was a positive and collaborative working culture that encouraged involvement and engagement from staff at all levels. This led to innovation in services, such as in the development of an oral chemotherapy service.
- There was a broad focus on sustaining and growing the service by nurturing future professionals, such as through the development of a band four practitioner role, the use of a trainee physician associate programme and a supportive environment for student nurses.

Vision and strategy for this service

- Senior staff had established a vision and strategy of improving care pathways for patients with multiple conditions and long-term conditions. This included

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reducing the numbers of predictable incidents, such as falls and pressure ulcers, and ensuring nurses and doctors had the appropriate training and skills to care for people.

- We spoke with the clinical lead for medicine about their strategy for the service, particularly around capacity and flow problems. They told us there was an “evolving strategy within acute medicine for closer ties with the emergency department.” The clinical lead felt the evolution of the service was limited by the trust’s need to recruit more acute physicians. The clinical lead said up to 30 additional medical beds were being planned to reduce the number of medical outliers.
- We were also told part of the vision for the service was to improve links with the community, including the use of community hospital beds for those requiring respite care and awaiting a placement. This would help to reduce the number of people being delayed in a ward unnecessarily.
- Although senior staff were able to tell us about future plans for the development of the service, particularly around reducing the number of medical outliers and improving access and flow, we did not find substantial or well-developed evidence to support this in practice. We asked medical staff about this. They said they were aware of the trust’s overriding vision and knew individual services needed to improve in some areas. There was not a consistent view from staff that the development and improvement of specific medical areas involved more than an improvement in staffing.
- We found the care of the elderly and acute medical unit services were well led, with a clear vision for the frailty service, a joint service for Parkinson’s and evidence of integration with community services.

Governance, risk management and quality measurement

- The divisional general manager led the medical division’s monthly governance meetings and was supported by two clinical governance coordinators. Clinical governance staff used monthly meetings to discuss incidents, accidents and risks. We looked at the minutes of four meetings and found they did not regularly include input from staff at all levels or a multidisciplinary team. In addition, incidents and risks were not always discussed in depth and appropriate actions were not always identified. For example, in the minutes of one clinical governance meeting, it was

noted there had been “a couple of incidents” relating to neutropenic sepsis plus, “Continued delays in closing incident forms.” However, the only action noted was to encourage staff to close incident forms. This meant there was not a robust and documented procedure for the appropriate identification of incident causes or the actions to be taken.

- We found personal patient details were routinely left on display on the electronic patient tracking monitors in ward areas. Staff told us patient information should not be left on the screen when they were not using it but because the screens were used so frequently, it was time consuming to lock and unlock it each time it was used. This presented a risk to patient confidentiality as we saw details such as medicines; discharge status and social risks were readily visible to passers-by and visitors. For example, on Cheetham Hill ward we saw one patient had ‘Lives alone’ displayed next to their name and another patient had the name of the care home they would be discharged to. This did not adhere to trust standards of information governance.
- A divisional risk register was in place that incorporated risks identified in each medical specialty and support services, such as pharmacy. Five work streams had been established that were used to attribute the service area in which responsibility for the risk lay. The five work streams were patient safety and quality; patient experience and community partnerships; finance; human resources and educational governance and infrastructure and environment. An operational lead for each identified risk was indicated in the risk register as a method of tracking actions and accountability and a risk management update from the lead for each work stream was documented at monthly clinical governance meetings to track progress.
- We saw variable approaches to the management and resolution of risks on the acute medicine risk register. For example, an amber risk had been in place for cancer services for two years without a change in its status. This risk related to use of a non-purpose-built facility for the vascular access team, who worked out of an office in Elizabeth ward. This ward was primarily a discharge lounge but was also used as a medical escalation ward Mondays to Fridays. Staff had identified this as a risk as the lack of purpose-built facilities and the busy nature of Elizabeth ward meant the team could not expand the service, which in turn could reduce the pressure from the operating theatres and interventional radiology. The

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last documented update to this risk was March 2013 but the actions implemented for this risk related to daily monitoring of the situation by the multidisciplinary team.

- The medical staffing of escalation and outlier wards was a key concern of senior staff and we saw this was represented on the divisional risk register. Oversight of the escalation wards had been allocated to a matron, which had mitigated part of the risk senior staff had identified with a lack of consistent staffing in these areas. The matron responsible for Simpson, Cheetham Hill and George Earle wards established a system that enabled nurses from Cheetham Hill and Simpson to work across those wards according to skill mix needs when they experienced short staffing.
- Senior nurses we spoke with had a clear understanding of governance processes and systems. For example, a senior nurse on Dunlop ward told us they had a monthly one-to-one with the assistant director of nursing and a weekly meeting with the matron. They also attended budget meetings with the divisional manager and told us the involvement of different levels of staff in governance meant they were more effectively able to contribute to improving the service.
- The governance coordinator for acute medical services led a weekly meeting to discuss the progress of complaints with senior staff.
- We found staff working on wards considered the safety of visitors in the same way they did patients. For example, the matron responsible for care of the elderly wards had identified the risks resulting from a large number of elderly visitors to the wards and as a result had ensured staff maintained vigilance around the environment.

Leadership of service

- Senior nurses had delivered training to staff that had incidents with medicines, and this was recorded on their personal HR record. Staff we spoke with said this was a positive example of good leadership in the medical division and said they felt supported to learn and develop after an incident.
- Staff we spoke with told us they were able to contribute to the running and development of the service because they received good support from the senior leadership team. For example, a clinical lead told us they had received fast, positive support to set up a chemotherapy

service without the need to submit a business plan. A respiratory consultant told us they had received “great support” when they had wanted to develop a new service.

- Staff felt the leaders they reported to directly in wards were approachable and aware of the challenges they faced with capacity and staffing. One nurse said, “I know we’re overworked but having a great [senior] in place makes it so much better.”
- Staff we spoke with at all levels of the medical division told us they felt confident in the use of the whistleblowing policy. They were able to explain the principles of whistleblowing to us, including the warning signs they would expect to see if they suspected abuse. Staff said they felt the trust promoted the whistleblowing policy openly. None of the staff we spoke had ever used the policy to raise concerns anonymously.

Culture within the service

- All of the staff we spoke with, regardless of job role and grade, spoke positively about the working culture of the hospital. A junior doctor who had relocated a significant distance to join the hospital told us consultants and registrars had willingly given them practice exams ready for their PACES exam and said, “I’ve had great support from my educational supervisor. This is a really friendly place where one soon knows everyone.” A clinical lead said, “I came here because it’s a hands-on service where management are truly patient-orientated.”
- Staff told us the senior leadership team were visible and accessible and they felt involved in the development of the service. All of the staff we asked said they felt listened to by the staff they reported to and told us they felt their opinions were valued.
- A band four practitioner told us their unique role was “embraced and respected” by the senior nursing and medical team. They said this meant they were able to progress the role and explore how it could continue to contribute to patient experience.
- The trust awarded staff and wards for their performance in key areas. We saw the Cheetham Hill ward team had received a ‘Wow!’ award for exceptional teamwork in November 2015.

Public engagement

- The medical division collected Friends and Family test data from each ward and senior staff in each area used

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feedback to make improvements. From August 2014 to July 2015, response rates to the Friends and Family test were slightly worse than the 25% England average, at 18%. From the responses that were received feedback was consistently very positive.

- An active body of volunteers worked across the hospital, including buddies on medical inpatient wards. Volunteers spent time with patients and their visitors, providing practical support such as directions as well as personal support during challenging times.
- Staff on care of the elderly wards had worked with the public to raise funds for reminiscence resources and to help provide a more suitable environment for patients with dementia.
- Medical inpatient wards displayed prominent notices in their entrance hallways detailing how they had engaged with the public and improved their practice and service, with examples such as improving visiting times and providing a better-equipped day room.
- Staff on the Ricky Grant oncology unit had engaged with patients and visitors to influence the redesign of the day unit. This included a brighter, more welcoming and accessible environment.

Staff engagement

- Nurses we spoke with told us the general shortage of nursing staff impacted their work. For example, one member of staff said, "The shortage of nurses is upsetting. I want to give the best care possible but you go home feeling you haven't fully done everything because you're so stretched. It does feel unsafe sometimes, it's a stressful environment, and there are crowded bays. I don't feel that we've [nurses] been asked how we feel about this or that we've been involved in whatever the solution might be. There's no visible input from the executive team on this. I know the matron is doing what she can but we're just told there's no budget for extra staff."
- Staff told us Cheetham Hill, Simpson and George Earle wards had staff meetings every three months, which were used as an opportunity to catch up with staff and find out what they needed and what their concerns were. We asked a nurse on Cheetham Hill ward about staff meetings. They said, "They happen very rarely. When they do happen, very few turn up because there's not much evidence anything ever changes. We just go over old ground about short-staffing."

- Senior staff had implemented a process to support international nurses. This included the offer of English language classes and coaching sessions to help them manage issues that might arise from cultural differences. We saw this worked effectively in practice. For example, a manager told us some nurses who had been recruited internationally had demonstrated an excessive subservience to doctors, which had impacted their ability to work as part of a multidisciplinary team. In such cases, a senior manager and a doctor had worked with the nurse to help them integrate into the collaborative working culture of the hospital.
- Doctors told us the chief executive and chairman of the trust attended junior doctor inductions, which contributed to their feeling of engagement.
- Staff on George Earle ward had been actively engaged in an improvement plan to build a more cohesive team and ensure staff felt adequately involved in the running and development of the service. This included facilitated idea-sharing meetings and team-building events to improve relationships and provide leadership training packages for band six and seven nurses. Staff also completed a dependency and acuity tool exercise to identify the optimum number of nurses assigned to the ward. Overall this programme was designed to improve morale, respect and feelings of achievement in the ward team.







Innovation, improvement and sustainability

- The hospital had engaged with an innovative trainee associate physician programme from Plymouth University. This was a two-year sponsorship that enabled trainees to undertake six-week placements at the hospital. We observed doctors were proactive in showing a trainee appropriate procedures and investigations and provided appropriate levels of supervision.
- A cancer services quality specialist was working within cancer services to develop, as part of the integrated care organisation, a community chemotherapy service and a direct-referral colonoscopy service to reduce the two-week wait for cancer treatment in the hospital.
- Permanent nursing staff fostered a positive and collaborative relationship with student nurses, which we saw encouraged them to plan their future career development on the trust.
- There were three vacant medical posts, which had been created to promote integrated care in the acute medical

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unit and care of the elderly wards. A recent recruitment drive had failed to fill these posts and the consultant leading this said they had been supported by management and were trialling different models of frailty care to mitigate the impact of the shortfall.

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Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Good	
Overall	Good	

Information about the service

Torbay and South Devon NHS Foundation Trust provide a range of surgery and associated services for residents in the South Devon area. Surgical services are contained in the surgical division and separated into four specialities and were managed by a trust divisional general manager and an associate director or nursing.

There were 21,000 spells of activity between July 2014 and June 2015. Within the same period 52% of surgery was performed as day case, 31% as emergency and 17% as elective (planned). During the time of the inspection the percentage of day case surgery had increased to 70%.

We visited all surgical wards, a selection of the 13 theatres (both inpatient and day-case), recovery, the surgical admissions unit, and the hospital sterilisation and decontamination unit (HSDU) during 3, 4 and 5 February 2016.

During our inspection we spoke with 69 staff including doctors, nurses, healthcare professionals, healthcare assistants, managers, social workers and housekeeping staff. We also spoke with 28 patients and carers, six volunteers, two students and looked at 15 medical records and care plans. We looked at six sets of medical record and care plans looking specifically at medicines' management.

Summary of findings

Overall we rated surgical services at Torbay and South Devon NHS Foundation Trust to be good because:

- There was a strong culture of incident reporting in the hospital which fed into the governance and management of risk. Managers had good oversight of the risks within the surgical division and risk assessments, action plans, and risk registers were detailed and used as an active tool to manage risk.
- There was a strong culture of evidence based practice which was reflected in patient outcomes. There were good results for national audits and they performed well nationally for surgery completed in the day surgery unit.
- Feedback about the care received was consistently positive and we saw good examples of interactions between staff and patients. Volunteers played a key role in the care of patient by completing regular questionnaires and auctioning changes to improve their experience.
- Patients living with dementia or learning difficulties had their specific care needs met. Patients we spoke with were complimentary about the staff and felt that their needs were being met.
- We found that local leadership was strong, even when under pressure from the demand of the service. Leaders led by example and were well respected by their peers.

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- The use of technology, such as virtual reality headsets, to learn from never events, provided staff with an engaging experience to improve their knowledge and skills.

However:

- We found that due to capacity issues within the hospital patients were waiting too long for their operations. However, there were actions to manage the risks to these patients and that work was being done with the community teams to reduce the demand of the service.
- We also found that during times of escalation, patients without MRSA confirmed status were being put on wards with MRSA negative patients. This compromised the status of all patients on this ward.
- Day to day risks to patients, such as regular assessments, was not always completed. These included venous thromboembolism assessments. We also found that there was some complacency around the checking of resuscitation trolleys.

Are surgery services safe?

Good



We rated safety to be good because:

- There was a good culture of incident reporting and we found a good culture of learning from incidents and near misses and were given multiple examples of where this learning had changed practice.
- The trust performed well on the safety thermometer and hand hygiene and we saw evidence of good practice to ensure this compliance. For example, following NICE guidelines for hand washing.
- We found that the environment and equipment was generally well maintained and kept patients safe from avoidable harm. However, there was no separate clean and dirty corridors to theatres (although mitigating action had been made).

However:

- There was complacency in the completion of records to evidence the checking of the resuscitation trolley on a daily basis, in line with trust policy. There was also complacency around the completion of repeat examinations, such as venous thromboembolism assessments for some patients.
- During times of escalation, patients who did not have their MRSA status confirmed were being put in orthopaedic wards where every other patient had their status confirmed. This compromised the status of all patients on the wards.

Incidents

- The trust reported two never events (serious incidents that are wholly preventable if all processes were followed) in the surgical directorate between October 2014 to September 2015. One was a retained swab during breast surgery and the other was a retained pack during throat surgery. Using the National Patient Safety Agency (NPSA) incident decision tree and the documentation available it was decided that both incidents were as a result of human factors coupled with deviation from protocol. There were seven serious incidents between October 2014 and September 2015 and resulted in various types of harm. There were no trends in these incidents.

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- The trust's performance report for October 2015 showed the numbers of medication incidents within the surgical directorate. The surgical directorate's target was to have less than 10 medication errors a month. During the period of November 2014 and October 2015 the average numbers of medication errors a month in the surgical directorate were 14, with only the months of December 2014 and October 2015 being better than the directorate's target.
- Being open and honest to patients was an embedded part of the surgical division's culture. When something went wrong (however serious) patients were told, given an apology and informed of actions taken as a result. Nurses and doctors gave us multiple examples of where they had apologised to patients which were then well documented in their medical records. We were given an example where a patient was informed by the surgeon of a never event occurring as soon as they woke from the surgery, and again on the following day, and were regularly updated on actions taken as a result of the incident occurring.
- We were shown evidence which assured inspectors that notifications to external bodies were taking place as soon as reasonably practicable after the event occurred.
- We saw examples of thorough reviews or investigations being carried out. We found that never events and serious incidents were investigated using the revised never events framework and the serious incident framework. If staff were involved in a serious incident or a never event they were fully included in the investigation processes. All staff were offered a debrief within 72 hours of the incident taking place. This gave them an opportunity to reflect and share experiences with the investigating officer. A member of the executive team was also available to support them through that difficult time.
- We saw multiple examples of lessons being learnt as a result of incidents at every level, and how practice had changed as a result. One example was the production of a video to explain the importance of debriefing after theatre. Inspectors watched this video and found it educational. It was a good tool to raise awareness of the never event which occurred and the learning taken from it. Other changes included the addition of a second safer surgical checklist when staff members changed as a form of handover. To raise awareness of safety in the theatres human factors training had been introduced.
- We found that lessons from incidents were generally shared well on the wards. Safety briefings each morning created the forum for these conversations, which were supported by weekly emails and newsletters for those who could not attend the sessions. In theatres the sharing of learning from incidents was more sporadic. Staff we spoke with in theatres had a good knowledge of the never events. However, some could not describe the learning taken from them, or identify what had changed as a result.
- Multi-professional surgical (including anaesthetic) mortality and morbidity (M&M) reviews were held regularly and were minuted. Learning was shared at these meetings and was then disseminated through clinical educational sessions, speciality team meetings and project steering group meetings. We saw multiple examples where the learning taken had fed into service improvement, including changes to processes.

Safety thermometer

- The service monitored the incidence of pressure ulcers, falls, catheters and urinary tract infections, and venous thromboembolisms. On all surgical wards this information was displayed appropriately to give transparency on their safety performance. Ward sisters commented that little feedback was given to them to learn from their performance. If they identified that standards were slipping using the information they were given, this was raised in the daily safety briefing to all staff and through emailed newsletters.
- The National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 3 statement 1 stated that all patients, on admission, should receive an assessment of venous thromboembolism and bleeding risk using a risk assessment criteria described in a nationally recognised tool. The trust's performance report for October 2015 showed completed assessments done on admission. The trust's target was 95%. The surgical directorate's average percentage of completed venous thromboembolism assessments was 89.7%. This put patients at higher risk of developing deep vein thrombosis or an embolism going unidentified.
- The NICE QS3 statement 4 states that patients should be reassessed within 24 hours of admission for the risk of

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venous thromboembolism and bleeding. We found that these reassessments were not done in all of the patient records we looked at. This increased the risk of harm to patients.

- The trust's performance report for October 2015 showed incidents of category three and four pressure ulcers between November 2014 and October 2015. The trust's target was to have no hospital-attributable pressure ulcers during this time. There were six pressure ulcers during this period.
- All staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. We were given multiple examples of where incidents were reported, and found an open and transparent incident reporting culture.
- Monthly dashboards were used to monitor safety goals and performance against them. The performance of the surgical division was good, with some areas of improvement. These included the number of grade three and four pressure ulcers, the completion of venous thromboembolism assessments on admission, and medication errors.
- The trust's target for harm free care was 95% or greater. The surgical directorate's average percentage of harm free care was 99%, so better than the trust's target. This was comparable with the rest of the trust.

Mandatory training

- The trust's performance report from October 2015 displayed the mandatory training rates of staff in the surgical directorate between April 2015 and October 2015. The average rate of mandatory training completeness was 86%. This was slightly worse than the rest of the trust.
- We spoke with staff on the wards and in theatres. The most common theme was that there were shortfalls in staffing to manage the acuity of the patients. This resulted in mandatory training being delayed. Where training was delayed or cancelled additional dates were introduced and ward sisters had a good oversight of where their short falls were.
- Additional mandatory training was provided in areas where specialist knowledge was required. For example in recovery, staff had appropriate intermediate and advanced life support training.

Safeguarding

- There was a trust-wide safeguarding policy which was available to all staff on the intranet. This 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.
- Staff we spoke with were confident about their roles and responsibilities to safeguard adults and children. Staff could direct us to the policy. We were given an example from staff where they have had to raise a safeguarding alert, which was in line with the trust's policy.
- Staff in theatres and recovery could describe to us additional training they had received to manage post-operative safeguarding risks.

Cleanliness, infection control and hygiene

- Three patients we spoke with said that the environment looked clean and tidy. Inspectors observed that the wards and theatres were also visibly clean.
- Hand hygiene audits were conducted monthly to monitor levels of hand hygiene compliance. The surgical business unit performance and quality data book showed a 94% compliance with hand hygiene compared to a 95% target.
- To reduce the risk of *Clostridium difficile* (C. diff) some of the wards had removed all gel dispensers to encourage hand washing. We saw that this system was effective on the wards and saw all staff using hand basins as appropriate.
- NICE QS61 statement 3 states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode or direct contact of care. We observed that all staff were following this standard and washing their hands appropriately.
- The wards had clear signposting for hand washing, gelling of hands, and to be bare below the elbow. However, on several occasions we observed doctors in clinical areas not bare below the elbow. On Forrest ward we observed a sister challenging a consultant who dismissed the sister's concerns.
- Due to ongoing building work around the theatres' area each theatre had a weekly deep clean or more often if recommended by the infection control team. The infection control team regularly took air samples and swabs to test the cleanliness of theatres.

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- NICE clinical guideline 74 sets out the guidance based on best evidence for the correct cleanliness processes for surgical procedures in the preoperative and intraoperative phases. We observed that all staff complied with this guideline.
- The trust policy for escalation put patients at risk of contracting methicillin resistant *Staphylococcus aureus* (MRSA). Ella Rowcroft Ward was an elective orthopaedic ward where all patients admitted were screened as being MRSA negative. However, during times of escalation patients who had not had a confirmation of their MRSA status were admitted to the ward. This compromised the status of all patients on the ward. This posed a risk to patients having surgery as orthopaedic lists would continue during this situation. This increased the risks to the patients acquiring an infection while in surgery.
- On Cromie ward we found commodes that showed signs of wear, which posed an infection control risk.

Environment and equipment

- The design, maintenance and use of facilities kept people safe in the ward environments. However, in theatres there was no separation of clean and dirty corridors. Dirty waste was bagged appropriately in the sluice room and then moved to bins outside of the corridor between lists. There was a risk that a bag might split and compromise the clean status of the corridor.
- We found the majority of equipment was maintained appropriately and within its service dates. However, there was equipment in theatres which was beyond its replacement date. When we asked about this we were shown that it had been raised to managers and was on the theatres' risk register.
- Surgical equipment and resuscitation equipment was fit for purpose and was mostly checked in line with professional guidance. Anaesthetic equipment in theatres was checked at the start of each list by an operating department practitioner (ODP) and an anaesthetist. Regular checks were conducted on all equipment by electrical services. This was clearly documented and logged in line with guidelines.
- A daily check of all equipment on the top and sides of the resuscitation trolley was required as stated in the trust's resuscitation policy. This included the checking of manual defibrillators, automated external defibrillators (AEDs), defibrillator pads, razors, scissors, portable suction units, oxygen cylinders (which should be at least

three quarters full), and gloves. We found that these checks, which should be recorded in a log book, were not routinely signed. For example, on Ainsley Ward we found that in January 2016 there were eight signatures missing. However, we were assured they were checked by other documentation found in the safety brief.

- Inspectors went into the hospital sterilisation and decontamination unit. We found this area to be well-managed and process/protocol driven. There were good systems for tracking equipment with audits being done on a daily and weekly basis in line with best practice. Staff in the unit were accountable for the work they did and errors could be tracked to an individual as a learning opportunity and for performance management.
- To manage winter pressures, 20 additional air mattresses were added to a rental contract to ensure that patients at risk of acquiring pressure ulcers were appropriately managed. It was stated in minutes of a pressure ulcer meeting that there were no ad-hoc rentals of mattresses meaning that all patients who needed an air mattress got one without having to wait for one to be delivered. To manage the proper use of air mattresses a training video had been produced, which was available to all staff on the trust's intranet. All patients who were assessed as having a fractured neck of femur were automatically allocated air mattresses from the emergency department to the ward.
- In theatres we found an extension lead across a floor with open plugs causing both a tripping hazard and fire hazard as liquids were nearby.
- All appropriate pressure-relieving equipment was used during surgery.

Medicines

- Arrangements for managing medicines, medical gasses and contrast media kept people safe. We found that medicines were stored securely in locked cupboards, fridges and medicine trolleys, in secure rooms. Intravenous fluids were stored in a secure room and no expired medicines were seen. 'To Take Away' pre-labelled medicines on Cromie Ward were held securely, produced and dispensed appropriately by two nurses. Controlled drugs were managed well and checked regularly for low stocks. However, we found

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that some medicines drawn up in theatres were left unlabelled, not dated and stored in an unsupervised room which was not in line with safe practice or the trust's medicines' policy.

- In terms of medicines, resuscitation trollies had in date supplies which were appropriately maintained and checked by pharmacy staff. If a box had been opened it was promptly replaced.
- Staff had access to policies on the intranet and could describe their responsibilities. Restricted lists of antibiotics were held on wards to remind nurses when "special requests" were required. These were often patient-specific and labelled for specific patients. Routine access to medicines was restricted to trained nurses who were permanently employed by Trust. Intravenous medication was prepared by trained nurses assessed as competent to do so. Online guides were available to assist nursing staff with calculations and methods of administration.
- The implementation of safety systems to monitor and improve practice was not always followed, particularly around refrigeration. Whilst current/maximum/minimum temperatures were recorded on the correct register in the majority of areas, there were deviations observed and actions not always recorded. We found in some areas that the staff were not using the thermometers appropriately, which altered the recorded temperatures.
- We observed two patients receiving medicines and found the process was safe and comprehensive. It included confirmation that it was the correct patient and an explanation of medicines to be administered was given. Doctor's bleep numbers were always recorded. However, we found that signatures were not always clear or legible.

Records

- In the surgical directorate individual care records were generally well written and managed in a way that kept people safe. We found that all surgical wards had medical records stored securely in lockable trollies which were always locked when not in use. However, we found in day case surgery that there were records kept behind the reception that were not appropriately secure. The area was open and notes could be walked away with without staff knowing. We also found that notes' trollies were not lockable or secure.

- We looked at five patient's records and specifically looked at medicines. We found that prescription chart observations were clear and comprehensive and showed low incidents of missed doses. Where doses were missed there was an annotation with an explanation in five of the six records checked. Allergies were well documented in all records. Medicine reconciliation and additional advice was well documented by pharmacy in all six records we looked in.
- We found there were issues in the retrieving and editing of letters which had already been archived. If amendments were needed a physical letter could be shredded. However, in a digital copy there were restrictions in place which meant that a letter could not be destroyed. This meant there would be two versions of a letter in circulation. There was a risk that patients or clinicians may be given the wrong letter and the wrong information.

Assessing and responding to patient risk

- We found comprehensive risk assessments were carried out for most patients and were in line with national guidance. However, for a small proportion of the notes checked we found that repeat examinations were missed, including MUST (malnutrition) scores, pressure area scores, and venous thromboembolism re-assessments. We also found that some assessments were completed, but not in the detail expected. For example one set of notes said that analgesia was given, but didn't explain if they continued to be in pain or were uncomfortable. In one set of notes we found that no bed rail assessment, falls assessment, or MUST assessment were done. We found in one set of notes that there were photos of a patient's pressure areas but no assessment was completed.
- Staff took the time to identify and respond to the changing risks of patients. Safety briefings were held each day on the wards to discuss in detail individual patient needs and risks. This highlighted to staff which patients needed most attention and allowed them to gain an oversight of the ward as a whole. We found on Forrest Ward that these were done as two separate teams (for each area in the ward) which then amalgamated to a joint safety brief afterwards.
- The Anaesthesia Clinical Services Accreditation (ACSA) commended the hospital for its preoperative assessments. Patients seen in the preoperative clinic

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had an assessment, individualised to them. This included an assessment of the risks and benefits to surgery, risks of alternative treatment, and of no treatment using an innovative risk scoring system. High risk patients were seen by dedicated anaesthetists who had received additional training to manage the risks appropriately.

- The service was compliant with the 'five steps to safer surgery', as recognised by the World Health Organisation. The Safer Surgery Checklist is an internationally recognised tool to ensure safety and quality during surgical procedures. The trust audited the use of these forms (in June 2015) and found that out of 102 forms audited 100 of them were fully compliant (98%). 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 their requirements.
- We saw effective use of the surgical safety checklist briefing and debrief before and after every list. This allowed issues to be discussed (broken down to procedure, equipment, surgeon issues, anaesthetist issues and other risks) on an individual basis. It included specific areas that went well, and suggested improvements and with actions allocated to staff to ensure they were implemented.
- During our inspection there were two surgical outliers on a medical ward. We looked in both of these patients' notes and found they were seen daily by either a registrar or a consultant from their speciality.
- It was recognised in a board paper in February 2016 that the numbers of pressure ulcers had been declining steadily since September 2014. In early 2014 the tissue viability services worked with the community teams to develop a programme to improve pressure ulcer prevention processes across the wider health community. This had led to the development of a SSKIN (surface, skin inspection, keep moving, incontinence/moisture, nutrition) bundle which makes the process of reducing pressure ulcers visible to all staff. All staff we asked about pressure care could discuss with us the principles of the programme and could describe the impact it has had to patient care. Within this programme were learning sets, support meetings and videos to improve staff awareness of pressure ulcer care. All patients had photographs taken of pressure sores,

which were stored on secure computer systems and printed as part of the patients' notes. This allowed doctors and nurses to easily track the condition of a pressure area.

- When benchmarked against the national average the trust reported low numbers of incidents against the number of falls expected for the population group. Staff were open and transparent about falls (either with harm or without) and found the low numbers of falls were due to enhanced education for all staff. The falls team had developed a "stability and balance" programme for patients post-discharge, which involved a programme to increase mobility of patients. This had been going for three years and had around 200-300 patients a year. Data has shown this has reduced the number of falls in these patients by 43%.

Nursing and surgical staffing

- We reviewed staffing figures for surgical wards between May 2014 and October 2015. We found wards were well staffed and working within national guidance of one registered nurse to eight patients on day shifts and one RN to 10 patients on night shifts. On average there was one registered nurse to five patients during the day (7.30am to 8pm) and one registered nurse to nine patients during the night (7:30pm to 8pm).
- The Royal College of Nursing guidance suggests the mix between staffing groups on a ward should be 60% RN and 40% healthcare support workers although it is recognised that acuity of patients and skills of staff can influence this ratio. The trust identified a ratio of 57% registered nurses and 43% healthcare assistants staffing mix and was achieving this target (within 1%).
- There were times where the acuity of the patients was greater than the expected and predicted levels. Acuity tools identified that regularly on Ainsley and Cromie wards this was regularly an issue.
- On Forrest Ward (a general surgery ward) we found that out of the 25 beds, 13 were being used for medical patients. The ward sister said they were not staffed appropriately to manage both the surgical and the medical patients due to the comorbidities of the medical patients and the challenges this brought. We were also told it was difficult to manage the consultant base for the ward. During the inspection there were nine consultants managing patients on the ward from various specialities.

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- We were told on Forrest Ward that it was difficult to train and support junior staff due to the pressures on the ward and often staff were stressed and tired. This had been raised with the matron and staffing levels and the acuity of patients were being reviewed.
- Staffing was a challenge in theatres. Out of an establishment of 187 whole time equivalent (WTE) roles there were 27 WTE vacancies. However, ten of these vacancies had been filled with the last due to start in April 2016. Mitigating actions included the use of agency staff. It was clear through documentation that each member of agency staff had a thorough induction programme which was bespoke to their needs. Another impact on theatre staffing was the lack of dedicated obstetric theatre staff. When there were obstetric emergencies staff were taken from elective lists to manage these patients, leaving the elective list teams understaffed. This impacted on the staffing levels in theatres, requiring a greater reliance on bank and agency staff to backfill.
- Out of a total of 156 medical staff the skill mix was relatively comparable with the England average. The largest difference was a 6% increase of consultants compared to the national average. Staff commented there was always access to medical staff when required. Medical notes we checked in had timely consultant reviews.
- On Forrest Ward there was one junior doctor to manage all patients. The senior sister and the doctor were working together to manage the needs of patients, combining experience and medical expertise.

Major incident awareness and training

- We saw major incident plan awareness was embedded in both wards and theatres. In theatres we saw a 'bronze pack' which had everything required of the staff in that area during a major incident.
- Staff were able to show inspectors where to find the major incident plan and could describe their responsibilities as part of it.
- We were not told of any major incident exercises taking place in theatres or wards from any staff.

Are surgery services effective?

Good



We rated effective to be good because:

- The trust participated in a number national audits and performed better than the England average in seven of nine measures of the Hip Fracture Audit and in three of five measures in the Bowel Cancer Audit
- The service benchmarked against other trusts and was a top performer in terms of effectiveness and patient outcomes.
- Multidisciplinary working was fully embedded in the surgical directorate and was inclusive of other areas of the hospital.

However:

- The trust performed slightly worse than the England average in two measures of the Patient Reported Outcome Measures (PROMs) and in some measures of the National Emergency Laparotomy Audit (NELA).
- Appraisal rates, although comparable with the rest of the trust, were not meeting targets and some areas, such as in pre-assessment, were not given opportunities to gain additional competencies to develop their careers.

Evidence-based care and treatment

- We found that both in wards and theatres relevant and current evidence based guidance, standards, and best practice legislation was identified and was used in the service. Staff could discuss with us recent NICE guidelines and how they impacted on the treatment and care delivered.
- Audit results showed that surgery was managed in accordance with NICE guidelines for CC24 hip fracture, QS49 and surgical site infection. In the 2015 Hip Fracture Audit, Torbay Hospital performed better than the England average in seven out of nine relevant measures. These included patients being admitted to orthopaedic care within four hours (18%) compared to a national average of 46%), and patients having surgery on the day or the day after admission 67% compared to a national average of 72%). Both measures had a decline in performance between 2014 and 2015.

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Nutrition and hydration

- We found that nutrition and hydration were well managed and monitored in patient notes. Of the notes we looked in, all patients had complete fluid charts. Patients we spoke with said they were in regular communication with the staff about their nutritional needs.
- Staff said that referrals to dietitians and speech and language therapists were easy to arrange.
- Four patients commented positively about being able to drink water when they were waiting for their surgery. However, one patient we spoke with was told conflicting information about being able to drink water as nurses didn't know what the right thing to do was.

Pain relief

- There was a pain team in the hospital (made up of nurses and doctors) who were able to prescribe and administer various types of pain relief as required. The service was available between 8am and 6pm with overnight cover provided by an on-call anaesthetist.
- Patients we spoke with said their pain was well-controlled and that analgesia was provided quickly when asked for. Of the notes we looked in pain charts were regularly completed for patients. We saw records in the notes showing that patients received pain relief in a timely way.

Patient outcomes

- In the 2014 Bowel Cancer Audit, Torbay Hospital was in line with two measures against the England average (case ascertainment rate and data completeness) and performed better than the England average in three (patients being discussed in a multidisciplinary team (MDT) meeting, patients seen by a specialist nurse and patients having a reported computed tomography (CT) scan). Other scores were comparable to the England average. The trust performed better than the national average for its patient reported outcome measure (PROM) audit in one measure (discussion of the patient at an MDT).
- The National Emergency Laparotomy Audit (NELA) is a national tool used to establish the quality of care provided for patients undergoing an emergency laparotomy (a surgical procedure involving a large incision through the abdominal wall to gain access into the abdominal cavity). In the 2015 NELA, Torbay hospital

was rated amber (50-69%) for most measures. However, the trust performed poorly for a consultant review being conducted within 12 hours of emergency admission, the documentation of risk and the assessment by a Medicine for Care of Older People (MCOP) specialist in patients over 70 years old.

- The standardised relative risk of readmission was better than the England average overall.
- Patient reported outcome, measure scores (PROMS) for the trust for April 2014 to March 2015 were similar to the England averages in terms of patients' health status after an operation. These audits measure the patient outcome for hip and knee replacements, groin hernias and varicose veins.
- The day surgery unit was nationally a top-performer in terms of effectiveness and delivery of surgery. Through the Better Care, Better Value website (a nationally used benchmarking tool), Torbay Hospital was ranked as a top-performer for patient outcomes for acute trusts nationally.
- Through using the British Association of Day Surgery (BADS) benchmarking tool of 200 procedures, Torbay Hospital was ranked as the top acute hospital nationally.
- The trust was benchmarked against the audit commission standards and was rated as a top-performer in all 25 procedures tested.
- The use of outcome data was fully embedded into the day surgery unit. We were told that using outcome data, changes had been made to improve the patient experience and outcome. One example of this was identifying a higher than expected unplanned admission rate for hernias due to pain and difficulty mobilising after surgery. Protocols were changed allowing the surgeon to administer anaesthetic routes allowing for better control of pain and reducing the percentage of patients having a longer than expected stay by 96%.
- We were shown data demonstrating that although the complexity of day surgery was going up the unexpected inpatient stays remained constant and steady.

Competent staff

- The trust's performance report from October 2015 displayed the appraisal rates of staff in the surgical directorate between April and October 2015. The average rate of appraisal completeness was 86.1%. This

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was comparable to, or better than, the rest of the trust. We saw information which showed, in most cases, that where appraisals were incomplete or nearly elapsed, dates had been arranged to get them done.

- The Anaesthesia Clinical Services Accreditation (ACSA) recognised that the hospital “had an excellent teaching and learning facility available for all departments to use in the Horizon centre”. The centre provided simulation suites and theatre simulation suites with advanced equipment and mannequins, including adult, child, and baby sizes.
- An audit of doctor revalidation was conducted as part of the 2014/2015 audit programme. The results found that the trust was in line with the GMC requirements and identified areas of good practice and areas of further action. Trust-wide days showed a good compliance with appraisal rates for doctors with only 34 of 249 doctors not having had an appraisal within 12 months.
- In the day surgery unit, performance data was broken down to individual surgeons to identify areas of greatest need and to show what was working well.
- In order to raise competence in all areas, all new surgical ward nurses were offered a six month rotation into theatres to gain experience in that area.
- Staff we spoke with said they had their learning needs defined and actioned through appraisal and continual supervision, and found it a positive environment to develop and grow professionally. Revalidation needs were recognised and supported by the trust and study days were being arranged to support staff further.
- On Forrest Ward there were patients who had tracheostomies and on Allerton Ward there were patients who required total parental nutrition. All staff had training and yearly updates in the management of this patient group and a spreadsheet was used to record competence.
- On Allerton Ward, all medical staff had an induction to explore the importance of good hand hygiene and the following of policies.
- We spoke with one student nurse who said they were well supported by their peers. We were told they had completed all of their mandatory training and were getting regular time with their mentor.
- In the pre assessment clinic nurses were not allowed to perform chest, heart or lung examinations even though

they had the appropriate qualifications to do so. This was because the staff were not banded appropriately as advanced practitioners and would not be following best practice as defined by the Royal College of Nursing.

- Cell salvage was used for all cases to reduce the usage of pre-packed blood products. Teaching on this was led by an operating department practitioner (ODP) who then followed up with yearly updates and a competency framework.

Multidisciplinary working

- Multidisciplinary team (MDT) meetings were held every Wednesday and included doctors, nurses, physiotherapists, occupational therapists and discharge co-ordinators. This was where patients’ care plans and subsequent actions were discussed. To ensure the information was available to the wider team stickers were used on patient notes to standardise how the information was shared.
- Physiotherapists and occupational therapists were based on the wards full time and we observed them working well with the wider team.
- We observed good communication between an ODP and the ward staff during a patient handover from recovery. This was clear and easy to understand for everyone involved.
- We found the discharge process for surgical patients was well coordinated and ensured effective discharge of patients. Discharge co-ordinators were employed to be responsible for discharge in three wards each and attended all bed meetings, safety briefings, and therapy handover meetings.
- The co-ordinators also attended daily control meetings with the discharge liaison teams for Torbay and Devon and social services. This acted as a forum to raise concerns and to pass information from one organisation to another.
- We saw in patient notes that discharge conversations happened on the day of admission. The discharge co-ordinator saw every patient admitted on the same day to get to know them and to discuss the forward plans for that patient.
- If packages of care were set up by the hospital (rather than social services) the co-ordinator regularly followed up patients after discharge between the package starting and discharge to ensure continual care for those patients.

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- As part of the integrated care between the acute and community trusts physiotherapists and occupational therapists from the community came into the hospital to assess patients for intermediate care. This was known as an in-reach team. This allowed the acute staff to manage their caseload of patients in a more timely way and allowed the in-reach team to get to know the patients better, thus improving continuity of care.
- The trust's performance report from October 2015 showed the percentage of care planning summaries completed within 24 hours of discharge. The trust's target was 77% on weekdays and 60% at weekends. Between the months of November 2014 and October 2015 the average number of summaries being completed in less than 24 hours of discharge on weekdays was 53% and on weekends was 24%.

Seven-day services

- Pharmacy, Imaging and Therapy services were available for all inpatients seven days a week. Consultants were on duty on site seven days a week for emergency care and on-call rotas were in place for all specialities.
- Seven day surgical lists were running for orthopaedics and the endoscopy service was also available seven days a week.
- Vascular patients were managed seven days a week through a joint working project with the Royal Devon and Exeter Hospital, through a vascular network. This allowed patients treated at either hospital at the weekends.

Access to information

- The Anaesthesia Clinical Services Accreditation (ACSA) commended the hospital for the management system used to flag and highlight patients with abnormal results. This system allowed anaesthetists to review and promptly refer patients as appropriate. It also allowed for an audit trail of patient identification throughout the pathway to ensure compliance with national policy.
- Staff on the wards had easy access to results of tests and examinations. We were told they were always completed in a timely way and that delays in the reporting of scans or samples was never an issue.
- There were protocols in place to ensure that when patients moved between teams in the hospital that all relevant notes and information were transferred in a way to effectively maintain the patients care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and could give us real and hypothetical examples of where it would be used. Staff were aware of who to go to when raising a concern.
- There was a trust-wide programme of consent recording, which included procedure details, anaesthetic information, and patient details. There was a local audit conducted of the surgical admissions unit between June 2014 and January 2015 where 75 records were examined. The audit showed the medical information was relevant and filled in appropriately with regard of best interest decisions included. However, legibility of consent forms and the use ease of understanding was poor.
- The trust had a policy to manage Deprivation of Liberty Safeguards and provided guidance for staff managing the care of someone over the age of 16 who may lack capacity in relation to specific decisions.

Are surgery services caring?

Good



We rated caring to be good because:

- Feedback from people who used the service and from those who were close to them was consistently positive about the way staff treated them. Friends and family tests produced good results and patients we spoke with were constantly positive about the care they had received.
- People were treated with dignity, respect and kindness at all times during all interactions with staff we observed.
- Patients and their relatives were given the support they needed to understand their care and treatment and there was a shared decision making process around this.
- Staff helped people and those around them to cope emotionally with their care and treatment with their needs being understood by all staff.

Compassionate care

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- All 28 patients we spoke with said they were treated with kindness, compassion and respect. Patients and relatives told inspectors that the care they had received was excellent and met all of their needs.
- Dignity was maintained at all times. We saw curtains were being closed for confidential conversations and examinations. Several patients commented about the respect and dignity they were given. One patient said all their needs were met and the staff were kind and treated them with respect. One patient said the staff had been polite, passionate and caring to them.
- Two relatives of a patient said their son had just come out of surgery and they were happy with the care received that day.
- One patient said they would be happy for any of their friends or relatives to be treated at the hospital.
- Four patients we spoke with said they had really good experiences with the staff in the day surgery unit and said staff had a good attitude and had been passionate, caring, and considerate. They also commented that the experience in hospital had been wonderful.
- One patient we spoke with said that when they had to use the call bell they were answered quickly. We observed on all wards that where call bells were going off there was only a short amount of time before they were answered. Staff always spoke to patients in a caring manner when responding to call bell alerts and were introducing themselves.
- Friends and Family test information was provided by the trust; however, response rates were worse than the national average throughout the hospital. Data provided by the trust showed the surgical divisions consolidated wards Friends and Family test results. Out of 2,518 responses between November 2014 and October 2015, 2,147 (85%) respondents were 'Extremely Likely' and 304 (12%) were 'Likely' to recommend the hospital as a place to be treated.
- Friends and Family Test questionnaire results were published monthly on a public website and each area promoted their results locally on a poster (if five or more responses had been received).
- We saw a good example of care where a patient, who was struggling to read the menu, had a healthcare assistant sit with them and explain the choices to them. The healthcare assistant was at the patient's level and regularly made eye contact to ensure they understood.

Understanding and involvement of patients and those close to them

- We spoke with two relatives of a patient in the day surgery unit. They said they had been fully involved in the process and were made to feel welcome. They were also included in information giving sessions to the patient and were given the opportunities to ask questions. One patient said they were well informed of anything that was going to happen to them and felt fully involved with their treatment.
- We saw all staff spoke kindly to patients and explained everything to them to the detail that best suited the patient's needs.
- We spoke with one patient 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 him down to see his daughter and had constant updates from the medical team involved in care.
- We were given an example where a patient had young children who would be unable to attend during visiting hours. The patient's family were allowed to attend outside of the normal visiting hours, in the evenings, and were told they could visit at any time for as long as they wanted.
- We were given an example of good care when a relative could not find a parking spot to visit a patient. When the ward found out about this they made arrangements to reserve a parking space for them the following day.

Emotional support

- One patient we spoke with said they had been fully supported throughout the processes of the operation and felt safe and secure.
- Another patient we spoke to was distressed because they had their operation cancelled prior to talking to an inspector. We saw some good emotional support being provided by the consultant surgeon who explained the reason for the delay and apologised to them. We spoke with the patient after the apology who said the doctor was gentle and kind and had a good sense of humour, which cheered the patient up.
- A third patient said they needed help with eating and drinking and felt embarrassed by this. However, the staff made them feel at ease when they helped them and maintained their privacy and dignity when feeding him.

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Are surgery services responsive?

Requires improvement



We rated responsive to be requires improvement because:

- The trust did not meet targets for Referral to Treatment (RTT) waiting lists in six out of seven specialities including ophthalmology, general surgery, trauma and orthopaedics, urology and oral surgery.
- The pressure for beds within the hospital meant that elective patients were not receiving surgery in a timely way. There were waiting lists in most specialities but we were shown evidence of how the trust was working with outside organisations (such as clinical commissioning groups, other acute hospitals, and general practices) to reduce these.
- The number of patients who had their operations cancelled remained higher than the England average.

However:

- The surgical division had clear processes in place for the management of patients living with dementia and learning difficulties. Staff could describe their responsibilities to these patients and we were told of examples where these patients had their specific needs met.
- Evidence collected showed that there were no mix sex breaches in the surgical division, that the average length of stay was better than the national average and that the number of cancelled operations remained low.
- Patient had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. One good example of this was with rapid recovery programmes.

Service planning and delivery to meet the needs of local people

- The trust was working with the CCG to develop trajectories for both five and 10 years' time and was looking at ways to limit the impact this would have on the service. It was predicted that in five years, due to the age profile of the area, demand will have gone up by 15% and in 10 years would have gone up by 39%.
- It was also recognised by the trust that demand was increasing from other trusts in the area. Two acute trusts

in Devon regularly referred patients to Torbay due to their own capacity and demand issues, increasing the pressure on the trust. This was particularly an issue for breast and ophthalmology patients.

- The trust was working with GPs to reduce the demand in the service by delivering learning sets for pressured services to reduce unnecessary referrals. It was found this had been beneficial to the demand in ophthalmology, ear nose and throat, and general surgery. The trust had also set up an initiative with GPs called Seeking Advice in the integrated care organisation (SAICO) which acted as an information delivering service for GPs. The GP would contact the consultant concerning a patient and would give advice about whether a referral was needed or not. This had been piloted in urology and had reduced referrals by 10%. This was being rolled out in all other specialities. Surgeons were facilitating additional surgical sessions and working longer sessions for gynaecology, upper gastrointestinal (GI) and ENT to manage capacity. Some consultants were also running twilight and weekend lists.
- All patients were risk stratified to great detail, which meant patients who were at highest risk had their operations first. Spreadsheets were used to identify individual patients allowing them to be easily contacted and pursued. However, this was having an impact on routine patients as operations were regularly being postponed. This was having the biggest impact on upper GI patients.
- In day-case surgery the department was in conversation with the breast care service and with vascular surgery (carotid surgery in particular) to find a way to make some operations day-case. The service was also planning to expand physically, gaining two more theatres to allow for more day case surgery away from the inpatient theatres. Meetings were taking place the week after the inspection to discuss this with other areas in the hospital.
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Access and flow

- The referral to treatment standards state that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral, after taking into account clock pauses (medical pauses in treatment), patients electively choosing to wait for treatment, and patients declining treatment altogether. The trust only met this

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target for its ear, nose and throat (ENT) speciality patients. Ophthalmology performed poorly with only 38% of patients being treated within 18 weeks, followed by plastic surgery with only 66% of patients being treated within 18 weeks. All other specialities (general surgery, trauma and orthopaedics, urology, and oral surgery) performed with 73% and 88% of patients being treated within 18 weeks.

- The trust met regularly with the commissioners to discuss the flow through the hospital and how the demand of the service is changing. Although demand for the surgical service was slowly reducing, the dynamic of the patients was changing from more patients being routine operations to more being emergency operations. For example, the demand for colorectal surgery was down by 12%; however emergency patients within two week waits were up by 4%. Similarly with urology, the number of emergency patients requiring treatment within two weeks were up by 7%.
- Managers told us that other limiting factors to the flow of patients in the surgical division were access to beds and access to critical care beds, and recruitment issues for theatre staff. During the inspection there were 30 medical outliers restricting the flow of surgical patients. A medical outlier is a patient who would be best placed on a medical ward, having to be on a surgical ward.
- The number of cancelled operations was higher than the national average but remained steady between quarter three 2014/15 to quarter one 2015/16. The trust's performance report from October 2015 showed a monthly trust target of less than 0.8% of elective operations being cancelled on the day of surgery. The average percentage of cancellations between November 2014 and October 2015 was 1.1%. The number of patients who had not had their operation within 28 days of initial cancellation remained below 10%, but was higher than the England average.
- The trust performance report from October 2015 showed there were no mixed sex breaches in the surgical directorate between November 2014 and October 2015.
- The average length of stay for both elective and non-elective patients, in the period between July 2014 and June 2015, was either comparable or better than the England average with the best performer being the trauma and orthopaedics speciality with patients being discharged three days before the national average.

- The average length of stay in the hospital for day case surgery was benchmarked nationally and showed the hospital was performing significantly better than the national average for gynaecology, head and neck, ophthalmology and vascular surgery.
- We were told that managing surgeons' time in the breast care centre was difficult. When they took annual leave there was limited staffing capacity to cover lists. This required lists to be extended both before and after a period of annual leave. Two years ago there were 34 breaches in the summer months as a result of annual leave. Last year a locum was employed to cover this period resulting in no breaches. This contract was due to be assigned again for the upcoming summer months.

Meeting people's individual needs

- The trust had a dementia strategy based on appropriate care for patients living with dementia (including both physical and mental welfare), the correct assessment of these patients, and the environments in which they were cared in.
- Wards were awarded a 'purple angel' status when over 90% of their staff had received training in the management of patients with dementia. All staff we spoke with could demonstrate their responsibilities for managing patients with dementia and spoke about 'This is me' documentation. We were also given positive examples where carers and relatives had been in discussions about patients' care and where dementia link teams were contacted to manage patients.
- Staff were aware of patients with learning difficulties before they attended the ward through good communication between the pre-assessment clinic, referring GPs and consultants. This gave adequate time to make appropriate adjustments to care.
- We were given examples where patients with learning difficulties had their needs met. One patient had photographs taken of the ward and the recovery area to allow them to understand better what was going to happen before they arrived. Another example was where the carer was allowed into recovery before and after the operation to be with the patient. We saw interactions between the patient and the learning disabilities team recorded in patient records.

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- 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.
- Patients had access to a wide range of resources tailored specifically to their surgical procedure. Where patients were under an enhanced recovery programme they had a very detailed pack taking them through every stage of their recovery. There were also leaflets produced for carers of patients to include them in the information giving process.
- There was information displayed in the waiting areas of day surgery relating to both adult and paediatric surgery. We spoke with two relatives of a child who said the information available was of a good quality. However, they felt this information could have been shared before attending the unit as it is a little too late to absorb properly when in the waiting room.
- We spoke with two relatives who said their son was given an electronic tablet device when attending the day unit to occupy him prior to his operation. We were also told that both relatives were offered refreshments on a regular basis throughout the day.
- One patient we spoke with was happy they had access to facilities such as Wi-Fi and a television in the day room. Another patient said that having access to the internet had “a big impact to them and their relative to reduce the boredom factor.”
- Four patients we spoke with were positive about the food and drink available to them. One patient described the food as “excellent” and that they had “the best sausages they had ever tasted”.
- One patient said that all of their dietary requirements were met without question or hesitation, showing a well-planned system of nutritional management.
- One patient commented that being on re-enablement (a method of increasing the rate of recovery) as part of the aftercare from their bowel cancer was really good. They felt supported during this and it increased their confidence to be more independent.
- We observed one patient who was refusing to take medicine as they were struggling to swallow a large tablet. The nurse agreed to speak to the doctor to identify an alternative method of administration.
- Patients were encouraged to mobilise themselves and gain independence through an enhanced recovery programme. Patients we spoke with about this were well prepared and enthusiastic about being involved in their treatments.
- The Anaesthesia Clinical Services Accreditation (ACSA) commended the hospital for its information management for elective surgery patients. All patients attending the high risk pre-assessment clinic received a copy of the letter that is sent to their GP and surgeon that summarises the consultation and states their perioperative (occurring around or during the time of operation) risk of dying. It also included comments on the mortality risk of not having surgery and perioperative morbidity. Patients were also invited to contact the doctor by telephone if they had any further questions about risks and benefits.
- When attending the preoperative clinics all patients were given an information pack to take home with them which included pre-surgery drinks, information on quitting smoking (if requested) and advice specific to the type of anaesthesia and surgery they would be receiving.
- Four patients we spoke with said they had received information on their operation in good time before attending the hospital, either through the post or by telephone.
- One patient we spoke with said they were happy with the timeliness and the quality of the information provided before the day of operation.
- One patient we spoke with was very happy because their operation was brought forward by two days to fill a spare slot. This made the experience positive for the patient and they were extremely happy with the care provided.

Learning from complaints and concerns

- We spoke with ward sisters about the management of complaints on the wards. We were told that de-escalation of complaints and managing them at the time they happened was encouraged. When this occurred the Patient Advice and Liaison Service (PALS) team were informed and it was recorded. This was in line with the trust policy.
- We were given examples where staff had managed complaints locally and telephoned patients and their carers to discuss their complaint and the learning taken from them.

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- We saw leaflets throughout the surgical directorate for PALS. They were easily accessible by all patients and visitors. Patients, in their information packs, were also given information on how to make a complaint.
- A total of 491 complaints were received by the trust between October 2014 and October 2015. Of these complaints 154 (31%) were related to surgery with 51% of these being responded to in 30-60 days. Themes included the attitudes of staff, delays in operations, cancelled operations, and poor care and treatment. However, only 15% of these complaints were upheld, with 38% only being partly upheld.
- Learning from both complaints and incidents were published monthly on the 'Listening and Learning' intranet page. These pages were also publicised through the weekly staff bulletin and the Communications Team to ensure distribution and dissemination of the learning.

Are surgery services well-led?

Good



We rated well-led to be good because:

- There was an effective governance structure in place which was supported by both time and resource. There was clear evidence of discussions and review on risks, incidents, audits, complaints, and quality performance at divisional level with clear process to escalate and disseminate.
 - The culture of the service was open and transparent with the patient's best interests at the centre of everything. Feedback from service users was regularly collected through the use of a questionnaire and we saw examples where this had changed practice and patients' experience.
 - Innovation was a clear objective which was embedded throughout the surgical directorate a focus on finding a way for the patient to be in the hospital for the least amount of time. Operations which were traditionally performed as inpatient cases were being done as day case with no effect on the safety or outcome of the patient.
 - There was innovative use of technology to act as learning resources for staff both in the use of videos on the intranet and virtual reality headsets to teach about never events and human factors.
- ### Vision and strategy for this service
- The vision and strategy for the surgical division was based around the recent restructuring into an integrated care organisation (ICO). A new structure was being developed to see how the community health element integrated with the acute hospital and how best to use resources to improve patient flow and experience in the future. Staff we spoke to about this were excited about the opportunities that the ICO may bring and that they were being fully informed of its progress and changes being made.
- ### Governance, risk management and quality measurement
- As of November 2015 there were 17 risks on the surgical risk register. Themes included backlogs in patients waiting for surgery, particularly in ophthalmology, and patients waiting longer than the 18 week standard for treatments for ophthalmology, general surgery, and breast care. Each item went into detail about control measures, how assurance would be gained (both internally in the trust and by external stakeholders) and individuals who were accountable for achieving this.
 - We were told that the division had been on a journey to get where they were during the inspection in terms of governance, risk management and quality measurement. A year prior to the inspection additional resource was given to the division to allow for greater staffing, increased governance time in consultant job plans, and the creation of a divisional medical governance lead.
 - The board challenged the surgical division on a bi-monthly basis at a quality and performance meeting and discussed progress from the last meeting and the required resources to manage the risks. This ensured a continuous loop of dialogue between the division and the board.
 - There were clear processes and pathways for the management of risk in the division, which was well managed by two governance co-ordinators and the divisional medical governance lead. They acted as the forum for issues to be raised, investigated and actioned appropriately.
 - Information about governance and risk was disseminated to the wards and theatres through leaflets about risk tailored to each speciality, as well as governance boards on each of the wards to display

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performance data. We also saw examples of a newsletter called 'The Gas' which disseminated detailed information about governance and risk management in an easily understood format. Within one issue of this we saw information about current risks, audits, and learning from never events.

- Governance managers were working with matrons and ward sisters to develop the culture of the division to be more governance focused. This had involved educating staff of the importance of governance and reporting incidents and using meetings as a forum to disseminate information. There were also weekly huddles being developed as a more regular forum to discuss governance. As a result of this we were told by managers that staff were open to changes and are gaining an understanding of how governance affected them and their role within it. This worked particularly well in theatres with the adoption of a briefing and debrief before and after every list.
- We were given examples where the governance processes in place had led to changes in practice and procedure for the benefit of patients. One example was the identification of patients with a delay in follow-up. This led to a retrospective look back at all patients in all specialities to get detailed stratification of their individual risks. This had led to improvements in systems and software to allow this information to be collected more appropriately.
- Risk registers in theatres and wards were "owned" by the matrons who took responsibility for raising concerns to divisional levels. There were monthly matron and sister meetings where risk management was discussed.
- In theatres there were monthly audit days where learning from incidents and risks could be shared to everyone.
- Clinical effectiveness days were used regularly to share learning between clinicians.

Leadership of service

- Senior managers said they felt that although there was a hierarchy it was flat, allowing staff to raise concerns as they wished to any level of staff. Staff we spoke with said they felt comfortable to raise concerns and could take issues with relative ease to their immediate management, or higher if required. When concerns were raised staff were listened to and were given updates from managers as to the progress being made.

- Staff said that when they had ideas to improve the service they were listened to and were acted upon. If ideas were not feasible they were given justified explanations as to why a project could not be started.
- During our inspection we saw ward sisters and matrons were visible on the wards and that they were approachable. Staff commented that the sisters' door was always open when they needed to talk to them.
- Staff could tell us of times when the executive team had visited the wards and theatres and gave staff opportunity to raise concerns. Staff said that when they did they were listened to.

Culture within the service

- Across the entire surgical directorate there was a clear culture of patient centred care, being respectful to one another and being open and honest.
- The trust's performance report from October 2015 displayed the sickness rates of staff in the surgical directorate between April and October 2015. The average rate of sickness was below 4%. This was comparable with the rest of the trust.
- In day surgery we were told about the satisfaction of the staff and their involvement with patients during the whole pathway. One member of staff we spoke with said that being a self-contained unit they found they had ownership of the successes it had.
- We spoke with three surgical secretaries who said they felt valued by the consultants and the wider team and that they were part of the clinical team.
- We were given examples where staff had been well supported during difficult times, such as bereavement. This included prolonged compassionate leave and staggered return to work based on the confidence of the individual.

Public and staff engagement

- The directorate regularly used volunteers to perform surveys with patients about their experience in the hospital. In a three month period 44 patients were spoken with. A 20 point questionnaire was used to allow the information to be quantified on a monthly basis and shared with all staff. We found these reports were informative and made recommendations on improving the patient experience. When the surveys were being taken, 'hot' feedback was given to the staff to allow them to make immediate changes to the care being delivered. Staff on wards could describe how its use had

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led to changes in practice. One example of where this had changed practice was by having all staff on a ward trained in clipping toenails as a result of patients raising concerns about access to podiatrists. Other themes identified were noise at night, which the directorate were resolving with the estates team.







- In the day-case unit all patients received a follow-up phone call to answer a questionnaire about how they were feeling and asking if anything could be improved about the care they had received. The top cause for dissatisfaction in the service was that everyone wished they could have a drink prior to their surgery. The trust looked into research and rolled out a trust-wide policy to have no restrictions on preoperative oral fluids to avoid dehydration. As a result of this patients were allowed to drink water up to 10 minutes prior to their operation. This showed significant improvement in patient satisfaction.
- The trust was involved in training outside of the hospital for the management of falls. There was a programme of falls prevention training for GPs and a website had been developed offering training videos and good advice around this.
- Staff felt the management teams were open and transparent when raising concerns or sharing ideas. We were given multiple examples where ideas had been shared with the management team. They were then either accepted and taken forward for feasibility, or rejected. Where an idea was rejected staff were given detailed explanations as to why the project would not work.
- All staff we spoke with felt comfortable to raise concerns with either their direct line managers or senior managers if necessary. They felt listened to and that their concerns were taken seriously. Managers we spoke

with discussed with us examples of where concerns had been raised and described the actions taken as a result. We found that the response by managers to the concerns was good.

Innovation, improvement and sustainability

- The division was using innovative ways to move inpatient surgical procedures into day case surgical procedures, and day case surgery into outpatient-led surgical procedures. We found that 70% of elective surgery was done as day case.
- The day surgery unit performed laparoscopic nephrectomies, a minimally invasive technique to remove a kidney; nephroureterectomies, a technique to remove a kidney with its ureter; uni-compartment knee replacements, vaginal hysterectomies, and laparoscopic hysterectomies (removal of the uterus through the use of keyhole surgery).
- The day surgery unit published and presented its findings from research regularly in international journals and conferences. Last year the unit published three articles and presented at five conferences.
- The directorate were involved with a team in the specialists' department to develop software to improve the patient experience and to offer training for staff. The team were currently developing an application for a smartphone to allow patients to get information on preparation prior to their operation.
- The trust had a selection of videos available to staff to act as training and further education. As part of this a selection of virtual reality videos has been created. This involved the staff member putting on a headset to see from either the patient's or the surgeon's eyes what the experience involved. Videos included going under anaesthesia, someone raising an issue during surgery, and chest pains resulting in surgery. This gave staff the experiences of going through those situations in a realistic way.

Critical care

Safe	Good	
Effective	Good	
Caring	Outstanding	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Torbay Hospital provides a critical care service to adults and children who need intensive care (described as level three care) or high dependency care (described as level two care).

Patients were admitted to the critical care unit following complex and/or serious operations, and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities within the acute hospital and to the emergency department.

The critical care service was located within a single unit. The unit had ten bed spaces to accommodate both level three and level two patients. There were two single occupancy rooms and eight curtained bays. There were also two beds located in the orthopaedic high care bay, which were led by the critical care unit.

The service was led by a consultant intensivist with support from the critical care consultant team and senior nurse.

The number of patients treated has fluctuated over the past five years, but was usually between 150 and 200 per quarter, with about 700 patient admissions per year. Elective (planned) admissions accounted for just below 30% of all admissions, with the remaining 70% being emergency (unplanned) admissions.

The critical care unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC: an

organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland). This is reflected in some of the statistical data used in this report.

As part of our inspection we visited the critical care services on 3, 4 and 5 February 2016. We spoke with a total of 39 staff, including consultants, doctors, trainee doctors, nurses, healthcare assistants, administrative support, the housekeeping team, pharmacists, dietitians, occupational and physio-therapists. We met with the consultant clinical lead for the service and the senior nurse who ran the critical care nursing team. We met with two patients who were able to talk with us, and with their relatives and friends. We checked the clinical environment and equipment, observed care and looked at records and data.

Critical care

Summary of findings

We have judged the overall critical care service to be good. The safety, effectiveness, responsiveness and leadership of the service were all good. Caring was outstanding.

- Patients were kept safe from avoidable harm. Staff worked in an open and honest culture that encouraged incident reporting and learning. Generally good levels of nursing, medical and allied healthcare professional staffing ensured patients received care care. Staff adhered to infection prevention and control policies and protocols.
- Treatment by staff was delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment. Patients' needs were comprehensively assessed and outcomes were recorded and monitored. Staff were skilled, experienced and worked as part of an effective multidisciplinary team.
- Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been overwhelmingly positive. Staff went above and beyond their usual duties to ensure patients experienced compassionate care and that care promoted dignity. Innovative support for patients was encouraged and valued by staff, patients and visitors.
- The critical care service responded well to patients' needs. Patients were treated as individuals, and there were strong link nurse roles for all aspects of patient need. There were few complaints about the department, but where a complaint was received it was dealt with in a timely and compassionate way.
- There was a clear vision and strategy, with staff being actively involved in the development and delivery. Staff, patients and their families were actively engaged with to identify areas of good practice, as well as areas that could be improved. There was a high level of staff satisfaction in a supportive, open 'no-blame' culture. The leadership drove improvement and staff were accountable for delivering change. Innovation and improvement were celebrated and encouraged.

However:

- The unit did not meet current standards for a modern critical care unit and had been recognised by the trust as not being fit for purpose. However, staff worked well within the environment to keep patients safe from avoidable harm and the building of a brand new unit had started.
- Staff had a limited understanding of the requirements of the Mental Capacity Act 2005, and the Deprivation of Liberty Safeguards (DoLS). We could not be assured that patients who required an authorisation under DoLS were having this requested by the unit.
- Bed pressures in the rest of the hospital affected timely discharges from the unit, but the numbers of these were below (better than) the NHS national average. Elective (planned) surgery was impacted on by bed availability in critical care. There were limited facilities for visitors and the unit did not meet the modern critical care building standards. However, a new critical care unit was being built and once opened would provide much improved facilities.
- Governance arrangements required some improvement. In particular a holistic formal review of safety information on a more regular basis was needed.

Critical care

Are critical care services safe?

Good



We have judged the safety of critical care services to be good overall.

- When things went wrong lessons were learned and improvements were made. This was supported by staff working in an open and honest culture that encouraged incident reporting.
- The unit was generally clean and well organised. Staff adhered to infection prevention and control policies and protocols.
- A critical care outreach team provided support to patients in the wider hospital as part of a formalised escalation process should a patient's condition deteriorate.
- There were generally good levels of nursing, medical and allied healthcare professional staffing.
- Most medicines were stored securely in accordance with trust policy and legislation, and equipment was well maintained.

However:

- Intravenous fluids were not secure and were at risk of being tampered with.
- At times there was no shift coordinator because vacancies in the nursing staffing rota were in the process of being recruited into.
- The unit did not meet current standards for a modern critical care unit and had been recognised by the trust as not being fit for purpose.

Incidents

- The critical care unit had a strong focus on patient safety and incident reporting. There was a positive culture amongst all staffing groups to report incidents, including near misses and low harm incidents. Managers encouraged and supported staff to raise incidents. Managers and staff recognised the importance of incident reporting as a learning tool to maintain and improve safety, and were aware of their responsibilities to ensure incidents were reported.
- Incident reporting was accessible and staff knew how to use the system. The trust used an electronic incident reporting system. This was available on computers

throughout the critical care unit and staff were able to access this easily. Staff were provided with guidance on how to use the system, and they told us they were comfortable using it.

- Incident investigations included relevant staff, where appropriate, and were conducted in a supportive manner to ensure learning opportunities could be identified.
- Learning opportunities were recognised and shared with staff in the unit. Once an investigation had been completed and an opportunity to learn had been identified, this was shared with staff verbally during the morning safety briefing, by email or by practice education. We were told that shared learning with other areas of the hospital could be improved, for example between the high care beds and the critical care unit.
- There did not appear to be a standardised process for feeding back to the incident reporter. This meant there were times when a reporter did not know what had happened as a result of their incident report.
- Mortality and morbidity (M&M) meetings were held monthly. Mortality reviews were completed at the beginning of the critical care consultants' meeting, with the majority of deaths being reviewed within one month. However, the minutes of the M&M meetings lacked detail so it was not clear how morbidity was being reviewed. We were told there was limited focus on morbidity at these meetings and this had been recognised by the governance lead who was developing this. There was good attendance from the critical care consultants, and occasional attendance from the junior doctors. The outreach lead nurse also attended. Learning points were identified and recorded within the minutes of the meeting, which were distributed to all critical care staff.

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
- There was a culture of openness and transparency in the unit. Staff understood their duty of candour to be open and transparent in their practice, and to give an

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explanation and apology if an error was made that caused harm and required reporting. Staff were supported to speak up about errors, and managers were supportive when things went wrong.

Safety thermometer

- The critical care unit participated in the national patient safety thermometer and achieved positive results. During the four month period October 2015 to January 2016 the department had reported no falls resulting in harm, no catheter-acquired urinary tract infections and only two pressure ulcers.
- Safety performance results were not on display in the unit, or in the staff room. It is best practice for incidences of patient harm to be displayed so staff, patients and visitors are able to see how the unit is performing, including recognising periods of harm-free care. However, the unit had limited space to publicise these results in the existing unit and we were told they hoped to have the information on display once the new unit opened.

Cleanliness, infection control and hygiene

- Staff adhered to infection prevention and control policies. Staff were observed to be 'bare below the elbows' and observed good hand cleaning procedures before and after each patient contact. Appropriate personal protective equipment, for example gloves and aprons, were used in accordance with national and local guidance and standards.
- The environment and equipment in the unit were visibly clean and kept tidy. Green 'I am clean' stickers were being used to identify that an item of equipment had been cleaned. The date it had been cleaned was recorded on this sticker. All areas we checked were found to be clean and free from loose dirt and soiling. The unit had a dedicated cleaning team who took great pride in their work and ensured the unit was kept clean at all times.
- There were no cleaning checklists being used in the unit. Staff relied on communication between themselves and the cleaners to identify when a bed space had been cleaned. There was no record sheet for staff to sign when a bed space had been cleaned or checked, which meant it was not possible to evidence when an area had last been cleaned or checked.

- Regular water outlet flushing was being completed and recorded, reducing the risk of patients acquiring water borne infections such as legionella.
- Regular infection prevention and control audits were undertaken. Infection prevention and control audits, including hand hygiene, consistently achieved 100% compliance between January and November 2015.
- The unit had two side rooms available that could be used to treat infectious patients. This reduced the risk of infections being transferred to other patients in the unit. The plans for the new critical care unit, planned to open in December 2016, included positive and negative pressure rooms to provide improved respiratory isolation facilities.
- The critical care unit had a consistently low rate of unit-acquired infections. There had been no cases of unit-acquired methicillin-resistant *Staphylococcus aureus* between April and October 2015. A small number of *Clostridium difficile* infections were reported between April and July 2015, with none reported between July and October 2015. There had been no cases of unit-acquired infection in the bloodstream since October 2013.

Environment and equipment

- The critical care unit was secure and safe for patients. The unit had access cards for staff, and a doorbell system with closed circuit television (CCTV) for visitors. Staff in the unit would always open the door in person rather than opening it remotely.
- The nurses' station had monitors displaying live observations from the patients' monitors, allowing remote monitoring should a staff member need to leave the bedside. Single occupancy rooms had windows (with curtains) to allow remote observation from outside the room if required.
- Resuscitation and difficult airway equipment was readily available. There were two resuscitation and two airway trolleys in the unit. Both resuscitation trolleys had a defibrillator and contained emergency resuscitation equipment, including resuscitation medicines. The trolleys were checked daily, and evidence that these checks had been completed was located with the trolleys. We checked the four trolleys and found all the required equipment was available and in date. Although none of the trolleys had a means of identifying if they had been used or tampered with, they were placed so they were always observed by staff.

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- There were clear waste and clinical specimen disposal arrangements and these were followed by staff. The unit had separate dedicated areas for clean and dirty equipment, linen and specimens, with clearly marked standard waste and clinical waste bins. Sluice facilities were contained in the dirty utility and items that had been cleaned and sanitised were labelled as such. Waste was regularly removed from the unit.
- The unit had immediate access to regularly used specialist equipment, and could request other equipment not held locally. Equipment in the unit included machines capable of haemofiltration (a process where a patient's blood is passed through a machine where waste products and water are removed before replacement fluid is added and the blood returned to the patient), syringe drivers and a portable X-ray machine. Additional equipment, for example bariatric commodes and hoists, were available centrally if required.
- Equipment in the critical care unit was regularly maintained. The trust had a medical equipment management department who were responsible for the management of all equipment in the hospital. There was an asset management record for all equipment showing its location in the hospital, service schedules and service history. All the equipment we checked in the unit had a sticker indicating when it had been serviced and when the next service was due, and all of these were current. However, some items did not have stickers confirming a portable appliance test had been completed. These included some medical equipment, for example infusion pumps, as well as some administrative equipment, for example a printer.
- The unit did not comply with current Department of Health building standards. The current Health Building Note HBN 04-02 for critical care units was published in 2013 as the standard to be met when a new critical care unit was built. The existing critical care unit was built approximately 30 years ago, adhering to the building standards at the time. National guidance from the Core Standards for Intensive Care Units (2013) recommends non-compliance with existing building standards should be entered on the risk register with a timescale for when the standards will be met. The risk register had been updated to record the fact the existing environment was not fit for purpose, and recorded that a new unit is currently being built and should be open in December 2016.

Medicines

- Medicines were mostly stored securely. Emergency medicines stored in the resuscitation trolleys were not tamper-evident. However, these trolleys were always observed by staff and were therefore at minimal risk of tampering. Intravenous fluids were stored in unlocked cupboards in the preparation area, as well as in an unlocked central store room. While these areas were often observed by staff, this was not always the case meaning that they were at risk of being tampered with. All other medicines were stored securely.
- Controlled drugs were stored safely and managed in accordance with legislation and policy. Controlled drugs were kept in locked cupboards and locked fridges. Keys to the controlled drug cupboards and fridges were held by a nominated nurse for that shift, identified to all staff at the beginning of each shift. All controlled drugs were checked on a daily basis, with evidence of these checks being recorded in the controlled drug registers. We completed a check of several controlled drugs, comparing the register to the stock levels and checking expiry dates. We also cross-checked register entries against patients' prescription charts and found records were being accurately maintained.
- Patients' own medications were stored securely. Medicines arriving in the unit with patients on admission were stored in a small locked drawer in the bed space. Patients' own controlled drugs were stored in the controlled drug cupboard and entered on the unit's controlled drug register.
- The unit was using a paper-based prescribing system, which was keeping people safe from avoidable harm. The prescription record had been specifically created for use in the critical care unit and was kept with the patient's care records. We reviewed nine prescription records and found they were accurately completed. However, we noted on five prescription records that the prescriber's signature was either illegible or missing. The prescription charts were checked daily by a pharmacist.
- Allergies were clearly recorded. We checked nine prescription records and found that all had the patients' allergy information clearly documented as required.
- Prescription charts recorded when a prescribed medicine had not been given, or had been delayed. Of the nine prescription charts we reviewed, two had delayed medicine clearly documented with a reason why this had been the case.

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- Fridge temperatures were regularly monitored and maintained in accordance with trust policy. Staff checked and recorded the fridge temperatures daily, ensuring they had been operating within the required temperature range (2 to 8°C). Guidance was included on the check sheet for the action to take when a fridge was out of range. We checked the records and noted one occurrence where the fridge had been out of range (above 8°C). The correct reporting procedures were followed, the stock was checked by the pharmacy, and the fridge was checked and found to be functioning correctly.

Records

- Records in the critical care unit were held securely, were mostly legible and up to date. The unit used a paper-based records system, with current records being kept at the patient's bedside in a dedicated drawer. Historical records were securely kept in a locked trolley in the unit's office. With the exception of some prescription signatures, all records were legible and updated by the multidisciplinary team in a timely manner.
- Risk assessments were completed and clearly recorded. We reviewed seven records and found they all contained appropriate risk assessments and care plans, including for falls, venous thromboembolism and pressure ulcers.

Safeguarding

- Safeguarding training data for the staff in critical care was not available. We asked the trust to provide us with mandatory training completion figures, but we did not receive this. Training compliance was only made available for the whole division.
- Staff were aware of their obligations with regard to safeguarding. Staff we spoke with were able to tell us what would constitute a safeguarding concern and told us they would report any concerns to the nurse in charge.
- There were processes and guidance documents available to support staff in managing safeguarding concerns. Policies and procedures relating to safeguarding were easily accessible on the trust's intranet system. The majority of staff were able to explain how they would access the guidance and complete a safeguarding referral, but some staff were not aware of how to make a referral and told us they would just raise their concerns with the nurse in charge.

Mandatory training

- Mandatory training data for the staff in critical care was not available. We were told that mandatory training attendance was recorded and monitored centrally, then reported to department leads bi-monthly. However, when we requested this information for the critical care unit the trust were unable to provide it. We were advised the data was only available for the whole division.
- Mandatory training was delivered through online tools and taught/practical sessions. Staff told us they were able to access the online training easily, and found all training sessions were appropriate to their needs.

Assessing and responding to patient risk

- Risk assessments were available and being used to develop care plans. The critical care unit had a range of risk assessments available, including for pressure ulcer, venous thromboembolism and falls. In all the care records we reviewed there were appropriate risk assessment and care plans being used.
- A hospital-wide early warning score (EWS) system was being used to identify patients at risk and clear escalation processes kept patients safe from avoidable harm. The EWS process was led by the critical care outreach team. Although the scoring system was not used in the critical care unit, it helped identify when critical care review and advice to a patient on a ward was required. An audit in October 2015 identified that escalation to the outreach team had taken place appropriately in the majority of cases. However, some cases where escalation to outreach had not been completed did not have reasons documented. Learning from the audit was shared with all ward managers and a further audit was scheduled to take place within three months.
- There was a critical care outreach service available to respond to deteriorating patients in the hospital. The outreach team operated seven days a week for 12.5 hours a day. The team was nurse-led and supported by consultant afternoon sessions Monday to Friday. Although the outreach function had been affected by some staffing issues in the critical care unit preventing it from operating (one day a month in March, April and May 2015), these issues appeared to have been resolved and the outreach team had operated at the planned times since this period. After 8pm the hospital at night team took over from the outreach team. Although the

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hospital at night team was managed by the critical care senior nurse, the team itself did not have any critical care staff within it. The hospital at night team's role was wider than the outreach team, including hospital site management, cardiac arrest response and verifying death. We were told planning work was being completed to implement outreach 24 hours a day, seven days a week.

Nursing staffing

- The numbers of nursing staff in the critical care unit kept people safe from avoidable harm. The unit was commissioned to provide six level three (intensive care) beds and three level two (high dependency) beds. Rotas were designed to provide cover for this using the ratios recommended in the Core Standards for Intensive Care Units (2013). Eight nurses were planned each shift to allow a ratio of one nurse to one level three patient, and one nurse to two level two patients. Staffing was managed in a flexible way so that changes in dependency levels could be responded to without compromising patient safety.
- The unit did not have a full establishment of nursing staff. The unit had seven nursing vacancies, from a total establishment of 58. Five of these vacancies had only been recently created following a successful business case supporting additional staff numbers. Gaps in rotas were being filled by agency nurses or the shift coordinator, and the recruitment process to fill the vacancies was well underway. Two incidents had been reported in the last year relating to staffing levels. In January 2015 a patient had to be transferred to another hospital because there were not enough staff in the unit to care for them. In February 2015 there had not been enough staff available to open the unit to its commissioned capacity. No further incidents had been reported after this time.
- Agency usage was kept to a minimum. Agency nurses were only employed when internal cover arrangements were not able to safely meet patients' needs, including to cover vacant lines in the rota or where the dependency of the patients meant additional nursing staff were required. The unit was below the maximum recommended safe limit of 20% of the staff being agency nurses.
- The unit had one senior nurse who assisted the lead consultant with running the unit. The senior nurse was supported by a team of matrons and supervisory

nurses. Although there was not a supernumerary coordinator on duty for some shifts, we were told that once recruitment to fill the vacant posts has been completed this recommendation would be achieved.

- The critical care unit was supported by a critical care pharmacist, adequate physiotherapists and other allied healthcare professionals to ensure patients received adequate safe treatment.
- The nursing handover followed a structured format. Twice daily handovers were completed following a set agenda. A record was kept of the handover and items discussed included staffing numbers, equipment issues and relevant patient-specific information. A daily safety briefing was also being used to communicate key safety messages from any incidents that may have occurred, as well as pertinent safety information relating to individual patients.

Medical staffing

- Medical staffing in the critical care unit kept people safe from avoidable harm. The Core Standards for Intensive Care Units (2013) recommend a resident doctor to patient ratio of one to eight, and a consultant to patient ratio of one to 15. The resident doctor remained on the unit at all times and did not have any other duties that would mean they had to leave the unit. This meant that in the event of an emergency on the unit the doctor was able to respond immediately.
- There was a full establishment of consultants on the rota. The unit employed 11 consultants who between them covered the unit seven days a week, 8am to 6pm. Between 6pm and 8am the consultants were available on-call. The consultants worked 50% of their hours in critical care and the other 50% in anaesthetics.
- The unit was able to have a consultant on site within 30 minutes during the on-call period. Some consultants lived further than 30 minutes away so they stayed in an overnight room located in the hospital. We were also told the consultants had a low threshold for coming in to support the unit, and staff therefore felt comfortable calling them when support was needed. If a patient in the unit was likely to deteriorate and require a consultant's input, or if a child was being cared for on the unit, we were told all the consultants would sleep on site to enable an immediate response if needed.
- There was a structured handover process in place for medical staff. The morning medical handover involved the night doctor handing over to the oncoming doctors

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and consultant(s), and in the evening involved the night doctor taking a handover from the off-going doctor. Each patient was reviewed in turn and safety issues were discussed.

- There were two consultant-led ward rounds every day of the week, once in the morning and again in the afternoon. The morning ward round was used to set treatment goals for the day, and the afternoon ward round reviewed progress against these goals and discussed any additional plans needed to ensure safe care and treatment for each patient.
- An additional consultant worked afternoon sessions Monday to Friday to enhance the care being provided to patients being supported by the outreach team.

Major incident awareness and training

- The trust had a major incident plan, which included action cards with specific instructions for critical care staff to follow. An emergency bag was readily available in the unit's office, containing the equipment and action cards required in case of a major incident being declared.
- The unit had not been involved in major incident training exercises and not all staff were aware of their responsibilities. While some senior staff had received major incident training, we were told there had not been any major incident exercises and a large number of staff had not received any major incident training sessions. Some staff did not know what would be expected of them in the event of a major incident.

Are critical care services effective?

Good



We judged the effectiveness of the critical care service to be good.

- Treatment by all staff, including therapists, doctors and nurses, was delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. The rehabilitation of patients was exceptionally well managed.

- There were comprehensive assessments of patients' needs, which included nutrition, hydration, pain and rehabilitation needs. Expected outcomes were recorded and monitored.
- Patient outcomes were reviewed and reported nationally. The unit generally performed in line with national averages and additional audit work was carried out to identify areas that could improve outcomes.
- Staff were skilled and experienced to provide the high levels of care required for critically ill patients. Gaps in experience or training were identified and additional training provided where necessary.
- Patient care was well coordinated by a multidisciplinary team who worked together to understand patients' needs and to promote good outcomes.

However:

- Staff had a limited understanding of the requirements of the Mental Capacity Act 2005, and the Deprivation of Liberty Safeguards (DoLS). We could not be assured that patients who required an authorisation under DoLS were having this requested by the unit.

Evidence-based care and treatment

- The critical care unit was compliant with all the Core Standards for Intensive Care Medicine (2013) relating to patient care and treatment.
- All patients were receiving rehabilitation in accordance with the National Institute for Health and Care Excellence (NICE) clinical guideline 83 'Rehabilitation after critical illness' (2009). Physiotherapists worked in the unit as part of the multidisciplinary team, ensuring rehabilitation needs were being assessed within 24 hours of admission and rehabilitation goals were planned and recorded. Additionally, the unit employed an occupational therapist who worked solely with critical care patients to ensure their rehabilitation needs were met. The occupational therapist worked with patients on the unit and with patients who had been discharged, including following up their rehabilitation at home.
- The critical care unit was using national best practice guidelines and research from relevant groups to ensure care and treatment was effective. Policies and practices were based on guidance from the royal colleges, NICE and critical care groups, for example the Faculty of

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Intensive Care Medicine. Additionally, the unit held a weekly journal club where it considered recent articles and research impacting on critical care, and considered its implications for the unit.

- Critical care bundles were being used to ensure compliance with national best practice. Care bundles ensured key aspects in the general care of a critically ill patient were regularly identified and checked. One care bundle being used was the 'FAST HUG', covering feeding, analgesia, sedation, thromboembolic prophylaxis, head of bed elevation, stress ulcer prevention and glucose control. This ensured patients were comprehensively assessed and treated, promoting good outcomes.
- Patients were safely ventilated using specialist equipment and techniques in accordance with national best practice. This included mechanical invasive ventilation to assist or replace the patient's breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe into the trachea). The unit also used non-invasive ventilation to help patients with their breathing, using masks or similar devices. All ventilated patients were constantly reviewed and checks made and recorded hourly.
- Patients who had acute respiratory distress syndrome (ARDS) were treated in accordance with national guidelines from the ARDS Network, with a dedicated care bundle being available to support staff.
- The critical care unit met best practice guidance by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. One of the experienced consultant intensivists was the clinical lead for organ donation, supported by a specialist nurse who directly supported the organ donation programme.
- Patients were being screened for delirium using a nationally-recognised risk assessment tool. The confusion assessment method for intensive care units (CAM-ICU) was used in the unit to assess patients for delirium. Patients in a critical care setting are at high risk of psychological effects resulting primarily from the medicines used to treat patients (for example, heavy sedatives). The Core Standards for Intensive Care Units (2013) recommend all patients are screened for delirium.
- The unit was completing regular audits of the care being provided. Audits included the ventilator care bundle and a haemofiltration research audit. Audit results were

being used to confirm standards of care were being met, and where this was not the case the practice education team would follow this up with staff. The haemofiltration research audit was also being used to evaluate the effectiveness of haemofiltration at different running speeds. The research was being used to identify the optimum running speed for longer filter life and better patient outcomes.

Pain relief

- Patients' pain was well-managed. Regular assessment of a patient's pain using assessment tools took place, and plans to manage any pain were quickly started. Pain scores were recorded on patients' observation charts at hourly intervals.
- None of the patients we spoke with were in any pain and there was evidence of pain assessments, both verbal and non-verbal, and administration of pain relief in all records we reviewed.
- There were close working relationships with the specialist pain consultants and nurses, and we observed pain nurses being involved in pain assessments on the unit.

Nutrition and hydration

- Patients' nutrition and hydration needs were being met. The unit monitored and responded to their patients' hydration needs using fluid balance charts to regularly monitor and manage hydration. Patients' nutritional intake was recorded and monitored daily, with dietitians being asked to review patients where specialist input was required. We reviewed nine care records and found they all contained regular records and observations.
- Patients were supported to eat and drink. Patients who were able to feed themselves were given the time and opportunity to do so. Food and drink was placed near the patient so they could easily reach it. Patients who required assistance were helped by nurses or healthcare assistants. Patients who were unable to eat, for example because they were sedated, were fed using a tube and liquid food. Standard feeding protocols were available for staff to follow to ensure these patients received adequate nutritional intake before a dietitian reviewed them.

Patient outcomes

- Patient outcomes were routinely captured and monitored against those achieved nationally. The

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critical care unit had contributed data to the Intensive Care National Audit and Research Centre (ICNARC) for at least the last five years, allowing national and regional benchmarking. Over the last year the unit performed similarly to the national average. Unplanned readmissions were slightly higher (worse than) than the national average across the period October 2014 to October 2015, but mortality rates across the same period were in line with the national average. Although the high care bay contributed to and received a separate ICNARC report, the trust was unable to provide us with a copy of this when requested.

- Two nurses coordinated the audit and data quality work to ensure patient outcomes were positively reviewed. The nurses fed the audit work into relevant team meetings, including the mortality and morbidity reviews, and this data was used to positively impact on patient outcomes. One example of this was the haemofiltration research audit, which was starting to show improved patient outcomes when the units were run at a certain speed.
- An audit calendar and peer review process was being used to monitor and improve patient outcomes. Regular audits were used to recognise good practice that was positively impacting on patient outcomes, as well as identifying areas that could be improved.

Competent staff

- The majority of staff received annual appraisals on time. Appraisals were completed using a paper-based system and included a discussion around performance and objectives. Completion was recorded and monitored centrally, with managers receiving reminders when appraisals were due. Staff told us they found the appraisals were useful and supported their professional development. Annual appraisals had been completed for 87% of critical care staff. All staffing groups were at 100% completion, with the exception of the registered nursing staff group, which was at 85%.
- Doctors and registered nurses were supported to revalidate with their professional bodies. All registered nurses were given the opportunity to attend a 45 minute session delivered by the trust to help them prepare for revalidation. Doctors' revalidation was incorporated into the annual appraisal review. Although individuals were

responsible for revalidating with their professional body, they were reminded this was required and supporting documentation was approved by appropriate managers.

- Practice development nurses ensured training and competency was being appropriately managed. Two part-time nurse practice educators were employed in the unit to oversee the training provision for the nursing staff group. We received positive feedback from all the staff we spoke with. We were told they felt "well supported" with the practice educators providing mentoring and support to new nurses and to any existing nurses working towards their critical care post-registration qualification.
- There were sufficient numbers of nurses holding a post-registration critical care award. The Core Standards for Intensive Care Units (2013) recommend at least 50% of the nurses working in intensive care hold a post-registration award in critical care. Of the 51 nursing staff employed in the unit, 32 (63%) held such an award.
- Staff development was available and encouraged. Training and development opportunities were posted on a noticeboard in the staff room and included learning opportunities hosted by the hospital, and by other hospitals and universities in the region. Additionally, staff were given the opportunity to attend the critical care conference in Brussels. Although staff wishing to take up this opportunity would have to do so in their own time, expenses were being paid by the trust. Staff were also supported with part-funded study time to support them through their professional development.
- The unit held monthly mandatory training, which was a mix of theory and simulated scenarios. The unit had made good use of the simulation facilities to ensure staff were competent in managing critically ill children.
- New nursing staff on the critical care unit started with a six week supernumerary period. This allowed new nurses to familiarise themselves with the skills required and equipment used in this environment while being supervised by an experienced nurse. Newly qualified nurses were required to get six months' experience before they would be considered for the critical care unit.
- Nurses caring for level 2 (high dependency) patients in other areas of the hospital were trained and supported by the critical care unit. A two-bedded 'high care' bay was set up as an orthopaedic recovery area for patients

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requiring lower-level high dependency care after elective (planned) surgery. Similarly, some lower-level high dependency patients were nursed in the theatres recovery area when capacity was not immediately available in critical care. The staff caring for these patients received training from critical care, and worked to a modified version of the critical care competency document. The staff also completed a period of time working in the critical care unit before being able to care for patients outside the unit.

Multidisciplinary working

- There were good multidisciplinary working arrangements in place. Pharmacy, occupational therapy, physiotherapy, radiography and dietetics were regularly visible in the department. The morning multidisciplinary ward rounds were attended by medical and nursing staff, as well as pharmacy, physiotherapy and dietetics. Microbiologists also attended the unit four days a week and liaised with the doctors and consultants, but they did not participate in the multidisciplinary ward round because it had been found this was not productive.
- There were good links with the end of life care team and staff worked closely with them to strengthen support to patients and their families at the end of a patient's life. If a patient was not expected to survive, the end of life team were contacted early so that relevant care packages could be arranged in advance. We saw the palliative care consultant and registrar attend a daily ward round because they had been alerted early to a patient who was being discharged from the unit but was requiring palliative care.
- Working relationships in the department were excellent. The unit had a 'family' feel to it with all staff, regardless of role or grade, being included and respected. Visiting staff, whether agency or specialty, were welcomed and valued. At all times we observed staff checking and challenging each other, asking questions and making sure things were being done in the patients' best interests.
- There were clear discharge arrangements, including a formal handover process. Patients were routinely followed up by the outreach team and occupational therapist. We tracked two patients who had been discharged from the unit to a ward. We found in both cases that relevant and pertinent information had been

handed over to the ward staff, including treatment escalation plans, physiotherapy rehabilitation goals and medication prescriptions. Handovers were recorded and stored with the patient's care records.

- Staff in other areas of the hospital were well supported by the critical care team. Staff told us the outreach team was extremely supportive and worked well as part of a multidisciplinary review of the deteriorating patient. The nurses on the orthopaedic high care bay told us they received good support from the critical care team, particularly from the consultants.

Seven-day services

- Consultants were available 24 hours a day, seven days a week. When the unit's consultant was not on site, they provided a thirty minute response (maximum) on an on-call basis.
- The unit had a ward clerk on duty seven days a week to assist with administrative tasks, releasing nurses to concentrate on direct patient care.
- There was good access to services seven days a week. Physiotherapy, imaging, pharmacy and microbiology were all available seven days a week, with out of hours' access available where required through an on-call system.

Access to information

- Patient records were accessible at all times. Every bed space had a drawer in which current care records were stored. Observational charts were readily available at the bedside, and historical medical records were stored in a locked trolley in the unit's office. Stickers were being used to identify particular aspects of a patient's care, for example physiotherapy needs. This made information easy to locate.
- When a patient was moved out of the unit, for example discharged to another ward, all relevant notes and records required to support their ongoing care were transferred with them. An 'SBAR' proforma (situation, background, assessment, recommendation) was used to communicate the patient's pertinent information in a standardised format. This meant information was easy to locate and was readily available.
- Test results, for example, X-rays and blood tests, were communicated and made available promptly. Tests and results were prioritised, which ensured the most urgent information was available at the earliest opportunity.

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- Policies, procedures and other supporting information were readily available when required. The trust's intranet system had a library of policies, procedures and other useful information, including safeguarding, mental capacity and Deprivation of Liberty Safeguards.

Consent and Mental Capacity Act and the Deprivation of Liberty Safeguards

- Staff had a varied working knowledge of the Mental Capacity Act 2005 (MCA). Some staff in the critical care unit were unaware of their role and responsibility in applying the act to keep people safe. Some nursing staff suggested mental capacity considerations were the sole responsibility of the doctors, while others recognised that they were required to consider a patient's capacity to make their own decisions. We were told that any mental capacity assessments and subsequent best interest decisions would be recorded in the patient's care record. We saw some evidence that this was being completed in the care records we reviewed.
- Training data for the staff in critical care was not available. We requested data from the trust to assure us that mandatory training was being completed by critical care staff. However, the trust was unable to provide us with this information. This data was only available for the whole division.
- Patients who had the capacity to make their own decisions were supported to do so. Staff took the time to explain treatment options with patients, helping them to understand the consequences of agreeing to or denying treatment. Communication tools were used for patients who were unable to communicate verbally.
- There was limited understanding of the Deprivation of Liberty Safeguards (DoLS) and the use of restraint. Most staff we spoke with were not aware of their responsibilities with regard to restraint and gaining authorisations; however, all staff said they would contact the safeguarding team if they needed advice and guidance. The unit did not have any useful guidance or support tools readily available for staff, so it was not clear how they would know when to seek the assistance of the safeguarding team. We were therefore not assured that a patient requiring an authorisation for the deprivation of their liberty would have this appropriately applied. There is work being completed

nationally by the intensive care network and the court of protection to gain clarification about how DoLS is managed within the critical care environment; however, at present no additional guidance has been produced.

- An incident in critical care in September 2015 highlighted the importance of good record keeping and staff knowledge in relation to the Mental Capacity Act (2005), Deprivation of Liberty Safeguards and the Mental Health Act (1983). The incident was still being investigated at the time of our inspection and so learning opportunities have not been confirmed, however early reports highlighted there was a lack of understanding, record keeping and misunderstanding between staff.

Are critical care services caring?

Outstanding



We judged the care given to patients as outstanding.

- Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been overwhelmingly positive. Staff went above and beyond their usual duties to ensure patients experienced compassionate care and that care promoted dignity. Staff got to know patients and built relationships with those who stayed for short or long periods, and with their families and those close to them.
- We found many examples of staff going 'above and beyond' to support patients and relatives at what is a difficult time.
- Innovative support for patients, such as the early development of patient diaries, was encouraged and valued by staff, patients and visitors. There was an innovative use of internet video technology to aid the involvement and support of relatives who could not attend the unit.
- Staff took the time to ensure patients and their families understood and were involved with care plans.

Compassionate care

- Patients and visitors were treated with compassion at all times. Patient care was truly at the forefront for everyone working in the unit and staff interactions with patients and visitors were exemplary. Staff took the time

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to talk with patients, explaining what they were doing and having friendly conversations. Visitors were welcomed into the department and staff made sure they took the time to talk with all visitors in a caring manner.

- Small pets were permitted to visit patients on the unit and patients who were able to be supported to go outside were accompanied by staff to provide additional stimulation. We were told of a small dog being allowed into the unit to visit a patient the day before we arrived. The patient had been anxious and seeing their dog had provided additional reassurance to them. We were also told of patients being escorted to the rose garden so they could experience fresh air and interact with other people away from the unit.
- Feedback from patients and visitors praised the caring nature of the staff. The unit had two large folders of complimentary cards and letters from patients and relatives praising staff for the care, attention and support they gave. Feedback forms were overwhelmingly positive about the care provided by all the staff on the unit.
- Privacy and dignity was maintained at all times. The majority of the bed spaces were within curtained bays, with four bed spaces in a square arrangement (two next to each other and two opposite) replicated on two sides of the unit (eight beds in total). The other two beds were in individual side rooms. At all times we saw privacy screens being used, curtains being drawn and doors closed to maintain privacy and dignity.
- Staff promoted patient confidentiality. Staff ensured care records were stored discretely to protect confidential patient information and discussions with patients were at a volume that allowed the patient and anyone else in attendance to hear, while limiting the risk of neighbouring patients and visitors overhearing.

Understanding and involvement of patients and those close to them

- Patients and their relatives were informed about, and involved with, patient care. We saw staff talking with patients and visitors, explaining in understandable terms what was happening and giving them the opportunity to ask questions. The parents of one patient told us they “were always kept informed”. Staff told us they had used video calling over the internet using a tablet to allow relatives overseas to communicate with doctors and patients ‘face to face’.

- The unit led on, and participated in, organ donation programmes. The clinical lead for organ donation explained how a specialist nurse for organ donation would be available to assist staff with initiating discussions with relatives around organ donation. We were told that family members were given time to understand what organ donation involved and how it could benefit other patients. Families were then enabled to make an informed decision about organ donation and would be supported by the staff throughout.

Emotional support

- The unit had good support mechanisms for patients and their friends and families. Patient diaries were used for all patients who were in the unit for more than four days, with good results. The introduction of patient diaries into the unit started ten years ago, so the use of them was fully established. The diaries were contributed to by staff and visitors, with entries being personal and relevant to the patient. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Patient diaries have been shown to provide comfort to patients and their relatives, both during the stay and after discharge. They provide an opportunity to fill the memory gap, 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.
- The unit was also using a ‘Getting to know me’ document for all their patients. This included information about the patient, such as the name they preferred to be known by, who their friends and family are, their hobbies and interests and any spiritual or religious beliefs they held. This enabled staff to provide emotional support to patients that recognised their individuality.
- A chaplaincy service was available to provide emotional support to patients and their relatives. The service was available 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.

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- Patients who showed signs of depression or anxiety could be referred to a psychologist to promote emotional recovery, and counselling services were also available.

Are critical care services responsive?

Good



We have judged the responsiveness of critical care to be good.

- The critical care service responded well to patients' needs. Communication aids, including translation and sign language services, were available for patients who could not otherwise communicate easily or effectively.
- Patients received a good response from consultants and nurses when new patients were admitted. Patients were treated as individuals, and there were strong link nurse roles for all aspects of patient need, including learning disabilities, dementia and end of life care.
- Care and treatment after discharge from the unit continued to be delivered in a coordinated way with critical care input. A follow-up clinic ran once a month in the outpatients' department, and community rehabilitation was coordinated by the unit's occupational therapist.
- There were no barriers to people who wanted to complain. There were, however, few complaints made to the department. Those that had been made were fully investigated and responded to with compassion and in a timely way. Improvements and learning were evident from any complaints or incidents.

However:

- There were bed pressures in the rest of the hospital that meant about 50% of patients were delayed in their discharge from the unit, but the numbers of these incidences were below the NHS national average. Very few patients were discharged onto wards at night.
- Elective (planned) surgery was impacted on by bed availability in critical care. In a four month period 54 operations had been cancelled because a critical care bed was not available.

- There were limited facilities for visitors to the critical care unit and as it was an old unit it did not meet the modern critical care building standards. However, a new critical care unit was being built and once opened would provide much improved facilities.

Service planning and delivery to meet the needs of local people

- The service had been designed and planned to meet people's needs. The unit was located within the hospital to enable staff to respond to emergencies either within the critical care unit or the operating theatres. The emergency department was not located in the immediate vicinity, but there were good access routes through the hospital. Despite issues with access and flow due to bed pressures in the hospital and elsewhere in the health economy, the unit was responsive to emergency admissions and was very rarely unable to promptly provide a critically unwell patient with a bed and the care and treatment they needed.
- Facilities for visitors were limited. The waiting room was located just outside the unit's front door, joining and overlooking a busy corridor leading into theatres. Patients being transferred into or out of theatres were in clear view of relatives waiting. The environment in the waiting room was not comfortable, welcoming or quiet, and staff often had to access store cupboards located in the area. A small visitors' lounge was also available, located a short distance away, which was more comfortable and quiet. This room had sofa-beds so that relatives could stay overnight, but the room was not designed for this purpose. Although parking at the hospital was limited, visitors to the critical care unit were able to get free parking permits.
- The unit did not have a dedicated consultation room. If the visitors' lounge was free, this was sometimes used by staff to talk to relatives in a quiet environment; however, discussions often took place in the office on the unit.
- The critical care unit had equipment to meet patient's health needs that could be unrelated to their critical illness or condition. This included, for example, haemofiltration machines to provide treatment for patients with kidney failure which might be unrelated to their critical illness.
- It was recognised that the critical care unit was a 'mixed sex' environment and did not meet all the gender separation rules. However, the Department of Health

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guidance recognised that gender separation was difficult to fully manage in the critical care environment and staff made best use of the available space and equipment to ensure privacy and dignity with this regard. Like many intensive care units nationally there was no provision of separate gender toilets or washing facilities to meet the element of the same-sex rules. The Intensive Care National Audit and Research Centre (ICNARC) data showed about 50% of discharges from critical care to a ward were delayed over four hours. This meant the unit often breached the same-sex rules as they related to providing washing facilities and toilets.

- The unit operated a 'stabilisation before retrieval' service for children under the age of 16 requiring level 3 (intensive) care. Children requiring high dependency care were usually cared for in the dedicated children's high dependency unit in the hospital. Children requiring intensive care were initially treated in the unit before a team from a children's specialist hospital arrived to retrieve the patient. In a few cases, children had been admitted to the unit for continuing treatment on advice from, and in close liaison with, the specialist children's centre. Critical care staff had undertaken simulation training for the management of critically ill children, and a consultant always remained on site if a child was being cared for on the unit.
- A follow-up clinic was available for patients who had been discharged from hospital. The follow-up clinic was held once a month and patients were invited to an outpatients' appointment to meet with the critical care team and, if required, a clinical psychologist who could explore any remaining psychological effects.
- The design of the new unit, due to open in December 2016, had been carefully thought out to ensure good access routes to theatres and the emergency department. It had also been designed to provide improved facilities for patients and their relatives, including increased capacity, new state-of-the-art equipment, a waiting area, overnight accommodation and patient showering facilities.
- Numerous information leaflets and posters were available in the waiting room. These included information about organ donation, consent and the Patient Advice and Liaison Service (PALS). An extremely informative visitor information folder was also available. This included pictures of equipment and what it was for, a satisfaction survey, an explanation of a critical care

unit and what to expect, the roles of the different staff, what the outreach team was for, availability of the chaplaincy service and what to expect if treatment was going to be withdrawn.

- There was very little information available on the hospital's website. Although there was a dedicated critical care page, this lacked details such as visiting times and what to expect in a critical care unit. There was one patient leaflet on the critical care page, explaining what 'pacing' is, but no other information leaflets were available.

Meeting people's individual needs

- The unit had access to, and good relationships with, learning disability and dementia specialist nurses. There were link nurses in the unit who were able to advise other staff on best practice, and specialist teams in the hospital were available to support staff and patients on the unit.
- Interpreting services were available through an external provider. We were told this was primarily telephone based, but an interpreter could attend if notice was given. Trained sign language interpreters were also available to assist staff and we were told of a recent example where the service had been used with good effect to communicate with a patient's relative.
- Communication aids for patients who were unable to speak were available. 'Low tech' communication aids, such as letter boards and coloured charts, were readily available, and the unit had also recently started using tablet devices as an alternative means for patients to communicate.
- All patients we reviewed had treatment plans with clear timeframes and objectives. We saw documentation was clear and concise. Records contained assessments, diagnoses and plans for treatment with rationalised objectives and achievable timescales for tasks and reviews.
- A clinical psychologist was available to support patients and visitors. The psychologist attended the unit on a regular basis and could be contacted by unit staff if needed.
- Specialist equipment was available to support bariatric patients. There was a central equipment store and the unit was able to access bariatric equipment from there. We were also told that if any additional specialist equipment was required it could be hired in from an external company.

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Access and flow

- The biggest challenge facing the unit's access and flow was patient discharge. In 2014 around 55% of discharges were delayed, although this was below (better than) the national average of about 60%. Between January and October 2015 about 50% of discharges were delayed, below (better than) the national average of about 60%. We were told the main impact on this was bed availability in other areas of the hospital, which meant patients could not be discharged to a ward at the earliest opportunity. Out of hours discharges were rare. The critical care unit performed better than the national average for the number of patients discharged from the unit out of hours. It is recognised that patients discharged overnight are at increased risk of deteriorating. Best practice is therefore that overnight discharges are limited; however, this can have an impact on inflating the numbers of delayed discharges.
- Few patients were transferred to other units for non-clinical reasons. On average one patient a quarter was transferred to another hospital because the critical care unit was unable to accommodate them. This was very slightly higher than the national average. All non-clinical transfers were reported internally as an adverse incident.
- Bed occupancy levels varied. The Royal College of Anaesthetists recommend maximum critical care bed occupancy of 80%. For the four months September to December 2015 the unit's bed occupancy reached 100% during two months, against a national average of 80% to 84%. The other two months the unit was at 75% and 63% against a national average of between 83% and 84%. Bed occupancy levels generally increased due to a lack of a ward bed into which to move a discharged patient, and, as with the national picture, due to an increasing demand for critical care beds which was not meeting rising demand.
- During the four months September to December 2015 a total of 54 elective (planned) operations were cancelled because there was not a bed available in the critical care unit. Four of these operations had been cancelled for at least the second time. We were told the reason for the cancellations was usually because there were not enough beds in the hospital to discharge patients from the unit, meaning there were no beds available to admit non-emergency patients.

- Bookings for elective surgery patients potentially requiring a critical care bed were managed centrally and were limited to two patients a day. Elective admissions were recorded in an electronic calendar on the trust's intranet system.
- Patients were sometimes nursed in the theatre recovery area due to a lack of beds on the critical care unit. These patients required level two (high dependency) care, which was provided by nurses trained by the critical care unit and who had been on a six week rotation working within the critical care unit.
- The hospital did not collect data about delayed admissions to the critical care unit. However, staff we spoke with felt there were very few delayed admissions and that space was always made to accommodate a new admission at the earliest possible opportunity.
- Although the high care bay contributed to and received a separate ICNARC report, the trust was unable to provide us with this when requested. This meant we were not assured that this service was providing a responsive service to patients.

Learning from complaints and concerns

- PALS was advertised in the waiting room, with leaflets about their services available for relatives to take away. Staff told us that should a patient wish to make a complaint they would attempt to resolve any concerns within the unit first before involving the PALS team.
- We were told that complaints were investigated by the lead clinician or senior nurse. The investigation and feedback process included the complainant and staff members, with meetings being arranged to enable good communication and understanding. Staff were provided support by their line manager throughout the investigation process.
- In the last year the critical care unit only received one complaint. This was a multidisciplinary complaint with good investigation processes and involvement of the patient's next of kin. Learning points were identified and shared with staff.

Are critical care services well-led?

Good



We judged the leadership of the critical care service to be good.

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- The unit had a clear vision and strategy for its delivery. Staff were actively involved in planning and delivering the strategy.
- Staff, patients and their families were actively engaged with to identify areas of good practice, as well as areas that could be improved.
- There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and consistently high levels of constructive engagement.
- Staff were actively encouraged to raise concerns through an open, transparent and no-blame culture.
- The leadership drove continuous improvement and staff were accountable for delivering change. Innovation and improvement were celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

However:

- Governance arrangements required some improvement, but the recent appointment of a governance lead with a clear vision of what needed to be improved saw progress being made. In particular a holistic formal review of safety information on a more regular basis was needed.

Vision and strategy for this service

- There was a clear vision for the critical care unit, and a strategy for its delivery. The main vision was the expansion and upgrading of the unit. Building had already started following careful planning and funding, and the League of Friends had agreed during the planning stages to fundraise to pay for the new equipment needed in the unit. A secondary vision was for the unit to move to a paperless record system. Managers in the unit told us they wanted to move to an electronic system for the benefits it would bring in improved data quality and availability, enabling them to review data more readily and focus on areas where improvements could be made to patient care.
- Staff were aware of the unit's vision and strategy and were actively involved in planning and research activities to help with its delivery.

Governance, risk management and quality measurement

- There was a clear governance structure in the critical care unit. There was a consultant lead for governance

who oversaw and managed the governance processes for the unit. Regular meetings were firmly embedded in business planning, and reporting structures between the unit, division and trust board were in place. However, shared governance and learning opportunities between the orthopaedic high care bay and the critical care unit were limited.

- The unit held monthly departmental governance and mortality and morbidity meetings. Attendance at the meetings was encouraged, and minutes were circulated to all staff afterwards. The unit's lead pharmacist, physiotherapist and outreach nurse attended and contributed to the meetings on a regular basis. Although reviews of mortality were completed, morbidity reviews were very minimal and the governance lead told us this was something the unit recognised as needing development. A spreadsheet capturing details of mortality reviews was being used to help identify trends in patient care that might be impacting on patient mortality. In the minutes we reviewed there was no evidence that safety performance, an overview of reported incidents and subsequent learning or quality indicators were being routinely discussed.
- The critical care unit participated in regular quality audits. The unit had two nurses dedicated to audit. These nurses ensure accurate completion of the Intensive Care National Audit and Research Centre (ICNARC) data returns, as well as completing and assisting with a programme of audit work planned in an audit calendar. Audit topics included nutrition, cardiac arrest management, early readmissions, record keeping and ventilator care bundle. The audit findings were being used to identify areas of good practice that could be replicated, as well as areas that could be improved.
- The unit had a risk register, which was linked to the divisional and trust risk registers at certain trigger points. The risk register was reviewed on a bi-monthly basis by the divisional governance lead, the unit's consultant lead for governance and the senior nurse. There were two items on the risk register, both of which were recognised and understood by the managers and staff in the critical care unit. The two items were:
- The unit was not fit for purpose. An old environment with limited space, particularly around bed spaces,

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meant the unit was not as effective as it should be. Progress was being made to resolve this risk, with building of a new unit expected to complete in December 2016.

- Evacuation of the unit in the event of a fire was difficult. Because of the layout of the unit an evacuation would be very difficult in the event of a fire. The fire safety and health and safety officers were aware and were monitoring this risk regularly. Staff training in fire safety was being prioritised. A final solution could not be achieved until the new unit opened – planned for December 2016.

Leadership of service

- The leadership of the unit by the lead consultant and the team of experienced staff was strong and committed. There was a genuine commitment to achieving an excellent service, with support being given to the governance lead to strengthen the existing governance arrangements. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the allied health professionals, and vice-versa.
- The nursing leadership of the service was strong. The senior nursing staff demonstrated a strong commitment to their teams, their patients and one another. They were visible on the unit and available to staff to assist with patient care at times of high demand, or if staff needed to talk something through. The consultants we spoke with had a high regard and respect for the nursing team, and the allied health professionals. Staff told us managers were “supportive and approachable”, and they were visible in the unit.
- Most shifts were coordinated by a supernumerary nurse in charge. We were told that supernumerary shift coordination was achieved in about 65% of all shifts. Additional staffing numbers had been agreed and recruitment was ongoing to fill the vacancies. We were told that once all the vacancies had been filled there would be a supernumerary coordinator on every shift.

Culture within the service

- Staff worked collaboratively in a culture that promoted safe and effective patient care. All staff, regardless of grade or position, were given the opportunity to talk openly with each other, and felt safe doing so. Where

conflict had arisen, this had been resolved through meaningful and respectful discussion involving all parties, with a common goal to ensure patient care was delivered safely.

- Staff were respected and valued as part of the critical care team. All grades of staff told us they felt valued and respected by others, including management. We saw day to day relationships in the unit promoting a respectful culture, with all staff appearing to be on a ‘level playing field’, regardless of seniority or role. Staff told us there was an open, ‘no blame’ culture that supported learning from errors.
- Staff wellbeing was an important consideration in the critical care unit. Managers and colleagues took a genuine interest in the wellbeing of staff in the unit. Being a strong team working closely together we found that day to day conversations always considered others’ wellbeing. There was a counselling service available, and the chaplain was also available to staff. Although the ability to debrief staff had reduced with increasing demand and vacancies needing to be filled, there was a commitment from managers to ensure staff were supported following difficult or traumatic incidents.

Public and staff engagement

- Visitors were encouraged to give feedback to help identify what was going well and where things could be done better. Feedback forms were available in the waiting room, both within the information folder and loose on tables. A post box was available for the forms to be returned, and this could be done anonymously if wished. Comments from visitors were used to help inform service planning and as supporting evidence in business cases.
- Staff were encouraged to get involved with service planning and developments. There were staff representatives from all grades involved with the design of the new unit, and a couple of staff had been to an equipment supplier in Germany to assess what was available and what would be needed. Staff were also involved with reviewing electronic care record systems and providing their input about what was needed. The hospital’s League of Friends had also been involved in the planning, resulting in an agreement that they would raise the funds for the new equipment.

Innovation, improvement and sustainability

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- There was a good focus on innovation, improvement and sustainability in the critical care unit. The education team was using simulation to maximise and maintain staff skills in caring for children on the unit, ensuring best practice for a patient group who were not frequently seen in the unit. The unit's rehabilitation programme and employment of a dedicated

occupational therapist was innovative. As well as working closely with patients in the unit, the occupational therapist also worked with patients who had been discharged, with close working links with the community. The occupational therapist had also been invited to speak nationally to promote best practice across the country.

Maternity and gynaecology

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

Torbay and South Devon NHS Foundation Trust provide a range of antenatal, intrapartum and postnatal maternity services from Torbay Hospital, Newton Abbot Hospital and a variety of settings in the local community.

There is a consultant led service provided at Torbay hospital with a stand-alone midwife led birthing centre in Newton Abbot. We did not visit the Newton Abbot unit during this inspection. There were 2,252 deliveries, across the trust, between July 2015 and June 2015 across both hospitals.

Torbay Hospital has eight birthing rooms on the labour ward, one of which has a birthing pool. There is one operating theatre next to the labour ward staffed by general theatre staff for elective and emergency operations. Gynaecology surgery took place in general theatres and day surgery theatres. There is also a bereavement suite on the labour ward.

John McPherson ward, with 20 beds, caters for antenatal and postnatal women. McCallum ward, with 14 beds, provides gynaecological care and treatment. Outpatient services include ante natal clinics, screening clinics, ultrasound clinics, a maternity assessment unit (each weekday and via the labour ward or antenatal ward out of hours), infertility clinics, an early pregnancy unit (each weekday and via the emergency department out of hours), a colposcopy service (a colposcopy is a procedure to find out whether there are abnormal cells on or in a woman's

cervix or vagina), a urodynamics service (urodynamics assesses how the bladder and urethra are performing their job of storing and releasing urine) and gynaecology cancer support services.

There is a Special Care Baby Unit with 10 cots next to John McPherson ward. If mothers need to stay in with their baby or had a baby in the Special Care Baby Unit they stayed on the ward as transition patients. Inspection findings from the Special Care Baby Unit are reported within the Children and Young Persons report.

The termination of pregnancy service is run from Castle Circus, located within the town of Torquay. Here women are assessed, counselled and medical terminations are performed up to 9 weeks gestation. Women attended Torbay hospital for surgical termination procedures up to 13 weeks and six days gestation.

Routine antenatal care is carried out at local GP surgeries and community clinics. Consultant led clinics are held at Torbay hospital

During the inspection we spoke with six patients and one relative, all of whom had positive comments about the services provided.

We spoke with 39 members of staff including consultant obstetricians and gynaecologists, middle and junior grade doctors, senior managers, matrons, ward sisters, supervisors of midwives, midwives, student midwives, maternity support workers, operating department technicians, healthcare assistants, administrative and housekeeping staff. We also looked at six sets of patient records.

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Summary of findings

Overall we rated maternity and gynaecology services as good. There was a culture of support and learning. Staff had the welfare of women and babies at the heart of everything they did. Staffing levels were such that women had one to one care in labour. There was good medical cover throughout the units and consultants came in if they were called out of hours to provide support and guidance.

Newly qualified midwives and junior medical staff said they had good learning and training opportunities and felt supported and encouraged.

All of the areas we visited were clean. Equipment was clean and labelled to show when it was last cleaned and most staff were seen adhering to trust infection control policies and procedures.

Are maternity and gynaecology services safe?

Good



We judged safety as good

- There were good staffing levels within the maternity and gynaecology unit. There was sufficient consultant cover of the labour ward and consultants came into the unit out of hours when requested.
- There was a positive culture around reporting and investigating incidents. Learning from incidents was shared and action plans were in place to ensure new learning was embedded in practice. Staff at all levels attended required training
- Women were risk assessed throughout their pregnancy and labour. Good communication between the integrated community and hospital midwives meant that information about risks was passed on to the right people at the right time.
- Clinical areas were clean and tidy and regular audits of infection control procedures was ongoing.
- Adult and neonatal emergency resuscitation equipment was checked regularly and a record maintained to show it had been checked. The exception was labour ward where recording the checks done had been inconsistent. This was explained by the fact a new book had been introduced and at times had been locked in the resuscitation trolley, therefore becoming unavailable to staff.

However:

- Though records seen at the time of inspection were fully completed, internal trust audits had noted that records were not always fully completed.
- The Maternity Assessment Unit was run by midwives with maternity care assistants (MCA) to support them. There were two midwives twice a week with no MCA support and the other three days there was one midwife and one MCA. It was sometimes very busy meaning women sometimes had to wait for a long period of time. After the unit closed at 5pm all women who needed to be seen were asked to attend labour ward which put

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added pressure on staff on duty. There was no data available to show how many women had to attend the labour ward when the maternity assessment unit was closed.

Incidents

- Staff were clear about how and when to report incidents. Staff told us they received feedback when they reported incidents via their electronic reporting system.
- We saw minutes from meetings both within the trust and wider regional networks that showed learning from incidents was shared with relevant staff groups. Staff said learning was shared at team meetings and via trust and maternity and gynaecology newsletters.
- One Never Event was reported in September 2015. A Never Event is a serious incident that is largely preventable if the available preventative measures have been implemented. NHS trusts are required to monitor the occurrence of Never Events within their trusts and publically report them on an annual basis. The incident was thoroughly investigated and learning points were shared with staff. It was also discussed at the Serious Adverse Events Review Group which included the Chief Executive Officer, Medical Director, Chairman and the Director of Patient Safety.
- Between October 2014 and September 2015 the trust reported six serious incidents. We were provided with relevant documentation about all of the incidents. They had all been fully investigated by the trust. The outcomes were shared with the trust board, the Learning and Sharing from Serious Adverse Events Group and Mother and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) where relevant.
- The Supervisor of Midwives (SOM) was made aware of incidents involving midwives and provided support to midwives as required.
- Perinatal mortality and morbidity meetings were held monthly. We saw minutes of two meetings. The meetings followed a set agenda that included discussion of incidents and serious incidents, learning from incidents and case studies.

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 notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We were told when concerns had been raised or incidents were being investigated the woman and/or family in question were contacted to discuss the situation, ask them what they expected from the process and expected timescales for investigations to be completed. Follow up letters were then sent and an opportunity to discuss the concerns or findings at any time was offered, either face to face or by telephone

- There was no formal training programme for duty of candour, but, we were told that openness, honesty and transparency were already embedded in the way investigations were carried out. Staff understood the term and spoke about being honest and open with people.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care and involves a monthly snapshot audit. The Safety Thermometer results showed that, between October 2015 and January 2016, McCallum ward (gynaecology) had had no pressure ulcers, no falls with harm and there had been no catheter acquired urinary tract infections.

Cleanliness, infection control and hygiene

- The wards and clinic areas we visited were all very clean and tidy. Equipment such as resuscitaires had stickers on them to show when they had been cleaned and that they were ready for use.
- The Care Quality Commissions Maternity Services Survey 2015 found the trust scored about the same as other trusts for cleanliness of room or ward (9.1/10) and cleanliness of toilets and bathrooms (8.7/10).
- Staff were adhering to the trust's bare below the elbows policy in clinical areas. There were hand gel dispensers or gel pump action containers throughout the maternity and gynaecology unit. We saw them being used regularly by staff, although not by all patients visiting the clinic areas.
- We saw the environmental checklist for each area for October 2015. They showed that posters displaying the "5 moments for hand hygiene" were displayed, there was working hand gel dispenser at every bedside and

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that three patients, in each area, were asked about their satisfaction that staff cleaned their hands and all had said 'yes'. Results showed some high level dust. This had been brought to the attention of the domestic staff.

- Cleaning regimes were in place and records maintained to show cleaning of the birthing pool, floor mats and balls used during labour.
- In order to reduce the risk of legionella, a 'flushing regime' of all water outlets was in place.
- The belts used to secure the transducers for the cardiotocography (CTG) machines were not single use, and were therefore washed after each use. The unit had a domestic washing machine that went up to the required temperature for this purpose.
- Women admitted to the gynaecology ward for elective surgery were screened for methicillin-resistant staphylococcus aureus. This meant women who were MRSA positive could be treated to prevent the risk of spread.

Environment and equipment

- The maternity and gynaecology services were located in the Women's Health Unit within Torbay Hospital. There was lift and stair access to all floors. Access to John McPherson ward (ante and postnatal) and the Labour ward was via a call bell for visitors or a swipe system for staff.
- There were CCTV cameras that monitored the entrance to the building. Staff said when they called on the hospital based security team they responded very quickly.
- There was a range of medical equipment available to staff including foetal blood gas analysers, blood pressure and pulse monitors and GTG machines. Staff said if any piece of equipment became unserviceable it was quickly repaired or replaced.
- There was emergency resuscitation equipment available on all wards and the ante natal clinic. The gynaecology outpatient area did not have their own resuscitation equipment but were able to access the one on the labour ward if required. The trust resuscitation team had assessed the risk and felt the situation was appropriate. Staff said the situation could be reviewed at any time.
- Adult and neonatal emergency resuscitation equipment was checked regularly and a record maintained to show it had been checked. The exception was labour ward where recording the checks done had been

inconsistent. This was explained by the fact a new book had been introduced and at times had been locked in the resuscitation trolley, therefore becoming unavailable to staff. The situation was resolved during the inspection with assurances received that compliance with recording the equipment had been checked was monitored.

- Emergency evacuation equipment was available to help women out of the birthing pool if necessary. Staff were trained in the use of the equipment.
- Scanning machines were in use in the antenatal clinic for dating and anomaly screening. They were serviced regularly and they were replaced as required and when guidance was updated.
- There was one dedicated obstetric operating theatre. It was staffed by general theatres during elective and emergency surgery. Recovery took place on the labour ward if the woman had a spinal anaesthetic and in the theatre recovery area if they had had a general anaesthetic. If a second theatre was required this had always been accommodated by using the general theatres close to the labour ward.

Medicines

- Medicines were managed safely. We looked at medicine management on McPherson ward and McCallum ward. We saw a nurse carrying out a medicine round on McPherson ward where they wore a tabard to indicate they should not be disturbed.
- Medicines requiring refrigeration were correctly stored and had their temperature checked and recorded daily. Though they were not locked, they were kept in a locked room.
- We saw that intravenous fluids and stock medicines were stored in locked rooms.
- Controlled drugs were stored appropriately in each area. We checked the controlled drugs registers and stocks of controlled drugs on McCallum ward and found them to be correct.
- Pharmacy technicians checked stock weekly on McCallum ward and daily where required. Technicians topped up supplies and removed expired stock.
- Allergies to medicines were correctly documented. Patients with allergies wore red wrist bands to indicate to staff checking the patients identity they should also check the allergy status.

Records

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- Patient records were mostly stored securely on the wards and in clinic areas. We did however see one office with notes inside briefly unattended on the first day of our inspection. The door was supposed to be shut when the office was left unattended. The matron reminded staff of the importance of ensuring confidential information was stored correctly. Each time we passed the office thereafter it was free from notes or the door was shut, but not locked.
- We looked at six sets of patient records and found them to be detailed, providing information about the patients care needs and treatment plans. They were well organised. The gynaecology pre admission assessment form was electronically generated and was easy to read and included information patients had been given about what they could eat and drink pre-operatively and any other special instructions. The infant feeding midwife detailed advice and support given to women so all staff could give consistent advice. All records we saw had completed venous thromboembolism assessments carried out.
- Women carried their own handheld records with them during their pregnancy and to each clinic appointment. They contained records of the pregnancy and choices around where and how they would like to have their baby. The women continued to hold the notes postnatally and took them to post-natal appointments where the health and progress of the women and baby would be recorded.
- The termination of pregnancy service undertook audits to ensure the procedure for completion and submission of paperwork to the department of Health occurred.
- The Local Supervising Authority annual audit report was published in June 2015. There were recommendations for example supervisors to audit the safe storage of records.

Safeguarding

- Policies and procedures were in place regarding safeguarding adults and children. These provided guidance to staff on the actions to be taken where they suspected a safeguarding issue including domestic violence and drug or alcohol misuse.
- Staff we spoke with clearly understood the safeguarding process and knew who to report their concerns to and how to access the relevant documents to make a safeguarding referral. There was a safeguarding

children's midwife available in the unit and a trust wide safeguarding team available to all staff. Staff spoke highly of the safeguarding staff and said they provided support and advice when required.

- Staff worked closely with the perinatal mental health team based in the unit and with other professionals such as health visitors and school nurses in the local community.
- Staff attended safeguarding training relevant to their role.
- An automatic safeguarding referral was made if a girl under 13 attended the termination of pregnancy service. Girls under 16 are risk assessed. There were four trained safeguarding supervisors at the service. The service reviewed 10% of all under 16 attendees weekly and audited looking to see if safeguarding was considered and appropriate referrals occurred. The audit template went in the notes and also went into the staff members files for review during supervision or appraisals. At times they struggled to hit 10%. The service submitted a business case for a safeguarding lead which got rejected in April 2015 and was due to be resubmitted in April 2016. All staff were alert for domestic abuse and had escalated concerns to access places of safety in the past. If people had been seen and booked for a termination of pregnancy but did not attend, where there are concerns, they were followed up

Mandatory training

- Staff were required to complete a programme of mandatory training which varied according to the job role. Data showed that, between April and September 2015, staff in the women's and children's division were between 89% and 90% compliant with mandatory training. The medical staff benefitted from a practice manager who organised their training and planned the time in each rota to ensure they could attend the training.
- Obstetric emergency training in the form of Skills Drills was held in workshop form at skills stations. The training was attended by multidisciplinary groups including paramedic students.

Assessing and responding to patient risk

- Risk assessments were carried out on all women from booking to their postnatal period. They were reviewed and amended as necessary. Risk assessments included, venous thromboembolism assessments, pre-eclampsia

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(a condition that occurs in pregnancy causing high blood pressure which can be serious if left untreated) and drug or alcohol misuse, At the time of booking a 'prediction and detection screening tool' was completed and seen by the in house perinatal mental health team to assess if a woman had any mental health issues that may need to be monitored during and after the pregnancy.

- Women with high risks were advised to deliver their baby at the consultant led unit at Torbay Hospital as opposed to home or the Newton Abbot Birthing Centre.
- Women wishing to use a birthing pool had a risk assessment completed to assess their suitability.
- Risk assessments were carried out on women booked for gynaecology procedures. They were detailed in pre admission assessments documents and included information about allergies, pre-existing medical conditions and smoking status.
- Women on the maternity unit were monitored before, during and after the birth to assess their health and wellbeing of their baby. We saw that comprehensive records were maintained that included an obstetric warning score system (prompts escalation to an appropriate practitioner). On the gynaecology ward an early warning score system was also in place to ensure if a patient deteriorated it was escalated appropriately.
- There were very good working relationships between midwives, consultants and medical staff. Multidisciplinary discussions took place daily and involved discussing patient's relevant risks and management of those risks.
- The risk management midwife was aware of all the serious incidents reported, the outcome of investigations and how any learning was to be put into practice and monitored for effectiveness. They worked closely with the audit specialist midwife and consultant lead for governance.
- Midwives said consultants came in when called and were very happy to provide support to the whole team. All staff of all grades we spoke with, considered each other approachable and interested in the best possible outcomes for women and their babies.
- Serious incident investigation report we saw showed that the systems in place to manage a deteriorating woman or baby worked well. In one case the emergency

resuscitation team were called and responded quickly. Another case involved a number of specialities who worked well together to ensure the best possible outcome for a patient.

- During the inspection an emergency arose at home following a successful home birth that needed urgent admission. Midwives responded quickly, and urgent transfer to hospital occurred. Due to the speed of response the woman had a successful outcome and was discharged home the next day.
- We saw World Health Organisation (WHO) Safe Surgery checklists (5 steps to safer surgery) had been completed for elective and emergency procedures. The WHO checklist is a system to ensure that conditions are optimum for patient safety and that all staff are identifiable and accountable.

Midwifery and gynaecology staffing

- The Royal College of Obstetricians and Gynaecologists (RCOG 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour states there should be a midwife to birth ratio of 1:28. The ratio for this trust had been consistently 1:28.
- There were no midwifery vacancies at the time of the inspection. This meant that staff provided one to one care to women on the labour ward.
- Labour ward staff did not 'scrub' for elective or emergency caesarean sections as the team was provided by the general operating theatres. Midwives were allocated to the theatre to provide support for the woman and to 'take the baby' once it was born.
- The maternity unit had worked as an integrated community and hospital based service for a number of years. There were core staff on labour ward and there was a band seven midwife on each shift who acted as labour ward co-ordinator. They managed the workload by calling in on call staff if the unit was busy. If a community based midwife had been on labour ward overnight with a woman in labour, their shift was covered the next day by other midwives on the rota. We saw the matron amend the duty rota accordingly when such a scenario had happened. Staff we spoke with told us this worked well and cover was always in place.
- The head of midwifery was supported by two midwifery matrons. They in turn provided support for the maternity and gynaecology staff. Staffing levels and skill mix were good. The exception was the Day Assessment Unit that was run by midwives with maternity care

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assistants (HCA) to support them. There were two midwives twice a week with no HCA support and the other three days there was one midwife and one HCA. It was sometimes very busy meaning women sometimes had to wait for a long period of time. The length of time each woman waited was not recorded. After the unit closed at 5pm all women who needed to be seen were asked to attend labour ward which put added pressure on staff on duty. We were told when the day assessment unit was really busy the midwife escalated the issue to the matron on duty. Sometimes extra help was sent but the staff did not know how the unit ran so it was not always helpful.

- Specialist midwives were available to provide support, such as for screening, safeguarding, infant feeding, public health such as drug and alcohol misuse, domestic violence and bereavement.
- The gynaecology ward had no vacancies. The ward was busy but had a good skill mix within the staff group that enabled patient's needs to be met.
- There were staff handovers at shift changeover times on labour ward, McCallum ward and McPherson ward. This included a daily safety brief about any current concerns.

Medical staffing

- The trust had a higher percentage of consultants and junior doctors when compared to the England average. The trust had less middle grade and registrars than the England average. Medical staff said it was hard to recruit to registrar posts and at the time of the inspection they were 1.3 whole time equivalent registrar posts vacant. Staff said they were able to get locum cover and regularly used the same doctors to ensure they knew the unit and could provide continuity.
- Data showed that between November 2013 and April 2015 there had been 40 hours labour ward cover every month. This complied with the Royal College of Obstetricians and Gynaecologists (RCOG) Good Practice Guidelines 2010 for a unit that delivered on average 2,250 babies a year.
- Consultants were on site from 8am until 6pm each week day. There was a consultant on call rota for out of hours. All staff we spoke with said they felt comfortable calling a consultant for advice and said they would often come in to see the patient.
- There were registrar and junior doctor presence 24 hours a day.

- There were three medical handovers per day. A formal handover occurred between 8.30am and 9.00am each day on labour ward with all medical staff expected to attend. A further handover took place at 1pm and 5pm with the consultant, registrar on call and the labour ward co-ordinator. The day registrar handed over to the night registrar between 8.30 pm and 9pm and the senior house officer handed over to the hospital at night team (who covered the whole hospital) at 9pm. Each patient on labour ward was discussed in detail. Every patient on the postnatal and antenatal ward and gynaecology ward was seen daily by a doctor. Staff on the gynaecology ward said their medical outlier patients were seen daily by the medical team and in between if necessary. Orthopaedic outlier patients, however, were not always seen daily but staff knew how to contact the relevant doctors when required.
- Anaesthetists saw women on the gynaecology ward prior to their operation. Patients said they took time to explain procedures and what to expect following an anaesthetic.
- The medical rota was checked weekly by the practice manager and consultant lead for education of trainees to ensure adequate cover and training opportunities.

Other staff

- Maternity support workers worked throughout the maternity services providing support in clinics and with infant feeding or personal care on the postnatal ward. Health care assistants provided care and support on the gynaecology ward.
- Sonographers and midwife sonographers worked in the ante natal clinic providing dating and anomaly scans. They were managed by the diagnostics division.
- There was a perinatal mental health team based on site who provided support to women throughout their pregnancy and postnatally. They were employed by the local mental health trust and managed by them. Although they were very integrated into the team at Torbay and spoke of very good working relations within the departments.
- Ward clerks worked on all areas of the maternity and gynaecology services providing support with documentation, taking and making telephone calls and greeting patients.

Major incident awareness and training

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- There was a trust wide major incident plan that staff were aware of. There was also a plan specific to the maternity unit to allow for business continuity should there be for example a failure of electricity supply.
- Staff were aware of how to access the policy and plans. The plan was reviewed regularly as part of the trust wide review process.

Are maternity and gynaecology services effective?

Good



We judged patients experienced good outcomes as they received effective care, treatment and support.

- Guidelines, policies and procedures were reviewed regularly to incorporate updated national guidance. They were available to staff at all times.
- Patients had access to pain control at all times.
- Data was collected to assess outcomes for women using the services.
- Supervisors of midwives were at the required numbers and available to support midwives when required. There was a preceptorship programme in place to support and develop newly qualified midwives.
- We saw multidisciplinary working well internally and externally. Midwives, nurses and medical staff spoke passionately about the women and babies being at the centre of everything they did.
- Patients were encouraged and supported to be involved in making decisions about their care and treatment.

However:

- There were issues with newborn blood spot screening samples (heel prick test to test for a range of rare but serious health conditions) as a significant number were rejected when they reached the testing centre. Some were because the post had not reached the testing laboratory in the timescale and some were due to poor samples. This resulted in the baby having to undergo another heel prick test which could be distressing to the baby and the mother. The matron said work was underway to improve the rate of rejection. The trust

were looking at potential ways to get the samples to the laboratory without using the normal postal system and ensuring that all midwives were competent in taking that blood samples.

Evidence-based care and treatment

- There was a trust wide audit team who reviewed guidelines, policies and procedures on a regular basis. There was a maternity specific audit midwife and one for the gynaecology services who reviewed maternity and gynaecology specific guidance, policies and procedures. This ensured documents were up to date and in line with new guidance. There were lead consultants who were part of the policies and guidelines group that ensured any new Royal College of Obstetricians and Gynaecologists (RCOG) or The Royal College of Anaesthetists (RCOA) was discussed and incorporated in to policies and procedures accordingly.
- There was an ongoing audit programme. There were a number of local and national audits ongoing during the inspection. Staff were engaged with audits. They said having an audit midwife to help them made a difference and they got feedback from her and final audit reports which showed how improvements could be made and/or how well they were achieving in some areas. We saw examples of completed audits (May 2015) such as intermittent auscultation (listening to a babies heart beat) – checking that records are completed correctly and in full and a bladder care audit to ensure postnatal women were being managed according to trust policy, which showed 89% compliance which was an improvement of the previous year.
- The policies and guidelines group met on a monthly basis. New guidelines were discussed in detail with timescales for completion of updating guidance and a named person identified with responsibility for ensuring completion and to feedback to the group.
- There were new National Institute for Health and Care Excellence (NICE) guidelines on Intrapartum Care in December 2014. These included changes to observations in labour and changes to cardiotocography (CTG) interpretation. Extra training had been made available and the policy updated.
- Staff had access to guidelines, policies and procedures via the trust intranet.
- Termination of pregnancy guidelines were updated alongside other gynaecology guidelines and in line with

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the most up to date best practice guidance. The policies and guidelines were available to the staff who saw and assessed women at the off-site health centre where the assessments took place.

Pain relief

- Patients had access to information about the variety of pain relief available to them during their labour. This was provided during ante natal clinic visits, via leaflets and the trusts website.
- Staff told us there was good access to an anaesthetist 24 hours a day. One woman we spoke to said she has requested an epidural and did not have to wait very long to see the anaesthetist.
- Anaesthetic cover was available 24 hours a day to labour ward. Patients said they had not experienced any delay when they needed an epidural anaesthetic.
- Nitrous oxide gas was available in every delivery room. Small mobile cylinders were also available for use as required. Pain relief by injection and epidural anaesthesia were also available.
- Women usually had access to a birthing pool. At the time of the inspection this was cracked and not able to be used. A new one was being sourced but until its arrival women were not able to access a birthing pool for pain relief. There was one birthing pool available to women at the birthing centre in Newton Abbot.
- Patients on the gynaecology ward (McCallum ward) had regular analgesia prescribed. One woman told us they had their pain relief medicine during the routine medicine rounds but when she had asked for some in-between the rounds the staff were quick to give it to her.
- Medicine administration charts were completed and showed when a woman last had her medicine.

Nutrition and hydration

- Meals were served in the dining room or by the bedside on McCallum ward and by the bedside only on John Macpherson ward, as there was no dining room available. Women were able to choose their meals from the menu that offered different choices for each mealtime. Specialist diets could be catered for.
- Snacks were available for people to help themselves to in between meals.

- Each delivery room had tea and coffee making facilities and a small refrigerator to keep drinks or snacks in during their labour. Drinks were available from the kitchenette or dining room and drinks rounds were carried out three times each day.
- We spoke with the infant feeding midwife who worked for 30 hours each week. They were involved in working towards the UNICEF baby friendly Initiative accreditation. The baby friendly Initiative works with health professionals to ensure mothers and babies receive support to enable successful breastfeeding. They were involved in audits and review of policies and guidance relating to infant feeding. They also ran training sessions around practical skills when helping mothers and babies to feed this included junior doctors and GP trainees.
- Peer supporters, albeit a small number, helped women mostly in the community settings with practical advice and help around breastfeeding.
- The maternity dashboard showed that between April and September 2015 the percentage of mothers breastfeeding at delivery had exceeded the trust target of 77% twice and for the remainder of the time it was around 72%.
- Nutritional assessments were completed on women admitted to McCallum (gynaecology) ward. The Malnutrition Universal Screening Tool (MUST) showed if a patient required help with their eating or drinking. If a risk was identified, a care plan was compiled. Patients we spoke with told us the food was “good and well presented” and “there was a choice offered”.

Patient outcomes

- Maternity performance dashboards, both local and regional, recorded activity to collect data about the outcomes for women and babies such as post-partum haemorrhage, number of inductions and number of elective and emergency caesarean sections.
- Between April and September 2015 there had been three months with no unexpected admissions to the Special Care Baby Unit with the other months averaging 6.5% which was within the trust tolerances. There had been no unplanned maternal admissions to critical care (ITU) in the same time period.
- Between June 2014 and June 2015 there had been 2,252 deliveries of these 61% had been normal deliveries.

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Elective caesarean sections had accounted for 11% of deliveries and emergency caesarean sections had accounted for 15% of deliveries. All three of these were similar to other trusts.

- Between April and September 2015 the percentage of women having an induction of labour had been above the trust target of 20% for six out of the seven months averaging 24%. The national rate for induction of labour in 2013 – 14 was 25%.
- The number of babies born before arrival at the hospital was on average two per month. The medical staff and midwives attributed this to the distance people often had to travel to reach the hospital. Each case was reviewed and no trends had been identified. There was no data to show if these babies had subsequently been admitted to the Special Care Baby Unit or needed any extra support.
- There were seven stillbirths between April and October 2015. Each case was reviewed and no trends had been identified.
- There had been 20 post-partum haemorrhages (PPH) of between 1500mls and 2500mls between April and October 2015. All were reviewed. There were two months that were above the trusts tolerance level, no specific cause could be found.
- There had been two post-partum haemorrhages of above 2500mls between April and October 2015. This was within the trusts tolerance level. On investigation no trend was identified.
- Third and fourth degree tears ranged between 2% and 6% of vaginal births between April and October 2015. These were within the trusts tolerance levels.
- The National Neonatal Audit Programme (NNAP) 2014 showed that 81% of mothers who delivered babies between 24+0 and 34+6 weeks gestation were given doses of antenatal steroids. This is below the NNAP standard of 85%.
- There were two maternal deaths between September 2014 and March 2015 (maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes). They were thoroughly investigated and found to be due to extremely rare conditions of pregnancy. The trust were open and

transparent through the process and shared their findings with the families concerned, within the trust and regionally. Ongoing support to families and staff had been provided as required.

- The gynaecology outpatient clinic met the referral to treatment time for patients who had suspected cancer. Patients who needed emergency gynaecology surgery were admitted to McCallum ward, where they returned following their surgery. The gynaecology clinical nurse specialist (CNS) had been involved in work related to gynaecology oncology. In 2014 there were 89 primary gynaecological cancers diagnosed by the gynaecology service and 9,966 two week referral patients seen of those 1295 women were confirmed as having cancer. The CNS was involved in audit locally and regionally to ensure they provided the most up to date care and support to these women at the time of diagnosis. Patient survey results from 2013/14 showed that 97% of patients thought they received adequate information about their diagnosis/cancer, 90% thought the information was personal to them and 94% said they had been given a named key worker or CNS to co-ordinate their care.
- There were issues with newborn blood spot screening samples (heel prick test to test for a range of rare but serious health conditions) as a significant number were rejected when they reached the testing centre. Some were because the post had not reached the testing laboratory in the timescale and some were due to poor samples. This resulted in the baby having to undergo another heel prick test which could be distressing to the baby and the mother. The matron said work was underway to improve the rate of rejection. The trust were looking at potential ways to get the samples to the laboratory without using the normal postal system and ensuring that all midwives were competent in taking that blood samples.

Competent staff

- A supervisor of midwives is a midwife who has been qualified as a midwife for at least three years and has completed additional training in midwifery supervision. By law midwives must have a named supervisor of midwives who they should meet at least annually. The ratio of supervisor of midwives (SOM) to midwives was 1:15. This met the recommended ratio according to the Midwifery Rules and Standards (rule 12 Nursing and Midwifery Council 2014) SOM's told us they had time to

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provide support and guidance to their allocated midwives and were able to spend time with them. Midwives told us they had access to their SOM's and found them to be supportive and approachable. There was a SOM on call overnight and we were told they came in to the unit to provide support if necessary.

- The Nursing and Midwifery Council defines preceptorship as 'a period to guide and support newly qualified practitioners to make the transition from student to develop their practice further'. Newly qualified midwives we spoke with were complimentary of the preceptorship programme they were on. They said all staff were approachable and willing to share their knowledge and gave them ample opportunities to develop their skills.
- There was a junior doctor induction day programme. As well as an orientation tour of the maternity and gynaecology unit there was trauma and orthopaedic and ear, nose and throat sessions for when staff were on 'hospital at night' duty. Some medical staff felt they were not competent to manage other specialities without on-site consultants. The trust were aware of these concerns and were working to make improvements to the system. We were not given any timescales for the improvements in which improvements were expected to be made.
- The infant feeding midwife had undertaken extra training to enable her to carry out release of tongue - ties in babies. This could sometimes be done whilst the baby was still in hospital enabling the baby to feed more successfully.
- A number of midwives had undertaken extra training to enable them to carry out examinations of the new born baby prior to discharge home. The baby examination is carried out as part of the Newborn and Infant Physical Examination (NIPE) screening programme and must be done within 72 hours of birth.
- Appraisal rates in the women's and children's division between April and October 2015 were on average 83% completed. This was below the trust target of 90%. Staff were being given dates for their appraisals and time was built into the rota to ensure they could attend their session.

Multidisciplinary working

- Staff at all levels spoke very highly of the multidisciplinary working both internally and externally. Midwives in the unit and community midwives worked

well together as community midwives came into the unit regularly to deliver women. Staff had worked as an integrated service for a long time and felt it worked really well.

- Staff spoke of working well with external providers such as other local acute hospitals in the region when needing to transfer a woman or baby to their service.
- Staff on John McPherson ward worked with the Special Care Baby Unit when babies needed to be admitted from or discharged to the ward. Staff spoke of good working relationships with paediatricians who visited babies on the ward regularly,
- There was multidisciplinary attendance at governance and policy groups. We also saw minutes and spoke with medical staff about attendance at the South West Regional Obstetric network (SWON) which gave medical staff the opportunity to meet and share ideas and learning.
- Newly qualified midwives on their preceptorship programme spoke about good team work between midwives and medical staff. Medical staff reported excellent working relationships with each other. The maternity and gynaecology services had a 'flat hierarchy' which allowed for good communication about the care and treatment of their patients.
- We saw a good example of multidisciplinary working when a woman had to go to theatre for an emergency caesarean section. Everybody worked well together and the woman was taken to theatre well within the set timescales.
- Serious incident investigation reports showed that systems in place to manage a deteriorating woman or baby worked well. In one case a number of specialities who worked well together to ensure the best possible outcome for a patient.
- Specialist nurses were valued within the maternity and gynaecology services. Other specialist nurses were accessed on occasions and staff spoke of the support they gave when required.
- Staff spoke very highly of the perinatal mental health (PNMH) team based in the maternity unit. They felt this provided effective and timely support to women and their families. The PNMH team told us they worked with midwives and other relevant healthcare professionals when developing a pregnancy plan with their patients.

Seven-day services

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- There was medical cover on the maternity unit and gynaecology ward seven days a week. Staff said consultants came into the unit any time of day or night if they were called.
- There was access to an anaesthetist seven days a week, 24 hours a day. Staff said they were attended the maternity unit promptly if they were called.
- Out of hour's radiology service were available seven days a week 24 hours a day. We were told about an incident where a CT scan was urgently required out of hours. Staff said the response was excellent and the radiology service they received was flexible and proactive.
- There was access to pharmacy support at all times either in person or by contacting the person on call.
- There was no physiotherapist attached to the maternity and gynaecology services. Staff said they could contact the physiotherapy team directly and patients would be seen. Staff said they would rarely have needed to contact them out of hours but knew how to do so if necessary.

Access to information

- Women carried hand held records, completed at every appointment attended by whichever health professional they were seeing. The notes informed health professionals and the woman about how her pregnancy was progressing. If a woman forgot her notes or was attending the services from out of the area and so not known to the service staff would contact their local midwife or GP to find out any relevant information about her pregnancy. Women took their records home on discharge from the maternity unit to ensure the community midwife had all the information required to carry on the care and support.
- There was access to leaflets about maternity and gynaecology subjects available in clinics, on wards and on the trusts website.
- Community midwife teams were contacted daily to inform them of who was going home or who had been admitted to the service.
- Administrative staff ensured patient records were available for clinics. They recognised if there was information missing, patients had been referred to the wrong clinic or specific documentation was required.
- Women more than 13 + 6 weeks pregnant attending the Torbay Pregnancy Advisory Service (TOPAS) were referred to another agency for their procedure. TOPAS

worked closely with the agency and they had an information sharing policy to allow the sharing of notes and scans, with the woman's permission, to prevent the woman having to repeat herself or have tests/scans repeated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Two doctors were available at TOPAS to sign the relevant forms authorising a termination of pregnancy. The completed forms were returned to the lead clinician to check they were completed correctly and they then sent them off to the Department of Health as required.
- We saw consent had been obtained for elective and emergency procedures. In one case on labour ward a woman who had gone straight to theatre from home had given verbal consent for the procedure. The consultant completed documentation after the surgery to show consent had been gained prior to the procedure. One patient we spoke with said they were clear about what procedure they had consented for and had been given information prior to the procedure to help them make an informed choice.
- Consent forms were detailed explaining to the health professional and the patient why consent was required and the risks involved in the particular procedure.
- Staff had an understanding of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. Senior staff were aware that more in depth training was required to ensure staff understood people's rights to make decisions and that training was being developed. Staff told us if they had any queries they would ask the safeguarding midwife or the on-site perinatal mental health team for their advice and support.

Are maternity and gynaecology services caring?

Good



We judged caring in maternity and gynaecology services to be good.

- Feedback from people who were using the service was overwhelmingly positive. We saw staff treating people with respect and dignity. Where staff felt dignity was compromised, due to the layout of the environment,

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every care was taken to ensure their dignity and privacy was maintained. People's choices and preferences were always a priority when planning and delivering care and support.

- Emotional support was provided via counselling services, the on-site perinatal mental health team and midwives trained in caring for women and their families who had suffered a bereavement.
- There was a positive culture around asking for and dealing with feedback from patients.

Compassionate care

- The NHS Friends and Family Test (FFT) was developed to help providers of services understand if their patients were happy with the services provided or if improvements were needed. The FFT feedback for the trust was collated by NHS England and showed feedback for maternity services was generally positive with feedback between September 2014 and September 2015 regularly higher than the England average. On occasions scores dipped below the England average with ante and postnatal care during the winter months of 2014 and birth and postnatal community provision dipping in April 2015.
- During the summer of 2015, CQC sent questionnaires to all women who gave birth in February 2015 (and January 2015 at smaller trusts), to find out about their experiences of care and treatment. The trust (South Devon Healthcare NHS Trust at the time) scored about the same as other trusts.
- We looked on NHS Choices website that allows people to leave feedback about the NHS services they have used. There were eight reviews relating to maternity and gynaecology between August 2015 and February 2016. All of them were overwhelmingly positive talking about the care and compassion they had received, about staff going the extra mile to make people comfortable and how well informed they felt.
- During the inspection we heard staff treating patients and their relatives with respect and kindness. Women and their relatives we spoke with told us staff had "been fantastic" and "very kind and helpful".
- We were given an example of staff going the extra mile to enable a large family to visit their relative on the McCallum ward on Christmas day so they could enjoy a family Christmas together.

- Privacy and dignity was reported as sometimes being an issue when women were waiting in the day surgery area for their surgical termination of pregnancy. There were sometimes children in the department who were able to overhear conversations.
- Staff said women who attended the infertility clinic had to walk through the antenatal clinic where obviously pregnant women were waiting. Staff told us there are long term plans to relocate the antenatal clinic and so avoid the situation. Currently as they only saw one person in the morning and one in the afternoon they tried to ask them to attend their appointments when the clinic was less busy to try to reduce any stress it may cause. Women attending the early pregnancy service also had to walk through the antenatal clinic waiting room.

Understanding and involvement of patients and those close to them

- The CQC survey of women's experiences of maternity services 2015 found that the trust scored about the same as other trusts when involving a partner or someone close to the woman during labour and birth.
- Patients who had used the maternity services we spoke with were very positive about their experiences and information provided to them throughout their pregnancy, labour and postnatally.
- We saw patients attending maternity and gynaecology clinics were able to bring somebody along with them and staff asked if they were happy to have the person come into the consulting room with them.
- Patients who had used the gynaecology services also spoke very positively about the services received. One person told us "staff are kind and I felt I knew what to expect".
- Women and their relatives we spoke with said they were provided with information and had their treatment options discussed with them. They said they felt able to ask questions and got clear answers.

Emotional support

- There was a perinatal mental health (PNMH) team based in the maternity department. There was a consultant clinic once a week, four fulltime equivalent registered mental health nurses and administrative support. Each woman that attended antenatal clinic was asked to complete a prediction and detection screening tool. The PNMH team assessed all the forms and offered to talk to

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women who may have or had been diagnosed with mental health issues. The PNMH team tried to ensure any women that needed to be seen by the team during their pregnancy had their appointments on the same day as their antenatal appointment to reduce the amount of visits they had to make to the hospital. Other service offered by the PNMH team were pre-conception advice for people with mental health conditions and advice and support for up to 12 months postnatally. There was also access to a carer support worker to provide support to a woman's partner if there is a difficult situation perhaps following a traumatic birth.

- Staff said they had good support from the chaplaincy team. There was no midwife lead for bereavement but staff said they all knew how to provide care and support in times of bereavement
- Counselling was offered to every person who attended the Torbay Pregnancy Advice Service to be assessed for a termination of pregnancy. All under 16's attending the service were given counselling. There was a two to three week wait for counselling services following a termination of pregnancy but staff said if it was deemed as urgent the patient would be seen sooner.
- The infant feeding midwife provided practical and emotional help and guidance to women having difficulties feeding their baby. There was also access to peer supporters, who are women who have themselves breastfed and have trained as volunteers to help other women.

Are maternity and gynaecology services responsive?

Good



We judged the responsiveness of the maternity and gynaecology services as good.

- The gynaecology service had introduced enhanced recovery to improve the flow of patients through the service. The maternity unit offered a day assessment unit facility Monday to Friday until 5pm. Women then had to go to the labour ward. To reduce the amount of women being sent to labour ward the maternity service

was looking into longer opening hours for the day assessment unit. Ante natal clinics were held in GP surgeries or health centres to allow women to access services closer to where they lived.

- There was a public health midwife who worked with people who may want to stop smoking, misuse drugs and alcohol or were subject to domestic violence. There was an on-site perinatal mental health team providing support to women who had mental health conditions.
- There were systems in place to make reasonable adjustments for patients living with learning disability or physical disabilities.
- The maternity and gynaecology units took a positive approach to concerns or complaints raised. Any learning was shared with the relevant teams and audits in place to ensure new learning had been embedded in practice.

Service planning and delivery to meet the needs of local people

- Maternity Voices (previously known as the Maternity Services Liaison Committee) made up of people who had used maternity services; maternity staff and commissioners met every quarter to help influence how services were designed to meet the needs of local women and their families. Minutes showed that local issues were discussed such as meals provided and special diets, infant feeding support and the issue of partners being able to stay overnight on ward areas.
- Partners were able to stay with women in labour. There was limited space for partners to stay overnight on the postnatal ward, however partners could visit at any time during the day or evening.
- The gynaecology ward (McCallum ward) often had medical and orthopaedic outlying patients. This meant at times they had reduced number of gynaecology beds available. Staff told us that due to the successful gynaecology day surgery and short length of stay for inpatient gynaecology operations gynaecology operations were rarely cancelled.
- The onsite perinatal mental health team was said to be a great success with patients having timely access to the team as required.
- The trusts own website had links to local resources such as the South West Neonatal Network, children's centres and the local Maternity Services Liaison Committee.

Access and flow

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- The early pregnancy unit was open Monday to Friday. Out of hour's women had to attend the emergency department from where they may be admitted to the gynaecology or antenatal ward for ongoing treatment.
- Out of hours emergency gynaecology patients went to the emergency department. The long term plan is for those patients to be able to go to an emergency assessment unit of the gynaecology ward.
- An enhanced recovery programme (**evidence-based approach that helps people recover more quickly after having major surgery**) was used in gynecology surgery. This meant that many surgical procedures could be carried out as a day case or requiring a very short stay in hospital. This increased the flow of patients.
- **The gynaecology ward (McCallum) had medical or orthopaedic outlier patients most of the time. The medical patients were seen by their team each day. Staff on McCallum ward were able to access physiotherapists, dietitians or tissue viability nurses for example to help support the patients to improve and rehabilitate if necessary.**
- The day assessment unit was open Monday to Friday until 5pm. After this time women had to attend the labour ward or antenatal ward. This put extra pressure on the respective units as they had to answer the phone and advise women if they needed to attend to be assessed and then manage the patients as well as manage who was already on the wards. Extra staff were bought in from the community on call rota if the workload became too busy. There were long term plans to increase the opening hours of the day assessment unit to relieve pressure on the wards. We did not know the exact timescale for this to happen. This issue had been on the obstetric risk register since May 2015. A business case submitted for 2015/16 to increase capacity to have extended day and weekend service was deferred to be re-submitted in 2015-16. Antenatal care was provided at local GP surgeries and health centres near to patients homes to make it easier for them to attend appointments.
- According to NHS England statistics the bed occupancy had been consistently below the England average from quarter two 2013/14 until quarter one 2014/15. The occupancy had risen steadily from quarter one 2014/15 (22%) to quarter one 2015/16 (29%).
- When a woman rang the labour ward to say they thought they were in labour where possible and in agreement with the woman a community midwife would go to their home to assess if they were in labour and discuss their choices for the birth. This had enabled women to stay at home for longer and in some cases a home birth had been facilitated that had not been previously planned for.
- Some midwives were trained as sonographers to help increase the flow of patients in the antenatal clinics.
- Outpatient induction of labour for some women was introduced in February 2015. This meant that women could go home and spend an average of 18 hours at home before needing to go to the labour ward.
- The consultant led maternity unit reported having never been closed.
- A number of midwives were able to carry out newborn screening checks. This meant women who were able to go home did not have to wait for a paediatrician to check their baby before they left.
- There was one dedicated obstetric theatre which was staffed by general theatre staff during the two elective caesarean section lists per week and for any emergency procedures such as emergency caesarean sections or removal of a retained placenta. If a second theatre was needed general theatres would be used. They were located near to the labour ward. Staff said this had never been a problem as it was unusual to need two theatres at one time. The Royal College of Obstetricians and Gynaecologists recommend a service that has over 4000 births annually should have a second dedicated theatre available. Torbay had 2,252 births between January and December 2014.
- Staff on the McCallum ward were able to supply frequently dispensed medicines from the ward for patients to take home, once a doctor had signed a prescription. This meant women did not have to wait very long to go home once they had been discharged

Meeting people's individual needs

- Staff had access to translation and interpretation services. The trust website had information on the services available and they included telephone and face to face interpreting services, British Sign Language and written translation services, easy read information,

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audio, large print and Braille. Staff said they did not have to use the services very often but when they did the systems had worked and had been quick to respond.

- Staff working in the gynaecology outpatients and on the ward said if they had people with complex needs or living with dementia they would access the appropriate link or specialist nurses for advice and support. The administrative and booking staff were made aware so the patient's appointments could be made at a time that suited their needs. For example patients living with physical disabilities may take time to get ready in the morning so an early appointment may not suit them.
- There was a flagging system in place so people living with a learning disability who were admitted to the hospital were able to be asked or assessed to ensure reasonable adjustments could be made to make their stay more comfortable. All matrons received an email each morning with a list of all patients in the hospital who were living with a learning disability. They said they did not often have people in the maternity unit who were living with a learning disability but if they did they knew how to contact the learning disability team for advice and support.
- There was a public health midwife who was available to support women who had issues with alcohol and/or drug misuse, were subject to domestic violence, teenage pregnancy or needed help to stop smoking. There was also a specialist screening midwife and an infant feeding midwife. They were available to provide support and advice to colleagues also.
- The on-site perinatal mental health team took referrals from booking midwives and assessed women who attended antenatal clinics to ensure they were meeting their needs.
- The CQC Survey of Women's Experiences of Maternity Services in 2015 found the trust was 'about the same as other trusts' in speaking to women in a way that could be understood and enabling women to move around when in labour and choose the position that made them most comfortable.
- Clinic waiting rooms had toys and magazines available for patients and their children whilst waiting for their appointment.
- Following feedback from patients, small fridges had been provided for each delivery room for women to use to store milk and other items they may want during what may sometimes be a long labour.

- We were told that midwives were aware that women and their families did not 'take in' all the information they were given when booking their pregnancy. As a result short videos, of about two minutes in length, were made available on the trusts website. They described 'your schedule of care', 'the screening programme', 'routine blood tests in pregnancy', 'eating the right diet in pregnancy', 'substances to avoid during pregnancy' and 'preparing for your pregnancy if you have diabetes'. We were told they had been successful and had prompted some women to come to their appointments with questions prompted by watching the videos.
- Call bells were available by each bed on John McPherson ward and McCallum ward. Patients we spoke with said the bell was answered quickly if they used it.
- The Local Supervising Authority annual audit report was published in June 2015. There were areas of good practice identified for example facilitating choice for women and accommodating those that may deviate from normal pathways.
- There was a bereavement suite on labour ward (known as the Mary Delve suite). There were facilities for parents to stay in the unit with their stillborn baby and a cold cot for the baby so that it could remain with the parents for longer periods of time if they wished. There were facilities for making drinks and meals could be eaten in the unit. We saw the memorial garden located at the rear of the maternity unit where families who had suffered the loss of a child could go to place a memorial and/or spend some time in quiet contemplation.
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Learning from complaints and concerns

- Information about how to make a complaint was displayed throughout the maternity and gynaecology services. There was a trust patient information leaflet on how to make a complaint available in the hospital and on the trusts website. It gave contact details for the Chief Executive Officer, the trusts complaints team, Patient Advice and Liaison Service (PALS), advocacy services and the Parliamentary and Health Service Ombudsman.
- We saw a spreadsheet that detailed reported incidents, verbal and written complaints and any compliments from patients receiving maternity and gynaecology services. There had been seven written complaints since June 2015. The spreadsheet showed they were reviewed

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monthly. Investigations and actions taken and any trends were detailed. For example a trend in returns to gynaecology theatre had increased so a review was taking place.

- Senior staff said if they received a complaint they would contact the person concerned to discuss personally with them their expectations from the process and expected timescales of the investigation. This was followed up by a letter.
- Staff said they were made aware of any complaints and the outcomes. Learning from complaints was discussed at staff meetings, team leaders meetings and at relevant divisional and governance meetings if necessary. We saw copies of minutes of meetings where learning from complaints had been discussed. For example, changes to practice that included information to relay to the ambulance service when requesting an urgent ambulance and information needed by Special Care Baby Unit when transferring a baby from the labour ward or postnatal ward.
- The resuscitation team now had swipe cards to access the maternity unit so they did not have to wait to be let in and therefore increase their response time.
- Patients were encouraged to complete the NHS Friends and Family Test to provide feedback about their experiences. Staff were encouraged to share their views on the service and any improvements that could be made.

Are maternity and gynaecology services well-led?

Good



We judged the leadership of the maternity and gynaecology services as good.

- Staff felt very supported by local and trust wide management. There was an open culture with all staff engaged in ideas about how the service could be improved. Public engagement was encouraged with opportunities to feedback through the NHS Friends and Family test and via social media pages relevant to maternity and gynaecology.
- Governance and audit were embedded in practice with staff reporting systems that provided feedback and as a result improvements to the service were made.

- We were given examples of innovative practice that showed staff were always looking to improve the way they delivered the services offered.

Vision and strategy for this service

- Staff were aware of the vision and strategy for the trust as a whole. Staff were clear the patient and their families were at the heart of everything they did.
- The service was awaiting the NHS England review of maternity services to be published (expected March 2016) before finally deciding on their visions for the future and how they could continue to improve services provided. The report was to set out current maternity provision and how it could be developed to meet the changing needs of women and their families.
- There were long term plans in place to move the antenatal clinic and day assessment unit to the same floor as the labour ward and move gynaecology outpatients to the same level as the gynaecology ward. This would prove more convenient for patients and less time travelling between floors for staff.

Governance, risk management and quality measurement

- We saw the two risk registers for maternity and gynaecology services. They were linked to the trusts risk register. Issues such as staffing levels and lone working had been on the risk registers for long periods of time. The risk register showed actions that had been taken in respect of staffing levels and lone working and ongoing review dates.
- The risk registers were reviewed at local governance meetings held weekly and monthly. The risk registers were linked to audit activity where appropriate or had action plans in place to ensure the risks were being managed.
- The consultant lead for governance was very committed to the role. They worked very closely with the risk management midwife, who both attended the weekly maternity governance meeting, the monthly perinatal (mortality and morbidity) meetings and the gynaecology governance meeting. They felt there was good support at trust level from the patient safety officer when required. Junior doctors attended the governance meetings as it was considered inherent in the role of staff to consider risk management and governance.
- We saw the clinical governance newsletters for November and December 2015. The front page had

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details of 'this month's important learning'. Inside were details of audit results for example the sepsis audit between January and June 2015 where 10 sets of notes were reviewed. Recommendations were detailed and included increase awareness was needed of Sepsis Bundle Stickers and review of when to escalate to a doctor. Details of how to access the full report were provided. The newsletters were engaging and easy to read but conveyed important patient safety information.

- The audit midwife worked closely with nursing, midwifery and medical staff and felt that staff were engaged in the process of audit. Staff said they felt audits were useful to improve practice and were happy to be involved as they got feedback which showed areas of good practice and areas where they could improve.
- The directorate governance team undertook a benchmarking exercise, following the publication of the Kirkup report (March 2015) into the maternal and neonatal deaths at Morecombe Bay. They looked at the five key themes highlighted in the report. One of the key themes was around culture and the directorate wanted to gain an objective assessment of where they were on the issue. An anonymous questionnaire was sent to all grades of staff in the directorate in August 2015. The results showed very positive responses to the statement 'my experience is that my colleagues and I work together for our patients' and 'I experience respect and dignity at all times within the department that I work'. There was an ongoing action plan developed which will continue to be monitored through the Obstetrics and Gynaecology Risk management Group.

Leadership of service

- Staff we spoke with told us of excellent local management within the maternity and gynaecology services. They described them as both supportive and approachable.
- Staff said they had felt informed about the recent merger of the acute and community trust and had received lots of communication and opportunities to attend meetings about it prior to the merger happening. Staff were familiar with the chief operating officer (CEO) and the chairman. They said when they had had some difficult times in the maternity unit both the CEO and chairman had visited to provide support and practical help.

- Staff told us a Non –Executive Director (NED) had been nominated to take a responsibility for maternity services at board level.
- Duty rotas showed there was always a co-ordinator on the labour ward and supervisors of midwives always available.
- The head of midwifery was supported by two matrons, with senior staff on duty on the wards and clinics each day.
- When being shown around the maternity and gynaecology units by one of the matrons it was clear all staff knew them and found them approachable.

Culture within the service

- Staff were very positive about working within the maternity and gynaecology services and about working for the trust as a whole. Midwives were proud of the integrated care and support they offered to women and their families. They described a lot of 'joined up' working with other specialities and professionals and felt it always benefitted the patients.
- Staff described an open culture in which they were encouraged and supported to report incidents. Learning from incidents was described by all levels of staff and seen as a positive result of reporting incidents.
- Newly qualified midwives told us their preceptorship process was invaluable and felt all staff encouraged and supported them to develop their roles.
- We saw good team work between the operating theatres and the labour ward and the special care baby unit and postnatal ward. Staff described excellent working relations between midwifery and nursing staff and medical staff. The sister on the gynaecology ward said the staff were able to liaise with the medical team who visited their medical outlier patients daily and found them very approachable.

Public engagement

- Maternity Voices formally known as the Maternity Services Liaison Committee (MSLC) met regularly. The group consisted of people who work in maternity care in South Devon and local parents. Their aim was to listen and take account of views and experiences of people who had used the maternity services. There was information on the trusts website and people were encouraged to join their 'virtual panel' to provide feedback and suggestions via email. Minutes for

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September 2015 meeting were detailed and included ideas of what could be done better and many positive comments about people's experiences of the maternity services.

- There was access to infant feeding advice and Maternity Voices via social media sites.

Staff engagement

- We were told and saw minutes of the monthly obstetrics and gynaecology directorate maternity team leaders meeting. They were said to be well attended and enabled ward and community team leaders to come together to discuss learning points and required actions, good practice and staffing levels. Information from these meetings was then cascaded to each individual team to be discussed at team meetings.
- Newsletters and update emails from the trust were said to be very informative and regular.

Innovation, improvement and sustainability

- 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.
- 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. Staff we spoke to said this had been a useful exercise and felt improvements in communication had been made.
- 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. There was no data to show if outcomes for women had improved but anecdotally the system was appreciated by families and midwives.

- 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.
- Social media pages had been developed to engage women with the maternity service for example, the infant feeding specialist midwife had a page that women could visit and ask questions. The pages were monitored regularly.
- An enhanced recovery programme had been introduced for the gynaecology service. This enabled women to spend less time in hospital which was better for people's wellbeing and increased the flow of patients through the service.
- Outpatient induction of labour for some women was introduced in February 2015. This meant that women could go home and spend an average of 18 hours at home before needing to go to the labour ward. It is thought that only one other hospital in the South West currently offers this service.
- 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. Matrons were not usually invited (although they could also access the support if necessary). There were no notes taken of the sessions so staff were free to speak. Staff said this had been very helpful and appreciated the opportunity to discuss situations with colleagues from all levels with someone who was a clinician themselves. This was a trust wide initiative with 15 people trained in the role across the trust.
- Staff award ceremonies took place to celebrate good practice and team and individual achievements. The trust WOW Awards are "a way of recognising the hard work and commitment of our staff and publicly say

Maternity and gynaecology

thank you to them in the workplace and then share that award on our internal and external websites". Staff could be nominated by members of the public or trust staff. A community midwife won a WOW award in October and a midwife won one in November 2015.

Services for children and young people

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

Information about the service

The children's and young people's service at Torbay Hospital cared for children and young people from 0 to 18 years. The service included an 19 bedded children's ward (Louisa Cary ward) which delivered the following services: care for children from 0-18 years with medical, surgical or psychological conditions requiring inpatient care, day case and day patient care. A play room and school were located within the ward. A short stay paediatric assessment unit was used for GP referrals and planned investigations and provided a service to children and young people from 9am to 9pm, five days a week. A young person's unit provided services for teenagers with age appropriate facilities A two bedded high dependency unit provided more intensive care for children and young people when necessary. There were overnight facilities for parents including en suite rooms, showering facilities and a lounge/ kitchen.

Children's and adolescent outpatient clinics were held in a designated area in the outpatient department. Children and young people were referred by GPs and consultant staff to the relevant paediatrician.

A Level 1 special care baby unit was situated adjacent to the Antenatal and Postnatal wards. There were 10 cots for babies who were small, premature or who needed extra care or observation. There were facilities for four mothers to stay with their babies in a dedicated four bedded bay in the unit.

There was an outreach service that provided care and support to babies and children and their parents who supported Louisa Cary ward and the special care baby unit.

The majority of planned children's surgery was carried out four days a week in day surgery, main and specialist theatres. This included general surgery, trauma, orthopaedics and dental surgery. There were no dedicated theatre lists for children but children were usually first on theatre lists. 3,219 children were seen by the service from July 2014 and July 2015.

We spoke with 40 staff, including nurses, consultants, medical staff and support staff, six parents and four children and young people during our inspection. We visited all of the paediatric wards and departments within the hospital and undertook observations of care. We looked at care records and other documents in each of the areas visited.

Services for children and young people

Summary of findings

We rated services for children and young people as good overall.

- There was a clear vision and overall strategy for children's and young people's services. The service provided effective and responsive planned and emergency care and support to children and young people and their families. People who used the service told us they felt safe.
- We found without exception, staff at all levels were caring and supportive and keen to do the best job they could. Children and young people were placed at the heart of care and we saw many examples of where staff had gone 'the extra mile'.
- We found paediatric services were well-led at local and unit level. Staff reported they felt engaged with the senior team in paediatrics and across Child Health.
- There was a clear governance and audit framework in place and staff felt able to raise issues and concerns with their local and senior managers. Staff said they were listened to and their concerns were understood.
- There were good examples of innovative practice. For example, the short stay paediatric assessment unit and the high dependency unit, dedicated child appropriate services in outpatients, involvement of children and young people in consultant interviews and development of paediatric outpatient services who delivered children and young people's medicines to their homes.
- Parents and children spoke highly of the service and we saw extensive examples of positive feedback and observed many examples of compassionate child focused care during our inspection.

However, some aspects of the service did not assure us that children and young people were always 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
- 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. Steps were being taken by the trust and clinical commissioning group to address this.

- Access to the treatment room on the paediatric ward was via the medicine storage and preparation facility. This compromised children's safety and could cause distress to children and young people in the vicinity. Staff recognised the problem and were acting on it.
- Staffing levels on Louisa Cary ward were often below the recommended guidance (RCN 2013) particularly at night. The organisation had taken action to mitigate the risks through comprehensive skill mix reviews.

Services for children and young people

Are services for children and young people safe?

Good



We judged services delivered to children and young people and their families as being safe.

- There were appropriate systems in place across all paediatric departments to ensure that incidents were reported and investigated properly. Staff were able to share examples of where learning had taken place which and had led to improvements in practice.
- The children's and young people's service was safety aware and there was a strong emphasis on ensuring children were cared for by staff trained in hygienic care practices and were clinically competent to care for children and young people.
- The Louisa Cary ward and special care baby unit had secure access to maintain the safety of babies, children and young people.
- The majority of staff had received safeguarding at Level 2 and Level 3 and knew how to report the signs and symptoms of potential abuse.
- The World Health Organisation (WHO) surgical safety checklists were in place for all surgical and anaesthetic procedures. Compliance audits were reported as being 100%.
- Early warning trigger tools (EWTT) was embedded in practice on Louisa Cary Ward and in the special care baby unit to enable the degree of illness to be determined and the appropriate actions taken for babies, children and young people.
- There was a lack of clarity and inconsistency around care planning for children and young people on Louisa Cary ward. A review of the care planning process was planned for the immediate future.
- Staffing levels at night on Louisa Cary ward were not always in line with national guidance (RCN 2013) and staff expressed concerns regarding this throughout the inspection. However, the organisation had reviewed staffing levels and plans were in place to address staff concerns.

- Storage facilities for breast milk on Louisa Cary ward and in the special care baby unit were not secure which compromised the safety of babies.
- The safety of children and young people with mental health needs were not always assured. There had been an increase in the number of children and young people admitted to Louisa Cary ward over the last 12 months (Safety Report 2015). The total number of Child and Adolescent Mental Health Service (CAMHS) related incidents for Louisa Cary Ward was 16 for the period April 2014 to March 2015. Staff reported difficulties accessing the CAMHS service, particularly at weekends. Staff told us they had not received training in supporting young people with mental health issues.
- Access to the treatment room on the paediatric ward was via the medicines storage and preparation facility. This compromised children's safety and could cause distress to children and young people in the vicinity.

Incidents

- There were appropriate systems in place across all paediatric departments to ensure that incidents were reported and investigated properly. Staff told us they received feedback after reporting an incident. Incidents were reviewed weekly by senior managers. Staff gave examples of actions that had been taken to reduce the risk of similar incidents occurring and how patient safety had been improved. For example, staff on Louisa Cary Ward had reported shortages of staff at night. The matron and ward manager had addressed the shortages in the short term through the allocation of temporary staffing. A skill mix review had been undertaken using recognised dependency tools (RCN guidance 2013) and a business case was being presented to the trust board in March 2016.
- Staff were able to tell us about the actions taken and felt they had been listened to. We looked at the investigations following incidents. They were thoroughly investigated with identified learning and actions to reduce the risk of similar incidents in the future. Information was disseminated via departmental meetings and safety briefings.
- The total number of incidents relating to children's and adolescent mental health for the paediatric ward was 16 for the period April 2014 to March 2015. This was partly due to an increase in children and young people with

Services for children and young people

mental health issues being admitted to Louisa Cary Ward. Staff reported difficulties accessing the CAMHS service, particularly at weekends. The problem had been recognised and was being acted upon.

- The trust performs 'about the same' as other trusts for all questions in the 'safe' category of the 2014 Children's Survey. For example, 89% of parents and carers felt their child was safe on Louisa Cary ward which was a similar response to other trusts.
- Child Health hosted the annual Child Death Review meetings for the local population in association with their emergency and anaesthetic department colleagues. In the year 2014/2015 there were 20 deaths linked to Torbay of which 13 notifications were made to the Peninsula Child Death Overview Panel. Examples of actions arising from the meetings were: Investigation into baclofen pumps therapy and monitoring of adverse events, and Health Visitors to maintain regular contact with a bereaved mother and to monitor for postnatal depression.

Duty of Candour

- Staff caring for children and young people in Torbay Hospital recognised the term 'Duty of Candour' (notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.) During our inspection a parent on Louisa Cary ward complained about the attitude of a clinician following a delay in the treatment of their child. The ward manager addressed the parent's concerns immediately and the matter was resolved to the satisfaction of the parent through an apology by the clinician

Safety Thermometer

- The safety thermometer (safety monitoring tool) was in place on Louisa Cary ward. Reporting for the period September 2014 to September 2015 identified that there were no pressure ulcers, catheter related urinary tract infections or falls resulting in harm. Safety crosses (from productive ward) were in place to monitor the paediatric nutritional screening tool (STAMP), CAMHS referrals, safety huddles, and the management of intravenous infusions (cannulas, wound sites and

intravenous giving set) were undertaken. We saw documentary evidence of this which demonstrated that staff were monitoring patient's safety and would take the appropriate actions if required.

Cleanliness, infection control and hygiene

- We observed staff at all levels on paediatric wards and departments washing their hands and using gel sanitizer according to trust policy. We observed the appropriate use of personal protective equipment such as aprons and gloves. Ward and department areas were clean and tidy and individual cleaning schedules were being maintained. The NHS Children's Survey September 2014 to September 2015 reported 87% of parents and carers on Louisa Cary ward were satisfied with the cleanliness of the ward.
- Hand hygiene audits on the paediatric ward and in the special care baby unit showed 100% compliance for the period October to December 2015. There were sufficient hand-washing sinks and gel dispensers in each area. We observed cleaning schedules were up to date and completed cleaning were clearly documented. This included the play area for children, which was clean and tidy to help minimise the risk of infection to children who regularly played with the toys.
- Daily cleaning checklists were used and reviewed weekly for compliance within day theatres, which included theatre, pre assessment rooms, recovery areas and waiting rooms. Equipment was stored in dedicated storage areas.
- Paediatric staff reported a good working relationship with the infection control team. There were infection control link nurses on the ward and in the special care baby unit to provide advice and guidance to staff.
- There were no reports of Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.Diff) related infections in either the paediatric ward or in the special care baby unit.
- Parents visiting the paediatric ward told us the ward was cleaned to a high standard. One parent who had stayed overnight in a cubicle with her child, told us how her bed had been stripped of its linen and cleaned

Services for children and young people

thoroughly after use. This demonstrated staff were aware of the importance of maintaining a clean and hygienic environment to limit the risks of infection to children and young people.

Environment and equipment

- The paediatric ward had a mixture of three bedded bays and 11 cubicles. There were five spaces for short stay for either beds or trolleys and one cubicle in the paediatric assessment unit. The high dependency area had been relocated 18 months ago and had two designated high dependency beds. Separate toilet facilities were available for children, parents and staff. There were facilities for parents to stay overnight (two beds) with en suite showering facilities and a kitchen/ lounge. The majority of cubicles (11) had put up beds to enable parents to stay overnight.
- The special care baby unit had two nursery areas for 10 cots each equipped with the appropriate equipment to care for small or premature babies requiring close observation. We were told that due to winter pressures in November 2015 to January 2016, the unit had supported the care of 14 babies. We noted the nursery environment was just big enough and had sufficient equipment points to care safely for the increased number of babies in the unit. Incident reports had been completed to record additional activity. This demonstrated that staff were aware of the risks associated with increased patient activity in the area.
- There was a rolling replacement programme in place for medical equipment on Louisa Cary ward and the special care baby unit. Currently, there were seven incubators for 10 cots on the special care baby unit and an eighth incubator was on order. Two specialist cots (hot cots) had recently been purchased to supplement the provision of incubators in the unit. We were told, should additional incubators be required, they would immediately be supplied either through the special care baby unit network or through a designated supplier. This ensured appropriate equipment was always available to support babies who required special monitoring in the special care baby unit.
- The Louisa Cary ward and the special care baby unit had secure access to maintain the safety of the babies, children and young people. Exit from Louisa Cary

ward units was via a high level button out of reach of children. Access to the special care baby unit could only be gained if let in or out by staff. This meant children's safety was assured.

- The Louisa Cary ward and the special care baby unit had resuscitation equipment appropriate for babies, children and young people. Equipment was checked daily and there was documentary evidence of daily checks being completed. Equipment in the paediatric ward, the high dependency unit, the special care baby unit and recovery in the day theatre was appropriate to each bed/cot space.
- A servicing and upgrading of equipment program was led by medical electronics staff. Staff said the system worked 'well' and equipment was maintained in a prompt and timely manner. Electrical testing had been carried out on all equipment we checked.
- We saw equipment required for use with the special care baby unit and the Louisa Cary ward transfers charged and ready for use at all times. Machines with batteries were plugged in to the mains to ensure batteries were charged.
- The Louisa Cary ward and the special care baby unit each had a milk kitchen which was not secured. This meant that any milk in the fridges or bottled baby milk could be tampered with unnoticed. We brought this to the attention of the staff on duty. Louisa Cary Ward staff immediately secured their milk kitchen and the special care baby unit staff placed an urgent order for a key pad lock.

Medicines

- Access to the children's treatment room on Louisa Cary ward was via the medicines storage / preparation facility. Children's safety could be compromised as medicine errors could be incurred by staff being interrupted during the checking of medicines. This could also cause distress to children and young people, for example, children who had a phobia of needles. We brought this to the attention of the staff on duty. Senior staff told us a risk assessment would be undertaken to identify measures to mitigate the risks to children and young people.
- On Louisa Cary ward and in the special care baby unit, we found medicines were securely stored. Medicines were kept within a locked room accessible only by staff. Controlled drugs were stored in separate locked

Services for children and young people

cupboards and should be checked twice daily by two qualified nurses. Checks were completed during the day but were sometimes missed at night. We were told there were less staff on duty and often increased levels of dependent children and young people on the ward. The inconsistent checking of controlled drugs could compromise the safety of children and young people. Where medicines needed to be kept in fridges, the temperature of the fridges was checked daily and were noted to have been within an acceptable range. There was good access to medicine resources, including current children's medicine formularies.

- Allergies were clearly recorded on prescription charts and no missed medicine doses were seen.
- Where medicine administration errors had taken place, we saw evidence to show they had been reported and investigated in line with the trust's incident reporting procedures. Staff were aware of the administration of medicines policy and had acted appropriately. For example, medicine errors had occurred with an infusion pump on Louisa Cary ward, which had not been calibrated correctly. The error was identified and the appropriate action was taken, no further incidents were reported.
- The paediatric pharmacist visited the wards daily. The pharmacy service provided a seven day and overnight on-call pharmacy service to the paediatric wards.

Records

- Children and young people's individual care records were not managed in a way that kept them safe. Baby's notes were stored securely in a locked trolley on the special care baby unit. However, medical and nursing records were stored behind the reception area on Louisa Cary ward. This was not secure storage. We noted on the risk register (January 2016) a lockable area for note storage had been agreed.
- Observation charts (temperature, pulse etc.) were available for babies, children and young people of different ages. Charts were comprehensive and included a Paediatric Early Warning System (PEW) score. Observations were clearly documented and completed in full.
- We reviewed 10 care plans on Louisa Cary ward. Core care plans (some dated 1998) were used to index the

care plan(s) for each child /young person. There was no evidence on the nursing care record of the care planned and delivered or the outcomes achieved for each child or young person. Nurses recorded each child's progress in the shared notes which was often not completed until the end of a 12 hour shift. We brought this to the attention of the staff on duty who told us they planned to review care planning systems and processes on the ward.

- Louisa Cary ward and the special care baby unit used standardised admission, assessment and observation charts. Care pathways were used within day surgery which incorporated preoperative checklists and anaesthetic care checklists through to post-operative care. This demonstrated that risks to the child and young person were mitigated against due to consistent practices.
- The World Health Organisation (WHO) surgical safety checklist was in use for all surgical procedures. There were audits carried out to ensure their use with all procedures. Results of the audits we reviewed showed 100% compliance with the checklist.

Safeguarding

- The trust had a safeguarding team (for children), which included a named nurse and two paediatricians for Devon and Torbay who shared the named doctor's role. The team were involved in safeguarding referrals within the hospital and serious incident investigations that included safeguarding issues. They were also available for advice and support to staff around safeguarding concerns or questions. The team sat on internal groups and committees and worked with external providers such as CAMHS, to ensure good working relationships were developed and maintained.
- Staff were aware of the paediatric liaison nurse role and had regular contact with the named nurse for the child protection and safeguarding team. The paediatric liaison nurse worked between the acute and community safeguarding service and was based in the hospital. This ensured children and their families were supported following discharge. However, we noted the document on the trust intranet 'Working Together to Safeguard Children' was the 2010 version, though an updated version had been released in 2014.

Services for children and young people

- Policies and procedures for safeguarding children were current but were not specific to Torbay and South Devon NHS Foundation Trust, which was causing confusion for staff accessing the information. This was being addressed by the children's safeguarding team. Staff were able to access the relevant policies and procedures electronically, although safeguarding information was stored in different places which could lead to confusion or information being overlooked.
- Extensive work had been undertaken to implement a three year safeguarding training programme developed in response to the Royal College of Paediatrics and Child Health Intercollegiate Document (2014). Staff were trained to the appropriate level, with 93% of staff trained at Level 3 and 81% of staff trained at Level 2.
- Supervision arrangements for safeguarding had been identified on the Child Health risk register as being of concern due to the number of supervisors currently available. However, plans were underway to address this. Child protection supervision sessions for high risk teams (Louisa Cary ward and the special care baby unit) were planned to be incorporated into mandatory study days. Sessions would be tailor made and facilitated by the named nurse for safeguarding children.
- Children and young people's notes had a system to alert practitioners to any child where safeguarding concerns were already known. This made staff aware of additional issues that might need to be considered for that individual child.
- Where children or young people failed to attend two clinic appointments, either as a new referral or a follow up appointment, a referral would be made to the children's safeguarding team and contact would be made with the child's GP and health visitor to find out if there were any issues for concern.

Mandatory training

- Training records for paediatrics showed that all staff on Louisa Cary ward and in the special care baby unit were either up to date with their training or had training days scheduled. Compliance in both areas was between 90% and 94% and was rated as Green against the trust targets.
- Staff were able to access on line mandatory training. For example, manual handling, infection control, safeguarding Level 1, and fire.

Assessing and responding to patient risk

- Each child or young person had a paediatric nursing assessment completed on admission. This included risk assessments in relation to manual handling, nutrition pain and pressure ulcer risk. Louisa Cary ward and the special care baby unit used an age specific paediatric observation chart. The chart included a paediatric early warning (PEW) score that helped staff recognise when a child's condition was deteriorating and when and how to seek further help and support from medical staff.
- The staff we spoke with were all familiar with PEW scores and problems had been escalated appropriately in the records we reviewed. PEW also included a RAG (red, amber, green) escalation plan to ensure staff were aware of the deterioration in a child's condition and knew the appropriate actions to take to escalate the child's care appropriately.
- World Health Organisation surgical safety checklists were used in theatres and for anaesthetic procedures. Staff we spoke with were well aware of the checks that needed to be done to ensure that consent had been obtained for each child for the correct procedure.
- When children were moved to the recovery area after their operation or procedure, the staff followed discharge criteria to make sure that children were safe to return to Louisa Cary ward or the short stay paediatric assessment unit or to be discharged home. Parents were allowed to be with their child once they were awake. If the child was returning to Louisa Cary ward or the short stay paediatric assessment unit ward post operatively, a qualified nurse escorted the child with the parent(s).
- Critically ill children requiring intensive care or specialist intensive care underwent retrieval to a major hospital. Staff told us this was an excellent service and the waiting times were very short. This ensured that children who required urgent treatment and care were able to receive it in a timely and appropriate clinical environment.
- Babies who were small or premature or needed extra care or observation were cared for in the special care baby unit. Where additional support was required, babies were stabilised and transferred to the closest neonatal unit in the regional network.

Services for children and young people

- An Early Warning Trigger Tool (EWTT) was in place on Louisa Cary ward and the special care baby unit to determine the degree of illness in babies, children and young people. A score of five or more would indicate an increased likelihood of death or admission to an intensive care unit. Louisa Cary ward and the special care baby unit consistently scored two for the period January to April 2015. This demonstrated that staff were able to identify and respond to the changing risks of children and young people.
- There was time built into shift changes to allow for handover on Louisa Cary ward and the special care baby unit. We observed a 7.30am handover on Louisa Cary ward. This was attended by approximately 15 nurses, medical and support staff. A review of each child and young person's early warning score (from overnight) was undertaken and safeguarding issues were highlighted. A printed handover sheet was used to document the process.
- Handovers were augmented by safety huddles, which met at four hourly intervals between the main handovers, which happen at 9am and 9pm daily and 5pm at weekends. The aim of the huddles was to ensure adequate and timely identification of issues/ potential issues with escalation to senior responders. For example, ward managers/ matron, the emergency bleep holder, consultants and critical care to happen in a more proactive manner. The other prompted outcomes could be to obtain a second opinion internally or from another speciality, a tertiary opinion or Paediatric Intensive Care Unit referral. A structured situational awareness plan was developed for the next four hours to ensure children and young people were safe.
- untrained staff during the day and three trained and two untrained staff at night. Vacancies for paediatric trained nurses had since been filled and newly recruited nurses were shortly to take up post.
- The total nursing establishment for the special care baby unit was 17.8 WTE with a reported actual establishment of 15.5 WTE in November 2015. This equated to minimum numbers of two trained nurses on each shift and one untrained on both day and night. A neonatal trained nurse had been recruited to the unit and was working in an agency capacity prior to taking up post. Recruitment was ongoing to fill the remaining vacant post.
- Three registered nurses and two support workers covered Louisa Cary ward (19 beds) at night. This included staffing the high dependency unit, which had up to two dependent children requiring one and sometimes two of the registered nurses to be based in the high dependency unit. Staff expressed concerns around the dependency of patients at night, particularly around the increasing number of children and young people with mental health issues who often required close supervision and could become violent and aggressive at times.
- The matron (for Child Health) had undertaken a comprehensive review of service provision against national guidelines, standards and national benchmarks. This had identified current service requirements and a review of proposed service developments to be undertaken. This had identified the current and future nursing establishments that were required to run a service that was safe for children and young people (Paediatric Safer Nursing Care Tool, RCN 2013, and badgernet for the special care baby unit). This included extending the hours in the short stay paediatric assessment unit to 24 hours a day to meet current service needs and an additional proposal for seven day working. The estimated revised establishment required 17 WTE, of which three were play specialists and housekeeping staff. A business case was due to be presented to the trust board in March 2016.
- The ward manager told us staff were used across all of the paediatric areas including children's outpatient services. This enabled short term sickness and vacancies to be managed proactively and promoted continuity of care across paediatric services. We saw

Nursing staffing

- Staffing levels on Louisa Cary ward and in the special care baby unit had been reported as falling short of recommended guidelines and staff expressed concerns during the inspection that there were insufficient staff, particularly at night on Louisa Cary Ward.
- The total nursing establishment for Louisa Cary ward was 43.1 WTE (whole time equivalent) with a reported actual establishment of 41.8 WTE in November 2015. This equated to a minimum of four trained and two

Services for children and young people

examples of this during our inspection. There was a bank of paediatric staff who had previously worked in all of the paediatric areas (including the children's community service) who were well known to the paediatric service and who were required to undertake their annual mandatory training requirements. Agency staff were used to support current staffing shortfalls on the paediatric ward and in the special care baby unit. We noted on the duty rotas, that where ever possible the same agency staff were used to help promote continuity of care for children and young people. Agency staff were required to complete an induction programme to ensure they were able to care safely for children in their care.

Medical staffing

- There were 13 consultant paediatricians and two associate specialists for acute and community paediatrics. The middle tier rota had one specialist registrar to support outpatient clinics and acute paediatric services. There were approximately 13 visiting consultants who provided tertiary specialist outpatient work which supported the skilled workforce in the paediatric service.
- Consultants provided cover on site from 9am to 9pm Monday to Friday and 8.30am to 3pm at weekends. There were 13 WTE consultants in post with a 14th post due to start in March 2016. A consultant of the week model was in place for inpatient paediatric care with an acute paediatrician from 9am to 9pm Monday to Friday who covered all acute admissions and provided consultant delivered care whilst supporting doctors in training. There was an out of hours on call consultant rota.
- In September 2014 the paediatric departments had a higher proportion of consultants (45%) compared to the England average of (35%). There were more middle grade doctors (17%) compared with the England average (7%) but there were fewer registrars (24%) than the England average of (51%). Junior doctors made up 17% of the workforce compared to 7% for the England average. The trust employed a similar proportion of junior doctors and consultants to the national average. Recruitment was ongoing to ensure the skill mix among the medical staff was able to meet the needs of children and young people.
- The consultant led model was deemed by the clinical director to be workable but was very busy. The

sustainability of the middle grade rota was due in part to a national shortage of middle grades on training rotations. There were also difficulties recruiting permanent staff grades into the trust but this was mitigated by consultants acting down. However, this was incurring additional costs and a lack of flexibility around sickness cover.

- Rotations were being managed on a six monthly basis and a sustainable plan for the future was being developed by the clinical director. The appointment of the 14th consultant would enable consultants to work additional weekends. This would help to reduce the staff grade job plans to a more manageable level and provide an improved consultant led service at weekends.
- We observed a medical handover at the beginning of the morning shift. The handover was precise and staff were up to date on their current inpatients. We found medical staff to be effective in delivering key information around patient's progress and there were clear plans put in place in readiness for the morning ward round. It was noted that the CAMHS workload was high as approximately 25% of the children and young people on Louisa Cary ward had a mental health need.

Major incident awareness and training

- Staff we spoke with were aware of the trust's Major Incident Plan and understood their roles and responsibilities within the process. Staff told us they had received training in Major Incident Awareness and understood the role of the paediatric service if a Major Incident was implemented.

Are services for children and young people effective?

Good



We judged services delivered to children, young people and their families as effective.

- Parents told us children's and young people's services at Torbay Hospital enabled their children to live full and active lives within the constraints of their clinical condition.

Services for children and young people

- Evidenced- based guidance, standards and best practice were used to deliver effective care and treatment
- Babies, children and young people were receiving age appropriate nutrition and hydration.
- We saw good examples of multidisciplinary working in the hospital around the needs of children and young people, and systems in place to support effective transition into adult services

However

- There was a backlog of discharge summaries on Louisa Cary ward, in part due to the changeover of medical staff and high levels of patient activity. The impact of GPs not receiving information in a timely way could have an adverse impact on the continuity of services to the child and their family.

Evidence-based care and treatment

- Evidenced- based guidance, standards and best practice were used to deliver effective care and treatment to children and young people. For example, development of a Sepsis Care Bundle and Neonatal Sepsis Guidelines based on the National Institute for Health and Care and Excellence (NICE), Guidance on the Inpatient Care of Young People with Eating Disorders, Neonatal Jaundice (NICE) and the Paediatric Diabetes Audit 2013/14 and an internal diabetes audit 2014/15.
- Policies, procedures and guidelines were available to all staff via the trust's intranet. Staff we spoke with knew how to access them when necessary.
- Documents and pathways of care had been developed in line with guidance from a variety of sources, for example: the Royal College of Anaesthetists Good Practice in Anaesthetic Services; Paediatric Anaesthesia Guide (2015). Guidelines used within the special care baby unit were standardised across the Western Neonatal Network.

Pain relief

- All wards and departments used an age specific paediatric observation chart. The one to four years and five to 11 years chart including Wong Baker FACES Pain rating scale (the use of happy and sad faces). Paediatric pain management recommendations and a visual analogue scale (scale of 1-10) was used for older children and young people. The FLACC Score, (a

behavioural tool) was used in theatre settings for children from two months to seven years and was effective when a child was sedated or had leaning difficulties.

- Prior to children and young people going to day theatre they were offered oral pain relief. We observed a child (in day theatre) who had refused oral pain relief being given rectal pain relief following consent from the parent. This demonstrated that children and young people's pain was being assessed and managed prior to day surgery.

Nutrition and hydration

- Children and young people were able to choose what they wanted to eat from a menu. Snacks were available on the ward and older children (once they were assessed) were able to help themselves to drinks and snacks throughout the day. Louisa Cary Ward had access to paediatric dietitians who were available for specialist advice with diets and food. Staff were aware of how to access the dietitian service. Staff were also aware of how to order specialist menu choices such as vegetarian or gluten-free meals.
- A paediatric nutrition and hydration assessment tool (STAMP) was in place to enable children and young people's nutrition and hydration status to be assessed. Ten sets of records we reviewed on Louisa Cary ward and showed fluid or dietary intake was monitored and recorded and where necessary reviewed. Two neonatal feeding plans and feed charts were reviewed and we noted they were up to date and clearly documented. This ensured that babies, children and young people were receiving age appropriate nutrition and hydration.
- Children and young people thought the food was generally good. One parent told us "the staff work really hard to ensure my child is offered food they like and on the whole they enjoy the food".
- A CQUIN (quality payment) was in place to help increase the number of babies discharged from the unit who were receiving breast milk. A breastfeeding policy and guidelines were in place to support mothers to establish breastfeeding. A 24 hour a day breastfeeding helpline and a breast pump loan service was in place to support mothers following discharge from the unit.

Patient outcomes

Services for children and young people

- The service participated in national audits for which it was eligible including the National Paediatric Diabetes Audit and the National Audit of Children with Asthma. The number of multiple emergency admissions (July 2014 to June 2015) for children with asthma, diabetes and epilepsy was slightly higher than the national average. Paediatrics were involved with the South West Maternity and Children's Network to reduce unplanned admissions.
- A significant focus was the 'Big 6', the six main causes of attendance and admission by children and young people. The project commenced in 2014 with acute asthma and fever. Gastroenteritis, bronchiolitis, abdominal pain and head injury were incorporated into the short stay paediatric assessment unit initiative which collects data in line with the national data sets. The sepsis bundle and pathways had been implemented on Louisa Cary ward and the special care baby unit to improve the management of febrile illness and sepsis in children.
- The trust performed 'about the same' as other trusts for all questions in the 'effective' category of the Children's Survey. For example, 89% of parents and carers reported a plan of care for their child had been agreed with them and different members of the care team were aware of their medical history. This demonstrated that staff were familiar with children's care needs and could support them appropriately.
- Rates of multiple admissions for long- term conditions in one to 17 year-olds are slightly higher than the England average. The biggest difference being for patients with diabetes. In the Paediatric Diabetes Audit 2013/14 Torbay Hospital performed worse than the England average for patient HbA1c levels. HbA1c levels are an indicator of how well an individual's blood sugar levels are controlled over time. The audit showed children with an HbA1c as being below 7.5% was 10.7% compared to England average of 18.5%. The median HbA1c (mmol/mol) was 77.2 compared to the England average of 71.7.
- The paediatric diabetes service had responded to the poor outcomes of the national audit through the implementation and monitoring of seven recommended care processes for children and young people over 12 years of age with a diagnosis of diabetes. Young people were supported by the implementation of a diabetes care pathway. The outcome of an internal diabetes audit in 2014/2015 identified improvements in children with an HbA1c as being below 7.5%. This had risen from 10.7% to 13.0% compared to the England average of 18.5%. This demonstrated there was an improvement in patient outcomes for children and young people.
- Further developments were ongoing concerning the wider engagement of the teenage population who had been living with diabetes for a number of years. There was a larger proportion of patients over 16 in the geographical area, (39%) compared to the national average (30%). Comprehensive transition processes had been established to ensure that young people were able to manage their diabetes with confidence and competence and were based on their life skills and clinical condition.
- The paediatric service reviewed neonatal admissions to the special care baby unit to help reduce the separation of mothers and babies and reduce the demand on neonatal services by improving learning from avoidable term admissions (>37 week gestation). Clinical outcomes of babies (<30 weeks gestation) were reviewed against the two year data outcomes to help avoid late detection of neurodevelopment and /or learning disabilities to help inform future service developments and improvement.

Competent staff

- Student nurses were mentored by experienced staff and supervised in their practice. They told us they had received an orientation to the ward before they started their placement and had all received good support from the staff on Louisa Cary ward. All of the student nurses we spoke to (four) told us they were enjoying their placement and one was planning to apply for a post on the ward when they qualified.
- Nursing and support staff at all levels told us about the supervision arrangements in their ward/ unit area. All staff told us that either their appraisals were up to date or they had dates booked. Staff on the wards/ departments told us they felt "well supported and worked really well as a team." Staff were happy to work flexibly across the paediatric areas and appreciated the opportunity to update their paediatric skills in each of the ward/department areas.

Services for children and young people

- A training plan was being developed with the CAMHS service to support staff that were caring for an increasing number of children and young people with mental health issues. Staff expressed concerns around caring for children and young people who presented with challenging behaviours and welcomed the proposed training plan.
- We saw evidence that all paediatric nurses on Louisa Cary ward had undertaken the high dependency unit course to enable them to care effectively for highly dependent children.
- Health Care Assistants in the paediatric ward/units were required to undertake a Care Certificate and were assessed in clinical practice by trust wide vocational assessors to ensure they were competent in their roles.
- Nursing and support staff on Louisa Cary ward were allocated into four teams to care for babies, children, teenagers and patients in the high dependency unit. Each team attended an annual team away day to enable them to review their specific training and development needs in relation to the patients they were caring for. Each team member had their own competency folder which they were required to maintain to ensure they were able to undertake the care appropriate to their group of patients.
- Medical staff undertook a two day induction programme and completed online mandatory training. Consultant appraisal and validation processes were managed through a centrally held data base, which worked well and was appropriate to their job roles. All consultant medical staff had a job plan, separate to the appraisal process, which contained 10 hours of time dedicated to their professional activities. This ensured they had the skills knowledge and experience to deliver effective care and treatment.
- Junior doctors were supervised by an educational supervisor in paediatrics and attended regional study days. Consultant paediatricians were described as accessible including out of hours, and the acting down arrangements provided additional support to junior medical staff
- Nurses were able to tell us about revalidation and told us how the trust was supported them through information and briefing sessions.

Multidisciplinary working

- We saw many examples of multidisciplinary team working across the paediatric ward and departments. We observed good working relationships with other health professionals for example, physiotherapists, pharmacists and dieticians. We were also told of good relationships with other specialist nurses from children's community services, the lead nurse for safeguarding diabetes and respiratory.
- Ward rounds were attended by a multidisciplinary team who reviewed each child or young person. Discussions were documented in the medical notes. Louisa Cary ward told us they had good working relationships with the local CAMHS service, but as nationally there was a shortage of suitable beds, children and young people were often admitted to the ward until more suitable accommodation could be found for them. Staff told us they could access the CAMHS team for advice as necessary but this was difficult out of hours and at weekends.
- There was good multidisciplinary processes to support young people as they transitioned to adult services. The paediatric service looked after children right through to the age of 18. There were systems in place (known as Ready, Steady, Go) to help adolescents transition to adult services. A review of the potential numbers of children who need to transition to adult services was undertaken in 2015. (Divisional Safety Report December 2015). There were 39 young people who were ready to go. The top four diagnostic groups were, ADHD, diabetes, epilepsy and complex conditions. A 'transition flag' was placed on the PAS system to identify those children undergoing transition to enable clinicians to be notified and assist with the ongoing transition plan. This was well established for children with diabetes. Sixteen to 18 year olds were given the choice if they wanted to be admitted to a paediatric or adult ward.
- The paediatric nurse in outpatients introduced young people to the concept of transition at 13-14 years, at 15-16 years they were familiarised on the 'transition process' and at 17-18 years, young people were feeling confident about leaving the paediatric service. The transition nurse worked closely with paediatricians and

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members of the multidisciplinary team to ensure all of the stages of the three step process were managed for each young person to ensure services worked together to deliver effective care and treatment.

- Paediatric services were active members of the South West Maternity and Children's Network and there was representation from the trust on each of the following work streams: Reducing unplanned admissions, transition, long-term conditions, palliative and end of life care, perinatal mental health and maternity. A quality improvement project has been commenced to work with local GPs, the clinical commissioning group information technology, the emergency department and Public Health Nursing to improve urgent care for children by reducing unplanned admissions.
- The paediatric clinical psychology service provided specialist mental health services for children and young people up to the age of 16. The service undertook psychological assessment and treatments for individuals, families and groups and liaised with medical personnel, social service, education and services relating to psychological care.
- The play specialist team of three supported children and young people during particularly difficult times. The team supported children through play therapy five days a week. The team were trained to use play therapy with children and young people. Staff across the wards and departments told us how important this was due to some children being anxious about particular procedures. The play team were able to work with the child and their family to overcome fears through play. The play specialist team was highly regarded by children parents and staff. The play specialist team was able to provide their personnel to wards and units across the paediatric departments and adult settings where children may visit such as day theatre, fracture clinic and a central play room on Louisa Cary ward. The play team were informed of planned admissions and involved in multidisciplinary ward rounds.

Seven-day services

- There were seven-day services within the paediatric ward and units, with the exception of day surgery and outpatient clinics and the short stay paediatric assessment unit. Play specialists were currently available five days a week.

- General theatres were available out of hours for paediatric emergencies not covered by the paediatric specific emergency list. Consultants reviewed their patients daily on ward rounds and at weekends and were available out of hours via on-call arrangements. Physiotherapy, paediatric pharmacy and imaging services were available out of hours via an on call system.

Access to information

- Discharge information was communicated to the child's GP as well as to their HV or school nurse. During our inspection we noted there were approximately 30 sets of medical notes awaiting discharge summaries on Louisa Cary ward. We were told this was an unusual occurrence and was due in the main to the changeover of medical staff and high levels of patient activity. The impact of GPs not receiving information in a timely way could have an adverse impact on the continuity of services to the child and their family.
- There was a comprehensive folder of information about each child and young person with long term conditions who were frequently admitted to Louisa Cary ward. This was designed to provide up to date communication between the patient, parents/ carers, community teams and hospitals without the same questions needing to be asked by each individual practitioner.

Consent

- Staff sought consent to care and treatment from children and young people in line with legislation and guidance. We observed that consent was obtained for children who were admitted for surgery, for a procedure in the pre admission clinic (the short stay paediatric assessment unit) and prior to surgery itself. Consent forms included details of the specific procedure and the potential risks and complications of surgery.
- It was clear during discussions with staff that they used the principles of Gillick competencies (used to help assess whether a child had the maturity to make their own decisions and to understand the implications) when making decisions about people's ability to consent to procedures, especially with adolescent patients.

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- Consent was obtained from parents or carers for each child or young person. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- We saw examples of how staff on Louisa Cary ward and units involved with children and

young people in their care and treatment and would seek the child's consent prior to doing anything, for example, taking a pulse.

Are services for children and young people caring?

Good



We judged caring to be good.

- Children and their families were cared for by staff who were kind and compassionate and ensured privacy and dignity needs were being met.
- Children were involved with the planning of their care whenever possible. Parents were closely involved throughout the assessment, planning and delivery of the child's care and were kept informed of changes and developments by members of the multidisciplinary team.
- Children were encouraged to self-care and were supported to achieve their full potential within the limitations of their clinical condition.

However

- Responses to the friends and family test were low at 11%. The children's and young people's service recognised the challenges of engaging with young people to obtain feedback, and was developing innovative methodologies through the use of information technology.

Compassionate care

- Staff were friendly and welcoming with children and their families. Interactions were compassionate and caring and staff were skilled in communication with children and young people. Children and young people

and their relatives told us how happy they were with the care throughout the paediatric departments. They said staff were very caring, one relative said they "Always felt fully informed".

- Written feedback from paediatric theatres included "Staff that met with and dealt with my daughter took time to explain, reassure and answer all her questions in a way that she could understand". We also saw thank you cards on Louisa Cary ward and in outpatients from parents and children expressing their thanks for the care provided. Staff went out of their way to be child centred and we observed many examples of where staff had established a trusting relationship with the child and their family. Parents spoke in glowing terms about the staff on Louisa Cary ward. One parent said "The staff always go the extra mile and nothing is ever too much trouble. If I have a problem I will talk to the nurses or the doctors and I know they will always be able to help me".
- The special care baby unit staff were sensitive to parents' needs and supportive when helping them to come to terms with their current situation. A parent (on the special care baby unit) had been admitted to the ward prior to the delivery of her baby as it was known baby would require care in the unit following delivery. The parent told us how kind and caring the staff were as this was her first child and staff were aware how anxious she was. The parent said "I can never thank the staff enough for how they have cared for me and my family which has made a difficult situation much more bearable".
- The Friends and Family test was carried out on Louisa Cary ward, the special care baby unit and outpatients. Responses rates were low (11%) and staff told us parents and carers were being encouraged to complete the questionnaires. We saw evidence of patient stories being used to support developments in Louisa Cary ward. For example, the creation of a purpose built paediatric the high dependency ward.
- The trust performs 'about the same' as other trusts for most of the questions in the 'caring' category of the 2014 Children's Survey. The trust performed better than average for written information. For example, 91% of children and young people in the 0-15 age group said they were given written information about their child's condition or treatment to take home with them.

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- The trust performed worse than average concerning privacy when receiving treatment. For example, 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. Results of the Children's Survey had been shared with staff at team meetings.

Understanding and involvement of patients and those close to them

- Staff explained care and treatments to parents, children and young people. For example, we saw a nurse explaining a procedure to a child. We saw how this reassured both the child and the parent. Parents told us that staff listened to what they had to say and involved them and their child where possible, in the care and treatment of their baby or child. All parents said that they were kept well-informed by staff.
- We observed a clinical intervention on a baby. We saw good preparation of the parent and grandparent and age appropriate communication with the child. Children and young people told us how staff involved them in their own care. A range of information on particular procedures and conditions was available for parents on all paediatric wards and departments. These added to the verbal explanations children and parents had been given. We saw that staff allowed time for questions from parents or the children themselves and checked understanding when procedures were explained to them.
- Information had been written in a way that children could understand. For example, the oral and maxilla facial paediatric service (children's dental services) had developed picture based information for children and young people. This enabled each child and young person to be informed of each step of the process prior to attending the dental suite in day surgery. Children and young people were given the choice of receiving a Tooth Fairy Certificate which indicated the tooth/ teeth that had been removed. Staff told us certificates had been put in place as children and young people were not able to take their teeth home due to infection control guidance.

Emotional support

- Staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this in every ward and department we visited. For

example during observation of a pre surgery assessment where staff were able to support the child and parent and ensured they understood about the forthcoming procedure.

- 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.
- The chaplaincy service was available throughout the paediatric departments to support parents and children and young people with their emotional and spiritual needs. Staff told us pastoral support was readily available regardless of faith.
- Children were assessed with regard to their emotional needs as well as their physical needs. We observed a child in the children's outpatient department undergoing treatment with the child psychologist for a phobia of needles. The child had a long term medical condition and would require ongoing hospital and outpatient treatments for their condition. The child had attended a number of familiarisation sessions with the psychologist and was able to talk positively about a planned hospital admission in the near future. The child said "I know what needles are for and how they will help me to get better when I come into hospital."

Are services for children and young people responsive?

Good



We judged paediatric services delivered to children and young people and their families as responsive.

- We observed that paediatric services at Torbay Hospital were providing a highly responsive service to babies, children and young people and their families who required specialist intervention and support either as an inpatient, outpatient or day case.
- Children and their families were listened to and were involved in the plans for their long and short term care.

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- Trends and themes from complaints and concerns were discussed at ward and speciality level. Good practice advice and required learning was identified and actions taken. Information was then disseminated to staff.
- An outpatient pharmacy dispensing service, implemented in 2015, delivered medicines to children and young people at home. Parents with children with special needs particularly appreciated the service as they were no longer required to leave their child to collect their prescriptions.

However

- The special care baby unit staff were involved in fundraising activities to improve the current facilities available to parents. Staff said there were insufficient rooms available for parents to stay overnight (four beds) and there was a shortage of chairs to enable mothers to nurse their babies appropriately. Parents said there were not enough rooms or chairs but they appreciated the facilities that were available and told us the staff made every effort to accommodate their needs.

Service planning and delivery to meet the needs of local people

- The paediatric service took into account the needs of children and young people when planning services for the future. Children, young people and their parents were involved in the recent consultant interview process. Prior to the consultant interviews, a selected group of children and young people met with each candidate and interviewed them. Their scores were fed back along with comments about each candidate which helped inform the interview panel. One of the questions asked of the candidates was "If you were a dinosaur what type of dinosaur would you be?" The outcome of the interviews was an agreement by both panels to appoint the same candidate.
- Children's outpatient appointments were in dedicated paediatric facilities. There were five consulting rooms one of which was used for assessment procedures. For example, blood taking and skin prick tests etc. Age appropriate play areas were in place for children and young people and were well supplied with toys and games etc. There was access to a play specialist if required.
- CAMHS services including child psychiatry were funded and managed by Devon County Council and the Devon

Partnership Mental Health Trust. Over the past 12 months there had been a significant increase in the number of children and young people with mental health issues requiring the support of CAMHS. A weekly report was sent to the chief executive and to commissioners. There had been an increase in the number of violent and aggressive incidents towards staff. At times of particular difficulty staff had been required to call the police for support. Weekly review meetings (led by CAMHS) had been implemented to assess the ongoing concerns of children and young people on Louisa Cary ward. A mental health training programme for ward staff was shortly to be implemented.

- Emergency surgery took place in adult theatres. A paediatric team including an anaesthetist, paediatric nurse and operating department practitioner were on call to cover those theatre lists.
- Louisa Cary ward had a departmental escalation plan for when there was a lack of capacity and demand for their services. We were told that in December 2015 the short stay paediatric assessment unit was relocated into the trust's admission unit to enable the ward to care for the increased numbers of children and young people being admitted to the hospital. Reasonable adjustments were put in place to ensure the clinical environment was appropriate for the care and treatment of children and young people. No complaints were received from parents, children and young people during the period of the relocation which was for five days. This demonstrated that services had been planned and delivered to meet the needs of children and young people and their families.
- Good working and transport arrangements were in place with neonatal and high dependency units across neighbouring counties as part of the regional transfer network. Critically ill children (the emergency department, the high dependency unit and those needing intensive care and specialist intensive care) required transfer to a regional intensive care unit. We observed policies and procedures were in place to aid transfer and retrieval to ensure that services were meeting the needs of children and young people.
- The paediatric diabetes service cared for 131 children and young people with diabetes each year. 130 children had type1 Insulin-Dependent Diabetes Mellitus (IDDM) and one child had Maturity Onset Diabetes of the Young

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(MODY). Over 50% of children were 14 years and over and had commenced transition to the adult diabetes service. The number of newly diagnosed children and young people constituted 20% of the patient population. Sixteen patients were diagnosed in 2014/15. The service was able to cope with the current capacity of newly diagnosed children.

- Male and female adolescents needing inpatient care on Louisa Cary ward had designated single rooms or bays. There were separate male and female toilet and bathroom facilities. There was a teenage lounge known as 'the swamp'. The name was chosen by the young people using the service.

Access and flow

- Between July 2014 and June 2015 there were 3,219 total number of spells for children and young people undergoing day case, elective and emergency surgery. 8% of total spells were day cases, 4% were elective and 88% were emergency surgery. The median length of stay for the trust is reported as 0 days, except for non-elective patients aged one to 17, for which it is one day. This was equal to the national average of 0 days for elective treatment and one day for non-elective.
- Pre assessment clinics were held a few weeks before surgery. During this appointment all relevant information was taken from the parent and the child or young person. Staff explained the procedure to the parents and child and consent was taken from the parents (and the young person where appropriate). Parents were asked to telephone the ward on the day of admission to check for bed availability.
- Children were discharged home directly from Louisa Cary ward. If there was any delay in their discharge, there were play specialists on hand to involve the child and their parent in activities while they were waiting.
- There were no single cubicles on the high dependency unit. If a child needed to be cared for in a single room due to infection control issues for example, a cubicle on Louisa Cary Ward would be used and staffed as required. However, this meant that a cot/bed was taken out of action in the main ward area.
- Louisa Cary ward provided a five day short stay paediatric assessment unit for children and young people. The service operated from Monday to Friday

from 9am to 9pm and accepted new admissions until 7pm. There were five bed spaces an isolation cubicle and treatment room. There was an allocated consultant paediatrician and children's nurse who saw children and young people referred by their GP and the emergency department.

- A 24 hour a day clinical site team was in place and had an overall view of the capacity and emergencies within the hospital. This included the access and flow through the children's unit.
- There was an establishment of 14 paediatricians for outpatient services for children and young people. Due to retirement and long term sickness the service was running with 12 paediatricians. An additional paediatrician provided support by undertaking two to three clinics a week. A new consultant paediatrician has been appointed and was due to take up post in March 2016. As a result, outpatient capacity and follow ups had increased (550). A recovery plan was in place to address outpatient capacity and reduce the delays of follow up appointments for children and young people.
- In line with the Best Practice Tariff for diabetes, children and young people were seen in paediatric outpatients at least four times a year by the multidisciplinary diabetes team. Children and young people were able to choose to be seen in Torbay Hospital or Newton Abbot Hospital. From March 2014 to March 2015 four or more appointments were offered to 86% of patients and 68% were seen a minimum of four times.

Meeting people's individual needs

- An outpatient pharmacy dispensing service, implemented in 2013, delivered medicines to children and young people at home. Parents with children with special needs particularly appreciated the service as they were no longer required to leave their child to collect their prescriptions.
- All areas we visited catered for the needs of children apart from day and main theatres who had made reasonable adjustments to accommodate children's needs as far as it was practically possible to do so. Whilst there were no paediatric theatre lists, elective theatre lists were coordinated to start at the beginning of the day. Children's theatre times were staggered to ensure there were minimal waiting times to help reduce

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the level of anxiety experienced by children and young people. Play specialists use 'bubbles' in day theatre to distract them and 'chocolate smelling' gas was used by the anaesthetist when an anaesthetic was required.

- The recovery area in day theatre had been designated for the use of children and young people and had curtains in place to protect children's privacy and dignity. However, the area was also used by adults
- The service supported children and young people in vulnerable circumstances. There was sufficient space for parents to sit with their child following surgical procedures. The waiting area (outside recovery) had been made as child friendly as possible. There was a television and a selection of age appropriate toys available. We observed a play specialist and a paediatric nurse (with the parent) waiting for a child when they left the recovery area.
- Parents told us they liked the short stay paediatric assessment unit for the convenience it offered and the quality of the treatments undertaken. The unit had reduced the number of children and young people being admitted to Louisa Cary ward and provided a more responsive service in a child appropriate setting with appropriate paediatric trained staff. A letter from a parent was presented at the directorate meeting, which said "The short stay paediatric assessment unit is a wonderful service and if I had been required to take my child to the GP or A&E [emergency department] it would have made an already stressful situation so much worse".
- There was a school service providing education to relevant children on Louisa Cary ward. Where the child was able to, they could attend the school to make sure they did not fall too far behind in their learning. The service liaised with the child's usual school and could support young people in taking exams if necessary. We were told there was access to translation and interpretation services, usually via the telephone. Staff said the system worked well
- During our inspection we did not observe any outliers, (that is, children on wards other than paediatrics due to capacity issues). Staff told us teenagers would be offered the choice of an adult or paediatric ward.
- We saw a wide range of leaflets and booklets that explained to children and their families about the services that were offered in the various departments across the paediatric services and about resources in the wider community.
- The play therapy team had a caseload of children to work with and also carried a bleep so they could respond to the requests to assist with and distract children who were having planned interventions.
- There was a flagging system in place on the trust wide intranet to advise staff about children and young people with learning difficulties. However, staff on Louisa Cary ward were not aware of the flagging system. In the event of a patient being admitted with learning difficulties, staff would seek advice and guidance from the learning disabilities team however they were unaware if they were seeking advice from the adult or the children's learning disabilities team.
- A parent with a child with learning disabilities told us about their child's admission to the ward which had occurred during our inspection. The parent had requested the ambulance crew to advise Louisa Cary ward of their child's pending admission to avoid waiting in the emergency department, which caused distress to the child. This occurred and as a result the child was admitted directly to the ward. The parent expressed their appreciation that they had been listened to and the needs of their child had been met and reasonable adjustments had been made.
- However the special care baby unit staff were involved in fundraising activities to improve the current facilities available to parents. Staff said there were insufficient rooms available for parents to stay overnight (four beds) and there was a shortage of chairs to enable mothers to nurse their babies appropriately. Parents said there were not enough rooms or chairs but they appreciated the facilities that were available and told us the staff made every effort to accommodate their needs.

Learning from complaints and concerns

- Information was displayed in all ward and departments explaining how parent's children and young people could raise their concerns or complaints. Staff we spoke

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with were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process.

- Staff were aware of any complaints that had been made about their ward or department and any learning that had resulted from them. There were 42 complaints received about the paediatric service for the period April 2014 to March 2015. Themes were around waiting times, communication and delays in care. We were told this had been a very challenging period for the service and there had been repeated complaints. We observed complaints issues had been addressed through the implementation of new services which had reduced delays in care and waiting times.
- We noted four complaints had been received in the period April to July 2015. There were three complaints about patient waiting times and one complaint about the treatment by a doctor. The complaints process had been followed appropriately and learning had been shared with the relevant staff and department.
- Trends and themes from complaints and concerns were discussed at ward level, speciality level and divisional level. Good practice advice and required learning was identified and actions taken. Information was then disseminated to staff.

Are services for children and young people well-led?

Good



Paediatric services offered at Torbay Hospital were well-led.

- Service line managers and line managers provided clear and visible leadership across paediatric services.
 - There were good governance systems in place with outcomes of audits and governance meetings were shared with staff across all paediatric services.
 - There were effective systems in place to ensure staff were trained, supported and appraised and were able to give feedback to their team leaders and line managers.
- There was a clear vision and strategy for child health and staff spoke with pride about the developments in paediatrics over the last three years. For example, short stay paediatric assessment unit, the high dependency unit, and developments in the transition service.
 - It was evident that staff were supported by the wider organisation and staff were aware of the wider vision of the trust.

Vision and strategy for this service

- The trust values were displayed in a number of areas we visited. Nurses, doctors and support staff knew about the values and some were able to tell us about them in detail. Staff said they knew about the trust's vision for the future and strategies by way of the trust newsletters and recent strategy documents.
- The clinical director and service line managers for child health told us about their vision and strategy. Staff were able to share the vision with us and were proud of the developments in child health. Their aim was to continue to provide consultant led care. There was an ongoing need to review and possibly extend the current level of cover further with increased activity which may then improve care, leading to improvements for children and young people in the trust. For example, the expansion of the short stay paediatric assessment unit service, development of day services for eating disorders, expansion of allergy and transition services and to work with colleagues to further develop paediatric liaison posts to support Minor Injury Units (MIUs) in the local area. The clinical director and service line managers told us how proud they were of service developments across paediatric services and how committed staff were in providing excellent 'child centred' care.
- A five year plan implemented in 2010, had achieved: a paediatric consultant workforce of 14 WTE. A dedicated paediatric outpatient service, implementation of the short stay paediatric assessment unit, the provision of a cardiac scanner, relocation of a dedicated high dependency service for children and young people and the appointment of an allergy/ asthma nurse to support developments in allergy services for children and young people.

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- Nurses, doctors and support staff told us they were proud to work at the trust and believed the care and support they gave to children and their families was of a high standard.

Governance, risk management and quality measurement

- Child health was part of the women's, children's diagnostics & therapy service delivery unit. The clinical director, matron and operations manager and designated clinical governance lead attended bi-monthly governance meetings and monthly unit and service level meetings. Governance minutes demonstrated incidents, accidents and near misses had been reported and investigated using the trust incident reporting system. The risk register was reviewed with actions being taken to address and reduce the risks.
- Service and line managers monitored and reviewed the provision of services. We were able to track where safety incidents had been raised and where safety actions had been taken. For example, concerns around the CAMHS service had resulted in weekly reporting to the Chief Executive and head of mental health commissioning for adults and director for South Devon operations. There was an ongoing review of all CAMHS related incidents and the use of agency specialist mental health nurses as well as security teams to be used where appropriate. Commissioners had devised an out of hour's escalation for CAMHS patients' awaiting tier four placement and internal escalation.
- The division produced a monthly performance dashboard which included child health. Information was gathered across a range of indicators for example, incidents, early warning trigger tool, breast feeding rates, mandatory training statistics and appraisals. The results of the dashboard were discussed at team and unit meetings.
- We spoke with doctors, nurses and health care professionals who were involved in local and national audits. We found staff to be engaged in the audit process and were able to show us examples of where audit results had improved and informed practice. For example, an audit of the short stay paediatric assessment unit service (opened in October 2014) identified the number of children and young people being admitted as an inpatient to Louisa Cary ward has reduced by approximately 11%. There was a saving of 323 bed days and children and young people were seen

in a more appropriate setting by appropriate paediatric trained staff. A GP reported in the audit "Excellent to be able to liaise with a consultant directly and find out what the most appropriate course of action was.

Patients who have attended the short stay paediatric assessment unit highly recommend it as a child friendly and comfortable space and much better than A&E [emergency department]."

- An audit programme was in place to provide assurance that lessons learnt from Serious Case Reviews were embedded in practice. For example, the named nurse (safeguarding) had a continuous programme of reviewing the documentation of 30 paediatric cases attending the emergency department each week. This ensures compliance with safeguarding requirements.

Leadership of service

- Child health were working closely with children's community leads to support the development of the children's health and social care agenda and were currently reviewing where children's services could be combined in relation to the integration of trust services. Work was ongoing with children's community teams, community hospitals, children's consumables, community health information systems and health visitors and school nurses.
- Nurses and support staff were all well aware of who their immediate managers were. The ward manager and matron for paediatrics were described as being supportive, approachable and visible. We were told the chief executive and the director of nursing was approachable and had visited some areas of the paediatric service.

Culture within the service

- Within the paediatric service we saw open and friendly engagement between all groups of staff. Nurses on Louisa Cary ward told us they had positive relationships with the nursing teams who supported children and young people in the community. The theatre suite staff, although managed by the surgical unit, told us of the good working relationships with the paediatric departments.
- Nurses, doctors, clinical professionals and support workers we spoke with were proud of the care they

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provided and of their team and service. The ward manager and matron were clear that the care of children and young people was at the centre of what staff did every day.

- The culture in paediatrics encouraged the reporting of incidents, concerns, and complaints to the ward manager or matron. Staff told us they received feedback or support as required as a result of reporting/ discussing their concerns. A nurse said “Our greatest strength is the staff that care for children and young people. Staff really do work together to ensure the best care and support for children and their families.”
- Nurses and support workers understood their individual roles and responsibilities and felt supported within their individual department areas. Parents told us they felt well informed and stated that nurses, doctors and support staff were friendly and professional and put children’s best interest at the heart of everything they did.

Public engagement

- Comment and feedback cards were available in all wards and departments. Themes of feedback were discussed at ward meetings and disseminated through appropriate newsletters.
- Parents, children told us they felt included in changes and developments planned for paediatric services. We saw examples of service development questionnaires undertaken prior to the development of paediatric services. For example, the short stay paediatric assessment unit and the high dependency unit.
- There were approximately 750 volunteers in the trust who were actively involved in supporting patients and families. Volunteers told they had a key role in service developments and quality improvement projects. For example, a volunteer queried the length of time children and young people were waiting for some outpatient services at a quality monitoring meeting. This was addressed at the next meeting by representation from the paediatric service who clarified the current position.







Staff engagement

- Staff received regular feedback via the trust and ward newsletters and team meetings. For example, we saw details of future training courses and team away days, safety information around the use of the safety thermometer and feedback from service users.
- The trust had developed staff champions and had worked closely with the staff unions to develop and promote the vision and values of the newly integrated care organisation. The integrated care organisation vision ‘Working with you, for you’, was created by the staff.
- The National Staff Survey recommended the trust as a place to work and staff were happy with level of care for their friends and relatives and felt happy to raise concerns.

Innovation, improvement and sustainability

- Paediatric services were innovative and focussed upon quality improvements. Nurses, doctors, health care professionals and support staff told us they were encouraged to share ideas about service improvements and spoke positively about how they were actively involved in service planning. For example the implementation of the short stay paediatric assessment unit, development of the high dependency unit, and the involvement of children and young people in consultant interviews.
- Paediatric services were planning to implement an improved surgical pathway to enable surgical children to be discharged overnight instead of being admitted to Louisa Cary ward and be returned to the short stay paediatric assessment unit earlier in the day.
- In 2016/17 the paediatric diabetes service were planning to increase 100% newly diagnosed patients with an HbA1c of less than 58 mmol/mol by one year from diagnosis and to equip young people with the skills to confidently care for their diabetes in adult life and to audit the process.

End of life care

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Torbay and South Devon NHS Foundation Trust was created on the 1 October 2015 from Torbay and Southern Devon Health and Care NHS Trust and South Devon Healthcare NHS Foundation Trust to form a new integrated care organisation providing acute, community health and social care. This report covers end of life care provided at Torbay Hospital.

Staff of Torbay Hospital provide end of life care in acute services as part of their day-to-day work. Those providing end of life care include ward nurses and doctors, staff from the chaplaincy department, ward housekeepers, porters, administrative staff and allied health professionals. End of life care in Torbay hospital is also provided by a hospital specialist palliative care team and cancer nurse specialists for patients needing complex symptom management. The specialist palliative care team and cancer nurse specialists also provide support when there is need of a complex acute hospital discharge or to provide specialist advice and education. The hospital specialist palliative care team is clinically led by a consultant in palliative medicine and the team work with other trust staff providing end of life care in the community. They also work closely with the local hospice.

From April 2014 to March 2015, the team saw 446 patients diagnosed with cancer (77% of total referrals) and 131 patients (23% of total) where end of life care was related to non- cancer diagnosis. The team also received 13 outpatient referrals in the same period. All referrals to the hospital specialist palliative care team were seen within two working days. The team visit patients or carers in the

hospital following a request from ward staff Monday to Friday 9am to 5pm. Outside those times, there is a 24-hour on-call telephone advice service from the local hospice. Nurse cover from the trust specialist palliative care team is provided on Easter bank holiday Monday and Boxing Day to avoid a four day gap of service. There is consultant medical cover available by telephone 24 hours a day, seven days a week.

During the inspection we visited the following wards and departments: Simpson, Cheetham Hill, Turner, Warrington, Forrest, Cromie and Allerton wards, the mortuary, chapel and multi-faith or quiet room. We spoke with 14 patients who were receiving end of life care and nine relatives. We also reviewed 16 patient records, which included information about nutrition and hydration, decisions about resuscitation and treatment escalation plans sometimes referred to as TEPs. Treatment escalation plans describe what should be done when health worsens or what a patient would like to happen if they needed resuscitation. We spoke with 44 staff including ward nurses, ward clerks, mortuary technicians and doctors. We also visited the chaplaincy, bereavement officers and patient advice and liaison service. We attended an end of life care multidisciplinary meeting where the care for 11 patients receiving end of life care was reviewed. Before and during the inspection, we reviewed data relating to end of life care at the hospital from the trust and from other sources such as Healthwatch, some of which is included in this report.

End of life care

Summary of findings

We have rated end of life care as requires improvement overall because:

Safety and well-led required improvement, and effective, caring and responsive was good.

- It was not clear how the trust learned all lessons from incidents and what improvements were made in end of life care.
- We were not assured that incidents in end of life care were being monitored effectively.
- There was inconsistent completion of patients' records.
- We found there were shortfalls in the frequency of recording the monitoring of the syringe drivers for some patients. This, coupled with inconsistent staff awareness of the policy, could have put patients at risk.
- The mortuary were using temporary fridges on a permanent basis and without effective temperature monitoring.
- There was not a coherent strategy identified and in place to deliver the vision staff had for end of life care as an integrated organisation. How the next step to an integrated end of life care service would happen was not clear.
- We were told there were no risks recorded for end of life or palliative care. In addition, actual risk that existed in a number of action plans were not on a local or corporate risk register. For example, issues in the mortuary raised during the inspection.
- We saw that not all of patients' spiritual, religious, psychological and social needs were taken into account in patient records.

However:

- Staff were aware of how to report incidents and their responsibility to be open and transparent.
- Anticipatory medicines were always available and patients being discharged home had their medicines provided promptly.
- There was a good level of consultant cover for the end of life service and out of hours.
- There were processes in place to assess and respond to patient risk.

- There was no evidence that patients had had treatment against their wishes. There was good documenting of a patients ability to eat and drink in the last 24 hours of life and medicines were reviewed in the last hours of life.
- The majority of patients had a treatment escalation plan including a resuscitation decision, which had been discussed with the patient and/or family.
- Compassionate care was provided to patients who were treated with respect and dignity by staff. We saw that patients and those close to them were treated with kindness, dignity, respect and compassion while they received care and treatment.
- Patients and those close to them were involved as partners in care at end of life. Staff communicated with people so that they understood their care, treatment and condition.
- Staff we spoke with had a good understanding of the impact that a person's care, treatment or condition might have on their wellbeing and on those close to them.
- The results of the national care of the dying audit published in March 2016 showed that in the quality indicators for care the trust scored significantly higher than the national average.
- The hospital specialist palliative care team monitored the numbers of patients who were at end of life on wards through a system of gold stars on ward interactive boards. In November 2015, 62 of 77 (81%) of predictable deaths were recognised and flagged with a gold star so that relevant staff were aware of end of life care needs.
- Bereavement officers had recently reduced the time needed to make death certificates available.
- Leaders in end of life care we spoke with had the skills, knowledge, experience and integrity that was needed.
- Staff we spoke with had a vision to provide quality, safe end of life care at all levels of leadership and improve upon that care.

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Are end of life care services safe?

Requires improvement



We rated end of life care to require improvement for safety because:

It was not clear how the trust learned all lessons from incidents and what improvements were made in end of life care.

The trust was able to identify that there were no significant themes emerging from incidents relating to end of life care that they were aware of. We were not assured that incidents in end of life care were being monitored effectively.

- There was inconsistent completion of patients' records
- We found there were shortfalls in the frequency of recording the monitoring of the syringe drivers for some patients. This, coupled with inconsistent staff awareness of the policy, could have put patients at risk.
- The mortuary were using temporary fridges on a permanent basis and without effective temperature monitoring.
- Staff in the mortuary had not been involved in major incident training or planning.

However:

- Staff were aware of how to report incidents and their responsibility to be open and transparent.
- Anticipatory or just in case medicines were always available and patients being discharged home had their medicines provided promptly.
- There was a good level of consultant cover for the end of life service and out of hours.
- There were processes in place to assess and respond to patient risk. Staff were able to contact members of the palliative care team for advice about deteriorating patients.
- Nursing and medical staff on the wards told us that the team were responsive and supportive to urgent requests for input.

Incidents

- Staff at Torbay hospital understood their responsibilities to raise concerns, incidents, and near misses, and to report them.

- It was not clear how learning from incidents at end of life would consistently reach all relevant staff in Torbay Hospital, or what learning was shared consistently with other parts of the integrated care organisation in the community.
- There were systems and processes in place that maintained safety in relation to the care and transfer of the deceased. We were provided with information on three incidents related to the mortuary. The trust had one incident relating to end of life care overall from wards between 1 November 2014 to 31 October 2015. It was not clear how the trust learned lessons and what improvements were made as a result of incidents associated with end of life care, and it was unclear if these incidents were collated centrally.
- The lead for end of life explained it was difficult to capture specific incidents relating to end of life due to the way incidents were reported, which used two electronic systems. The incidents were not coded as end of life in a uniform way. For example, in December 2015 an issue had been raised that the clinical commissioning group wanted to have recorded as a serious incident. The end of life steering group felt it was not a serious incident and was recorded as a concern. Some incidents that were identified as end of life or palliative care had been discussed in an end of life steering group meeting, and there was a plan to code the incidents differently in future to identify the potential themes. No date had been set for the coding to start.

Duty of candour

- Staff we spoke with had an understanding of duty of candour and we saw the trust had followed 'duty of candour' processes in a recent incident. 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 be open and transparent with a patient when things go wrong in relation to their care and when the patient suffers harm or could suffer harm, which falls into defined thresholds."
- We saw evidence that patients and relatives who used the end of life service were told when they were affected by something that had gone wrong, were given an apology and informed of any actions taken by the trust.

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Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained. Staff were seen to adhere to infection prevention and control practices in all wards and departments we visited. They were observed washing hands appropriately and wearing personal protective equipment. For instance, gloves and aprons were in use when we visited the mortuary.
- The hand gel dispenser outside of the mortuary entrance was not working and this was reported to the senior mortuary technician. The technician responded immediately and addressed the issue
- Some prayer mats were stored along with cleaning products and floor mops in the multi faith or quiet room. The floor carpet of the room was stained with areas of carpet missing. Some of the fabric of the chairs was also stained.

Environment and equipment

- Equipment was not always used as intended and there was a lack of monitoring of such equipment.
- We visited the mortuary and found 12 temporary fridge spaces were being used as a permanent facility. They were not regularly monitored as there was no automatic temperature monitor in place for the temporary fridges.
- Staff told us a safer more efficient way of monitoring deceased progress through the mortuary was waiting to be implemented. They had been waiting approximately three months to implement it.
- The general environment of the mortuary required attention as some of the walls needed maintenance and repainting and the staff shower facilities needed tiles replacing. These issues had been raised with the estates department of the trust several weeks earlier.
- We raised our findings and concerns with the trust who responded quickly and immediately and provided clear comprehensive action plans. During the unannounced inspection on 14 February 2016, we confirmed that some environmental actions had been completed for example; automatic monitoring for all fridges and an improved monitoring system had been put in place. Some were being resolved such as the staff showers.
- If the permanent mortuary refrigerator temperatures were out of range an alarm was triggered and on call

staff were called. There had been a warning that fridge temperatures had triggered the on call system recently and estates department had been involved resolving a mechanical issue appropriately.

- We saw the most recent health and safety risk assessment for the mortuary dated 27 January 2015. It was not clear when the next full risk assessment was planned. The risk assessment had been partially updated 4 February 2016 during our inspection. Full risk assessments should be completed every year.
- Staff had access to syringe drivers for patients at end of life. The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end of 2015. Information supplied by the trust after inspection showed one syringe driver, a Graseby MS16a, in service in the respiratory clinic. We requested clarification for this Graseby driver and were told a clinical assessment had been undertaken and it was the most appropriate equipment to use for the patient concerned. We were told that risk assessments were in place and that arrangements for transfer of patients to new devices existed. The syringe driver was outside the specified maintenance period. We saw evidence the trust requested it for service in February 2016 following inspection.
- The maintenance of syringe drivers was not up to date. Information from the trust about service intervals and which syringe drivers had been serviced showed that some were not serviced within the period specified. Of the syringe drivers located in Torbay hospital at time of audit (approx. 123), four termed as 'high risk' equipment were out of date of service (not completed within 12 months).
- There were 20 'medium risk' syringe drivers (on a 24 month service cycle) and 1 low risk (on a 36 month service cycle). All were recorded as in service.
- During a visit to a ward we identified that monitoring of syringe drivers was inconsistent with other wards. Two syringe drivers were being monitored twice in a 24 hour period instead of four hourly, which would be usual practice. When we reviewed the policy the monitoring frequency for acute hospital wards wasn't mentioned. The trust policy states: community hospitals should

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monitor the syringe driver every four hours to make sure that medicines were not being infused too quickly or slowly and to monitor skin condition. Monitoring for home setting is once every 24 hours. As patients in acute hospitals are often sicker and have more complex medicine regimes than community hospital, a four hourly regimen for monitoring is required.

- We did not see any patients come to harm, but in the ward where monitoring was only done twice in 24 hours, patients were not being protected from avoidable harm. Staff, including the palliative care team did not appear to be aware of the updated trust syringe driver policy.
- We raised this with the senior nurse on the ward who addressed the issue immediately. They also put in place actions to address a lack of clarity as to what the policy was regarding syringe driver checks. The ward manager updated the ward safety brief, planned a discussion with the hospital specialist palliative care team about procedure and ensured it was an agenda item for discussion at next ward meeting.
- We returned to the wards later and the syringe drivers were being checked more frequently. The concerns were not raised as a formal incident at the time.

Medicines

- Most arrangements for managing medicines kept people safe. We saw evidence that medicines were appropriately prescribed for a range of issues for those patients receiving end of life care. For example, anticipatory or just in case medicine was prescribed to help manage symptoms such as anxiety or pain.
- We saw some evidence that arrangements for managing medicines through a syringe driver for a patient receiving end of life care on a ward was not effective. The understanding of the policy on the wards was unclear. This was reported to the nurse in charge at the time and dealt with.
- Information about prescribing medicines for patients at the end of their life was available and easily accessible on all wards we visited. Guidance and advice from the specialist palliative care team was available for those patients with complex needs.
- We received some feedback prior to inspection about lack of pain relief however we did not see evidence of this during inspection.

Records

- The patients' records reviewed were accurate and complete with few exceptions, legible, up to date and stored securely. We visited Simpson, Cheetham Hill, Turner, Warrington, Forrest, Cromie and Allerton wards and reviewed 16 patient records. The information we reviewed included information about nutrition and hydration, medicines, assessment of needs.
- We also reviewed treatment escalation plans sometimes referred to as TEPs, which described what should be done when a patient's condition worsens or what a patient would like to happen if they needed resuscitation. We looked at 16 records that included discussions and decisions for treatment escalation plans, all were completed.
- Patients' individual care records were written and managed in a way that was safe but we found inconsistencies in where and how information was recorded on each ward. For example, nursing care plans did not always record bladder or urinary needs, bowel care needs, pressure area care, hygiene needs and mouth care in the same section of the record. This could have caused confusion, duplication or delay in treatment.
- We found the specialist palliative care team were aware of the issue of recording and were training staff in end of life care on a rolling programme of two visits a year to every ward. We also saw evidence of senior nurse's and clinicians awareness of the issue but it was not clear what action plan was in place to address it. The issue of inconsistent recording had been identified in an audit of 80 patient records. The audit was discussed at an end of life group meeting on 10 December 2015. However, there was no evidence of an action plan in place to address the issues identified.
- Patients at end of life did not have their cultural, psychological and spiritual/religious needs assessed fully. We saw some examples where in the sections to record these needs 'refer to chaplain' was written. In the patient records we reviewed these needs were rarely documented.

Safeguarding

- There were systems, processes and practices in place that safeguarded patients from abuse. Staff we spoke

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with understood their responsibilities and adhered to safeguarding policies and procedures. They were able to confirm the process for referring a patient to the safeguarding team. We were told of a recent example where a patient receiving end of life care was supported by the specialist palliative care team through the safeguarding process.

- Volunteers who worked in the trust providing visiting and support services for those receiving end of life care had received disclosure and barring checks or DBS checks to support the safety of those who could be vulnerable.
- The safeguarding team and processes were well known by the hospital specialist palliative care team.
- The hospital specialist palliative care team were compliant with safeguarding training.

Mandatory training

- End of life care was not part of the mandatory training for staff in Torbay hospital.
- The specialist palliative care team and lead cancer nurse were up to date with mandatory training. Mortuary staff were up to date with nearly all mandatory training.

Assessing and responding to patient risk

- The Liverpool Care Pathway was discontinued after a national review in 2013. Following the review the specialist palliative care team designed and implemented resources on all wards to support practice and recording for dying patients. Risks to patients at the end of life care were assessed, and their safety was monitored and maintained by staff providing care. Advice and support was available by telephone or pager from the specialist palliative care team for staff caring for patients whose condition was deteriorating.
- Staff did not always demonstrate in records that they had identified and responded appropriately to changing risks to patients who were at end of life. Priority five from One Chance To get it Right by the leadership alliance for the care for dying people 2014, describes good practice as an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, which is agreed, co-ordinated and delivered with compassion.A

comprehensive care planning approach including guidance on how to record the five priorities was available for staff to use for patients at the end of life. This included a holistic assessment and the management of risk. It was not fully used.

- According to a recent trust audit of documentation. The holistic assessment of patients' needs through an individualised plan of care was often present. Staff tended to record when symptoms were present but not when they were absent. We found that risk was assessed but recording was in different places. The recent audit showed that, medicines were reviewed in the majority of cases in the last 24 hours of life, eating and assisted nutrition assessment and provision was generally well documented in last 24 hours, generally good documentation of patients' ability to drink in the last 24 hours. There was poor recording of spiritual care assessment and provision.
- The specialist palliative care team met every Wednesday to discuss the support needed for patients receiving end of life care treatment.

Nursing staffing

- Nurse staffing levels and skill mix of the specialist palliative care team were planned and reviewed so that patients received safe care and treatment.
- In the specialist palliative care team there were two full time nurses one of whom led the team. There were also two part time members of staff. One worked Monday, Tuesday and Wednesday the other Wednesday, Thursday and Friday. The team had administrative support four days one week, five days the following week. The cancer nurse specialist lead nurse provided supervision for the hospital specialist palliative care team.
- The specialist palliative care team had recently recruited and were waiting a new member of staff to start within the month.

Medical staffing

- Medical staffing levels of the specialist palliative care team supported patients to receive safe care and treatment.

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- The Trust employed one full time consultant in palliative medicine. In addition to out of hours support the consultant was present 4.5 days per week at Torbay hospital (12 programmed activities). Their job plan included Thursday afternoon at a local hospice.
- Another consultant who worked mainly at the local hospice had a clinical session at Torbay hospital on a Wednesday afternoon (one clinical session per week). They also attended end of life management meetings for the trust where operational issues were decided.
- Another palliative care consultant worked three days per week supporting community palliative care via the local hospice and attended the urology cancer multi-disciplinary team meetings at Torbay hospital on a Thursday.

Major incident awareness and training

- Not all risks to the service were anticipated and planned for in advance and major incident training was incomplete for mortuary staff.
- Mortuary staff told us there had not been any major incident standby or training in the last year. However as part of a response to the issues we raised during inspection there was a plan put in place during inspection for staff to have locally delivered training as it was not possible for staff to attend the next available course in February 2016 due to workload.
- We were told that further blocks of 12 spaces for temporary mortuary capacity was available at short notice and had been used earlier in the year before the unit was used as permanent. Current capacity was adequate but had little room for any surge in demand. It was not clear where further additional capacity would be sited within or near the mortuary if needed. This posed a problem for temporary mortuary capacity.
- There were no risks identified related to end of life care on a local or corporate risk register; for example, what might need to happen if the supplier of the temporary fridge space was not contactable.
- The hospital specialist palliative care team had not been involved in any practical major incident training but knew how to contribute to urgent discharge planning where appropriate and necessary for those patients at end of life.

Are end of life care services effective?

Good



We rated the effectiveness of end of life care as Good because:

- There was good documenting of a patients ability to eat and drink in the last 24 hours of life and medicines were reviewed in the last hours of life. The majority of patients had a treatment escalation plan including a resuscitation decision, which had been discussed with the patient and/or family. Staff in the specialist palliative care team had the skills, knowledge and experience to deliver effective care and treatment.
- The hospital specialist palliative care team responded quickly to referrals and provided good support to ward staff. The team and the palliative care consultant were well regarded for clinical support they provided.
- Torbay hospital had taken part in the National Care of the Dying Audit and the results published in March 2016 were as follows for the clinical aspect of the audit;
- The audit found that there was evidence within the last episode of care that recognised that the patient would probably die in the coming hours or days in 95% of cases. This was significantly above the national average of 83%. This demonstrated that there was good recognition of when a patient may die soon.
- The audit showed that there was evidence that patients were given an opportunity to have their concerns listened to in 98% of cases. This was significantly above the national average of 84%.
- There was also evidence shown by the audit that the trust performed significantly above the national average in demonstrating that the needs of people close to or important to the dying patient were asked about. 80% of cases showed this against 56% nationally.
- There was documented evidence that in the last 24 hours of life a holistic assessment of the patient's needs regarding an individual plan of care existed in 96% of cases. This was significantly above the national average of 66%.
- There was no evidence that patients had had treatment against their wishes
- Comprehensive resources were available on wards for personalised care plans for the dying patient.

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- Numbers of some patients who achieved their preferred place of care or their preferred place of dying were known by the trust.

However

- The information recorded was not always contained within a consistent template for example the use of malnutrition universal scoring tools was inconsistent. The personalised care plans for end of life care were not always evident.
- Summaries from the two most recent Specialist Palliative Care Team audits totalling 100 patient records described care and treatment outcomes being achieved through 'some excellent care'. Areas for action were related to documenting the holistic assessment and plan of care to meet peoples spiritual needs.

Evidence-based care and treatment

- End of life care often achieved most aspects of the five priorities for care of the dying person set out by the Leadership Alliance for the Care of Dying People 2014. The main variance was seen in record keeping. The trust was aware through recent audit that some practices such as record keeping needed improvement which was not embedded across the trust yet.
- The lead consultant for the specialist palliative care team had completed an audit in June 2015 against National Institute for Health and Care Excellence quality standard 13 and we saw actions relating to areas of improvement needed recorded.
- The hospital specialist palliative care team had worked alongside the trust community services and the local hospice to form guidance to support end of life care, following the withdrawal of the Liverpool care pathway. They had introduced local resources to enable staff in both primary and secondary care to care for patients approaching end of life. The resources included symptom control guidelines, personalised care plans for the dying patient, a coping with dying Leaflet and the rapid discharge pathway. We saw symptom control guidelines were being used along with aide memoirs that staff carried for opiate conversion.
- Torbay hospital had taken part in the National Care of the Dying Audit and the results for the clinical aspect of the audit published in March 2016 were as follows;
- The audit found that there was evidence within the last episode of care that recognised that the patient would

probably die in the coming hours or days in 95% of cases. This was significantly above the national average of 83%. This demonstrated that there was good recognition of when a patient may die soon.

- The audit showed that there was evidence that patients were given an opportunity to have their concerns listened to in 98% of cases. This was significantly above the national average of 84%.
- There was also evidence shown by the audit that the trust performed significantly above the national average in demonstrating that the needs of people close to or important to the dying patient were asked about. 80% of cases showed this against 56% nationally.
- There was documented evidence that in the last 24 hours of life a holistic assessment of the patient's needs regarding an individual plan of care existed in 96% of cases. This was significantly above the national average of 66%.
- In an earlier audit by the specialist palliative care team the notes of 20 patients whose deaths were expected were audited in 2015. This was part of a joint audit with the local hospice and the strategic lead for palliative and end of life care for the trust. The audit measured the use of five priorities of care described by the leadership alliance for the care of dying people 2014.
- For the 20 patients in Torbay hospital, staff had delivered good recognition of death occurring (91.3%), demonstrated sensitive communication in most cases (97.4%), met needs of families (84.2%) and ensured an individual plan of care in place (78.7%). Where the hospital staff had performed less well was in supporting involvement of the patient and of those close to patient in the care and treatment needed (45.5%). The audit was submitted January 2016 for approval as a locality report for the trust.
- There was no evidence that there had been a recent audit of anticipatory or just in case medicine prescribing.

Pain relief

- We reviewed 16 patient records for evidence of anticipatory or just in case medicines being prescribed. We found that anticipatory or just in case medication was prescribed in 12 of the 16 patients who should have been prescribed them. We also saw that staff had

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administered the anticipatory or just in case medicines to 10 of the 12 patients because the patients had needed them. The other two patients had not required them yet.

- Staff used appropriate pain scoring tools.
- We asked seven patients about their experience of pain relief all described that their pain was well controlled.

Nutrition and hydration

- We looked at the way the trust recorded how patients' nutrition and hydration needs were assessed and met. We also spoke with patients at end of life who had consented to speak with us. Nutrition and hydration needs were identified assessments within the trusts end of life care resources. All patients we saw were having nutrition and hydration needs met. We saw evidence of good, mouth care.
- In a small proportion of notes for medical patients the Malnutrition Universal Scoring Tool or 'MUST' was not always used to monitor the weight of patients or to implement food and fluid monitoring charts. malnutrition. When it was used it was not always completed correctly for example missing dates when completed.
- During the inspection we spoke with 14 patients and nine relatives in total. We reviewed 6 records specifically in relation to nutrition and hydration on Turner ward. Five of six records did not have a Malnutrition Universal Scoring Tool chart. One of the six had two Malnutrition Universal Scoring Tool charts. Two of six did have a completed food chart and four did not. Two of the six had fluid charts, one of the six had the chart discontinued as not needed. Five of the six had records of intentional rounding where fluids were offered. Three patients had mouth care the other three did not require assistance with it.
- Recording of nutrition and hydration assessment and monitoring was carried out. However there did not seem to be a uniform means of recording this information. The information was present in notes and records rather than on charts. Due to the information being located in different places in patient record it may have been difficult to find for someone not familiar with the record keeping on the ward. This may have caused delay or duplication and was not best practice. The specialist palliative care team acknowledged that 'seeing the information' required some 'digging'.

- Details from within patient records showed 'swallowing assessment by speech and language therapy with dietary recommendations' in one patient's nursing notes. In the same patients notes staff had 'assisted with fluids and diet, 'encouraged oral intake, mouth care given'. Other notes showed similar records.
- On Simpson ward staff were knowledgeable about end of life care nutrition and hydration needs. There were mealtime assistants who were trained in the correct way of assisting people to eat and drink. Red trays were used so that staff could identify patients who needed assistance to feed at a glance.
- We spoke with one patient identified as in the last year of life who had water within reach and did not require assistance with eating or drinking who described the food as 'not good'. Another patient described the food as good. When we spoke with a patient and family members we were told that food and drink were given and support was available to eat and drink when needed. Also family members felt they were looked after by staff ensuring they had food and drink. A patient who had been in hospital for some weeks told us they had been referred to the dietitian as they had experienced a poor appetite. All patients we spoke with and family members felt safe and looked after.

Patient outcomes

- The specialist palliative care team had conducted several audits about the outcomes of patient's care and treatment. There was not a central means of collecting, monitoring and sharing information across the trust about the outcomes of patients care and treatment. The information was being used locally to support further improvements in the service.
- The trust had participated in the 2015 National Care of the Dying Audit and the results of the clinical aspect of the audit were good against the national averages. The trust were part of the national transforming end of life care in acute hospitals project. The trust did not participate in the gold standards framework accreditation scheme for end of life care. Patient's care and treatment outcomes had been monitored through a recent audit and information collected was used to form an initial discussion about what actions were needed next. There was no timetable for the actions.
- The summaries from the two most recent audits totalling 100 patient records described care and treatment outcomes being achieved through 'some

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excellent care'. The audit noted that the care needed to improve against recording whether patients had existing advance decisions to refuse treatment or lasting powers of attorney. It also noted improvement needed against priority five in one chance to get it right by the leadership alliance for the care of dying people 2014, documenting the holistic assessment and plan of care to meet patient's spiritual needs. There was no evidence that patients had received treatment against their wishes. There was good documenting of a patient's ability to eat and drink and review of medicines in the last 24 hours of life. However better recording of symptoms that were not present was needed. The majority of patients had a treatment escalation plan including a resuscitation decision which had been discussed with the patient and/or family.

- We found a similar picture when we audited patient records.
- Electronic white boards were available on the majority of wards in the acute trust. They enabled staff to more easily identify patients who were at end of life. This was introduced in February 2015 following discussions at the end of life steering group. The team knew about people needing or receiving end of life care through direct referrals from ward staff and electronic methods such as noting a gold star on the electronic whiteboard. The following percentages related to 126 patients seen by the hospital specialist palliative care team between 1 January and 31 March 2015. There were 91 patients seen the same day, 32 were seen the following day and three were seen within two working days. Therefore, 100% were seen within the response time of two working days. The audit was repeated every year.
- Audits were conducted relating to discharge of end of life patients from Torbay hospital. Numbers of deaths of patients who were on an end of life pathway or being supported by end of life guidance was known. The number of some patients who achieved their preferred place of care or their preferred place of dying were known by the team. Of a total of 1429 registered patients, 693 or 48% had a recorded preferred place of care. Of patients dying from oesophago-gastric cancer 40% had died in their own home.

Competent staff

- Staff in the hospital specialist palliative care team had the skills, knowledge and experience to deliver effective care and treatment. The hospital specialist palliative

care team had good arrangements for supporting and managing them and appraisals were up to date. Some members had achieved level two training in understanding psychological issues in relation to end of life care. All but one member of the specialist palliative care team had completed the advanced communications skills course. There had been no further funding available for the course but once this was in place all staff were planned to receive the training.

- Ward staff were supported by the hospital specialist palliative care team every six months with a rolling programme of education on the resources in place following review of the Liverpool care pathway. Three nurses in the team provided end of life education and also promoted the use of the end of life folders to staff in Torbay hospital between January and April 2015. A total of 104 staff attended. There were plans to continue with the rolling education programme resulting in all the wards receiving end of life education by the specialist palliative care team twice yearly.
- The team leader and medical devices trainer had encouraged staff to attend train the trainer sessions around syringe pump training. Attendance had historically been low. The team leader and medical devices trainer had so far trained 15 Registered Nurses in two sessions to enable them to train and assess the competencies of other registered nurses in the acute trust. The specialist palliative care team were planning to put on more train the trainer sessions until there were two registered nurse trainers in each ward area.
- The team supported education around symptom control in the trust by visiting wards and reinforcing good practice guidelines.
- The team continued to support the training of breaking bad news.
- The team had trained 479 staff and 366 hours of education had been provided in 2015. However audit had showed that not all staff were following record keeping guidelines for good end of life care. Although there seemed to be good recognition that patients were at end of life.
- There was not a formal end of life / link worker for end of life care on each ward.

Multidisciplinary working

- All necessary staff were involved in assessing and planning the delivery of patient's care and treatment. We

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observed the weekly multidisciplinary meeting which coordinated professionals and information to assess and plan patients care and treatment. We observed staff working together to assess and plan ongoing care and treatment, including referral, discharge and transition. The consultant from the specialist palliative care team, one of the chaplains, a psychologist, nurses and other staff attended the multi-disciplinary meeting.

- There was good attendance at a range of cancer multi-disciplinary team meetings by members of the specialist palliative care team.
- Multidisciplinary work occurred between acute, community local hospice staff. However there was a lack of acute hospital and community hospital multi-disciplinary meetings where planning across the whole end of life care process would occur.
- The hospital specialist palliative care team promoted the use of the electronic palliative care co-ordination system which was Devon wide. An alert was placed on the system when a patient was admitted to the acute trust to inform the staff that there was more information available with regard to the patient if needed. We were told that some teams did not access the electronic palliative care coordination system regularly and so not all professionals in the community were aware of the most recent information for end of life care on discharge from Torbay hospital. Other systems used were between community and the local hospice.
- There was a framework of resources for multi-disciplinary personalised end of life care recording in place. This had been implemented from July 2014 after the Liverpool care pathway ceased to exist in 2013. It was developed prior to integration of the Trust. The framework of resources was available on all wards in the end of life folder supplied by the hospital specialist palliative care team. It was not consistently used. In our audit of patients records staff were recording information following five priorities of care outlined in one chance to get it right by the leadership alliance for the care of dying people 2014. They were using some of the resources available to them for care planning. The specialist palliative care team told us that embedding the new end of life resources on each ward using the resource folders backed up by ward based education had been time-consuming and needed continual awareness raising and support.
- The specialist palliative care team supported multi-disciplinary education. They supported the

‘enhancing palliative care skills course’ delivered by the local hospice by providing clinical placements. The team support the consultant medical staff in delivering education around end of life and symptom control to junior doctors, The team also provided placements for medical students on a regular basis

Seven-day services

- End of life care services from the specialist palliative care team were provided Monday to Friday 9am to 5pm. Outside those times, there was a 24-hour on-call telephone advice service from the local hospice. Nurse cover from the trust team was provided on Easter bank holiday Monday and Boxing Day to avoid a four day gap of service.
- There was consultant medical cover available by telephone 24 hours, seven days a week.
- Three consultants provided a seven day out of hours advice line to Torbay and South Devon NHS. They also reviewed patients in the trust out of hours in urgent situations. The service was provided by a palliative care consultant who was on call for the week for the whole specialist palliative care service. The consultant was contacted through the local hospice.
- Planning for seven day services had been discussed but staffing levels prevented implementation.

Access to information

- Staff caring for patients who were in the last year or hours or days of life had all the information they needed to deliver effective care and treatment to patients. This was through the specialist palliative care team in person or access to the end of life folder on wards. They could also access telephone advice from the specialist palliative care team in and out of hours.
- When patients moved between teams and services, all the information needed for their ongoing care was shared appropriately. General practitioners and community staff were informed that a patient had been identified as requiring end of life care through electronic palliative care system although their use of it was low. The specialist palliative care team and ward staff ensured that community teams had information on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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- We saw that patient's needs were assessed and care and treatment was delivered in line with legislation. During our inspection of patient records we saw that staff had regard to the Mental Capacity Act 2005. For example assessment of decision making capacity.
- Staff we spoke with understood the relevant consent and decision making requirements of the Mental Capacity Act 2005. Of the 16 records we reviewed 13 had a record of decision making capacity in relation to 'do not attempt resuscitation' forms sometimes referred to as DNAR, the other three were not appropriate. Of the 16 records we reviewed 11 of them had been reviewed by a senior clinician. Resuscitation decisions in the records we reviewed had been made appropriately.

Are end of life care services caring?

Good



We rated caring in end of life care to be good because:

- Compassionate care was provided to patients who were treated with respect and dignity by staff. We saw that patients and those close to them were treated with kindness, dignity, respect and compassion while they received care and treatment.
- Patients and those close to them were involved as partners in care at end of life. Staff communicated with people so that they understood their care, treatment and condition.
- Staff we spoke with had a good understanding of the impact that a person's care, treatment or condition might have on their wellbeing and on those close to them. We heard about staff taking the time to speak with a relative who arrived un-expectedly on the ward a few weeks after the death of their family member who needed emotional support. Staff took the time to answer any questions and concerns they had and arranged a follow up meeting to ensure all issues were addressed.

Compassionate care

- We saw that patients and those close to them were treated with kindness, dignity, respect and compassion while they received care and treatment

- In all but one instance, when care was being provided curtains were drawn or doors were closed to protect patients' privacy and dignity. We witnessed mortuary staff closing doors to ensure that the dignity and respect of the deceased was maintained.
- Turner Ward received many compliments and thank you cards from patients and their families about end of life care.
- All patients and family members we spoke with reported that the nurses promptly supported them with their individual personal needs.
- The local population was predominantly Christian and the trust provided a seven day chaplaincy service. The hospital had a large chapel and a small quiet room for people of different or no faith. There was a dedicated washing facility for people to wash before prayers. The direction of East was marked on the floor. There was a movable curtain to separate the room; however it was unclear how male and female staff or visitors could pray separately if they wished to do so. Holy books including a bible, Quran and Bhagavad gita - a key Hindu text were available.
- The chapel had been used to provide wedding ceremonies to those who were approaching the end of life.
- We saw clear instructions for practices that were to be carried out when patients of different faiths or beliefs passed away. We were told that time and space was given on wards and in the mortuary for religious practices to be carried out. Relatives of patients who had died were able to wash them in the viewing room of the mortuary. We heard of one member of staff going to great lengths helping with this preparation well beyond the scope of their usual role.
- At the time of our inspection the viewing room was open with restricted opening times and so there was limited time for viewing deceased patients. It had recently reopened after refurbishment and relatives had previously had to attend funeral directors to view the deceased. There were plans for training of portering staff on new equipment to allow normal opening times to operate, including out of hours viewing.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in care at end of life. Staff communicated with people so that they understand their care, treatment

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and condition. We observed compassionate and dignified care when dealing with a patient who was agitated. Nurses spoke and listened to them in a calm and respectful way. Staff recognised when people who were receiving end of life care and those close to them needed additional support. This helped them understand and be involved in their care and treatment. Family members reported staff continuing to talk and explain things to patients who were not conscious in a kind and caring way. Two relatives we spoke with reported that staff “bent over backwards” to understand what was important to them and their relative. We heard how staff listened to patients and relative’s questions and beliefs, and that their care had changed as result of this. We saw this recorded in a patient’s notes. Relatives reported that they were communicated with in a way to ensure they understood what was being said.

- Staff responded to patients’ needs. We heard about staff helping ensure that someone was present to converse in a patient’s primary language if they could not get a response when speaking in English. Relatives were supported to stay often overnight and visit freely. We heard how staff cared for both the well- being of the patient and that of their relatives by ensuring they took breaks to rest.

Emotional support

- We saw that patients and those close to them received the support they needed to cope emotionally with their care, treatment or condition
- Patients who were receiving end of life care who did not have family, friends or carers to support them were supported spiritually and emotionally by the large chaplaincy volunteer support service. Although the specialist palliative care team had seen that documentation of those needs in patient records needed to improve during a recent audit.
- Staff we spoke with had a good understanding of the impact that a person’s care, treatment or condition might have on their wellbeing and on those close to them. We heard about staff taking the time to emotionally support a relative who arrived un-expectedly on the ward a few weeks after the death of a relative. Staff took the time to answer any questions and concerns they had and arranged a follow up meeting to ensure all issues were addressed.

Are end of life care services responsive?

Good



We rated the responsiveness of end of life care as good because:

- From April 2014 – March 2015 the team saw 446 patients diagnosed with cancer (77% of total referrals) and 131 patients (23% of total) where end of life care was related to non- cancer.
- The hospital specialist palliative care team monitored the numbers of patients who were at end of life on wards through a system of gold stars on ward interactive boards. In November 2015, 62 of 77 (81%) predictable deaths were recognised and flagged with a gold star so that relevant staff were aware of end of life care needs.
- Hospital staff provided the day to day end of life care and we observed rapid referral by hospital staff for patients who needed specialist support and timely response by the specialist palliative care team
- Wards and other areas such as the bereavement offices, mortuary and quiet room was wheelchair accessible.
- Bereavement officers had recently reduced the time for death certificates to be available.

However:

- We saw that not all of patient’s spiritual, religious, psychological and social needs were taken into account in patient records.

Service planning and delivery to meet the needs of local people

- Some information about the needs of patients receiving end of life care was used to inform services. The numbers of predictable deaths in Torbay hospital in relation to dying patients seen by the hospital specialist palliative care team was monitored yearly. The rate was approximately 20%. The care of a higher proportion of dying patients was influenced by telephone advice both in and out-of-hours but this was not audited or measured. The information was useful to support further recruitment to the specialist palliative care team.

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- The specialist palliative care team patient satisfaction surveys were handed out with the results collated on an annual basis in time for the annual report so that some of the needs of patients at end of life were known. This information was used to inform plans for service design.
- There were no designated beds for people receiving palliative care. Access to side rooms was reasonable although the team were conscious that this could vary. The issue of whether there was enough access to side rooms had been raised at end of life group meetings. We spoke with several staff members at Torbay hospital and no one felt that patients at end of life would be moved from a side room when there were patients needing a side room to manage infection prevention and control issues.

Meeting people's individual needs

- Care for patients receiving end of life care and people close to them we spoke with, took account of the needs of different people, including those in vulnerable circumstances. Services were planned to take account of the needs of different patients, on the grounds of disability, race, religion or belief or complexity. For example, those living with dementia or those living with a learning disability.
- The trust worked with a learning disability nurse who was employed by a local partnership trust. Staff knew when patients living with a learning disability were admitted when the electronic system was used so there was support available. We also saw the end of life care for learning disabilities national guidance document on trust intranet that staff could refer to. There were videos relating to learning disability and other issues on the intranet to support staff development and understanding of the need of people living with learning disabilities. Staff also used a communication book which had pictorial aids for supporting communication. There were learning disability link nurses on wards.
- End of life care provided by the specialist palliative care team and staff on wards was delivered equally to patients who needed it. A quiet room or room for different faiths was available however the maintenance of the room and contents did not appear to be a priority. For example cleaning products were kept in an unlocked lockable cupboard, the heater for the water heater for shower was easily accessible and some of the carpet was missing, some of it stained.

- Wards and other areas such as the bereavement offices, mortuary and quiet room was wheelchair accessible.
- We saw that not all of patient's spiritual, religious, psychological and social needs were taken into account in patient records.
- The bereavement office had produced a booklet which was given to grieving relatives. It contained information about counselling, support groups and the processes that may be required to be completed following death.

Access and flow

- Patients had access to initial assessment, diagnosis and urgent treatment for end of life care. From April 2014 – March 2015 the team saw 446 patients diagnosed with cancer (77% of total referrals) and 131 patients (23% of total) where end of life care was related to non- cancer. This was a reduction in referrals from the previous year (650) although an increase in non-cancer referrals from 20%. The team also received 13 outpatient referrals in the same period.
- Patients who needed support for end of life care accessed care and treatment in a timely way. The specialist palliative care team prioritised care and treatment for patients with the most urgent needs. Staff provided the day to day end of life care and we observed rapid referral by hospital staff for patients who needed specialist support and timely response by the specialist palliative care team. The specialist palliative care team monitored numbers of gold stars on ward interactive boards. The boards showed that staff were recognising when patients were dying. Numbers had increased and in November 2015, 62 of 77 (81%) predictable deaths were recognised and flagged with a gold star so that relevant staff were aware of end of life care needs.
- The specialist palliative care team annual report 2015 recorded the percentage of people seen by them within 24 hours was 100%.
- There were 126 patients seen by the specialist palliative care team between 1 January and 31 March 2015, 91 of 126 (72.2%) were seen the same day, 32 of the 126 (25.4%) were seen the following day and three of the 126 (2.4%) were seen within two working days. Therefore 100% were seen within their standard for response time of two working days.
- The trust had a rapid discharge pathway in place for patients wishing to go home in the last days of life; the aim of the pathway was to ensure timely and efficient

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discharge of patients wishing to spend their last few days at home. There were no audits conducted for 2014/15 or 2015/16 relating to discharge of end of life patients from Torbay hospital. The most recent audit had been completed in 2011/12. Numbers of deaths of patients who were on an end of life pathway or being supported by end of life guidance was not known.

- Staff we spoke with in the specialist palliative care team had said it was difficult to monitor this due to the many factors that affected the outcome. For example delay could be due to accessing care from other agencies, there could be difficulties for family members to make quick decisions at a time of stress which would affect the time of the discharge. There had been issues sourcing appropriate care packages in the community for patients with complex needs who were candidates for rapid discharge also.
- However, we saw that the issue had been discussed at board level and that staff worked hard to balance issues around safety and patient choice and where possible. Staff made every effort to ensure patients were cared for in their preferred place of care.

Learning from complaints and concerns

- We saw some evidence that patients who used the service and those close to them knew how to raise a complaint.
- We were told that all incidents and complaints were reviewed by the chief nurse the executive lead for end of life. There had been three complaints received about end of life care in the previous year none of which were upheld. There were no recurring or consistent themes noted by the executive lead for end of life care at time of inspection.
- The specialist palliative care team were asked for comments or involvement in complaints meetings where appropriate but there was no information available of how often this occurred. The consultant and clinical nurse specialist met with some patients and responded in writing to others. Bereavement officers gave out feedback cards to bereaved relatives which were discussed with line their manager. Feedback resulted in the trust enabling bereaved relatives to park free. They also contact the relatives six weeks after bereavement to identify any other concerns or comments which is then fed back to clinical teams. Although currently no formal report or audit of this activity is produced.

- We were told the specialist palliative consultant had attended a meeting with a family to explain what had happened and to understand what could be done better in end of life care. One outcome from this meeting was reinforcement to the emergency admissions unit that out-of-hours palliative care advice was available from the consultant on call via the local Hospice.

Are end of life care services well-led?

Requires improvement



We rated the well led domain of end of life care as requiring improvement because:

- There was not a coherent strategy identified and in place to deliver the vision staff had for end of life care as an integrated organisation. How the next step to an integrated end of life care service would happen was not clear.
- It was not clear who the 'strategic lead' for palliative and end of life care for Torbay and South Devon NHS Foundation Trust was.
- We were told there were no risks recorded for end of life or palliative care. In addition actual risk that existed in a number of action plans were not on a local or corporate risk register. For example issues in the mortuary raised during the inspection.

However,

- Leaders in end of life care we spoke with had the skills, knowledge, experience and integrity that was needed.
- Staff we spoke with had a vision to provide quality, safe end of life care at all levels of leadership and improve upon that care.
- The leadership and culture of staff who delivered end of life care and that of the hospital specialist palliative care team reflected the vision and values of the trust, and encouraged openness and transparency.
- We saw an example of innovation where bereavement officers had improved the time taken to issue death certificates so reducing emotional stress on recently bereaved relatives.

Vision and strategy for this service

- The organisational strategy for good end of life care had not been developed. Leaders in the trust for end of life

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care had yet to formalise what was needed for their organisation to further develop the vision, strategy and ensure actions were taken. The necessary elements of a coherent strategy for quality end of life care in an integrated care organisation were available. However the elements were not yet combined and being acted upon with clear timetables.

- Staff we spoke with had a vision to provide quality, safe end of life care at all levels of leadership and improve upon that care. The vision talked about was a general trust vision 'working with you, for you'. Staff said they aimed to maximise the independence of individuals with health and social care needs. When care was required, staff said it should be person and carer-centred and delivered close to home when appropriate. However there was not yet a coherent strategy identified and in place to deliver the vision staff had for end of life care as an integrated organisation. For example ensuring that all of the priorities in one chance to get it right by the leadership alliance for the care of dying people 2014 were delivered.
- Guidance existed within the trust in response to the Ambitions for Palliative Care, the national framework for local action 2015-2020 and One Chance to get it Right 2014. This had been developed by the person identified as the strategic lead who was based in the community arm of the trust. The role was not yet fully integrated across the trust. The key elements of end of life care were shared with trust staff in Torbay hospital by the hospital specialist palliative care team through daily interaction and an education programme based on One Chance to get it Right, and the Ambitions for Palliative Care a national framework for local action 2015-2020.

Governance, risk management and quality measurement

- The governance framework ensured that responsibilities were able to be identified from the trust board of directors, through to the quality assurance committee and quality improvement group where the end of life steering group was located. The medical director was part of the quality improvement group and the executive lead for end of life care was part of the end of life steering group. The end of life steering group met every three months included the consultant in palliative care from the specialist palliative care team, lead nurse from palliative care, chaplain and others involved in end of life care.
- Staff we spoke to were clear about what clinical practice and care they were accountable for. Staff told us there was some residual effect of recent organisational change and staff appeared to be waiting for structures to be affirmed and implemented so they could take action on outstanding plans.
- However, it was not clear who the 'strategic lead' for palliative and end of life care for the trust was. Some acute and community trust documents referred to the role and a member of staff in the community was identified as such. It was not clear if they were responsible as strategic lead for the acute hospital and acute services who would engage with external stakeholders as well as the community teams and hospitals as part of an integrated organisation.
- Day to day working arrangements with partners and third party providers such as the local hospice were managed well. The main area where a gap seemed to be was achieving integration between acute and community end of life and palliative care to move forward with actions
- There was not a holistic understanding of performance, which integrated the views of people with safety, quality, activity and financial information. Most of the information was available but not yet as a whole.
- There was no alignment between recorded risks and what people said was 'on their worry list'. We were told there were no risks recorded for end of life or palliative care. When we asked the chief nurse who was the executive lead for end of life care what their top three concerns were they said:
 - 'the plethora of guidance following loss of the Liverpool care pathway',
 - 'as an integrated care organisation ensuring they identified governance of the whole path that end of life care covers'
 - 'forming a coherent strategic plan'.
- We asked the same question of the clinical lead for the hospital specialist palliative care team what their top three concerns were; they said 'Where are we as an integrated care organisation and what does that mean [[for end of life care]?', the Governance paths and process [for end of life care] and the lack of an 'education strategy that includes a training needs analysis across the integrated care organisation'. In addition actual risk that existed in a number of action plans were not on a local or corporate risk register. For example the mortuary issues raised during the

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inspection were not on the risk register but were known about. None of the issues identified in the 80 case note audit carried out were recorded on a local risk register for example inconsistent recording in patient records potentially affecting end of life care.

Leadership of service

- Leaders in end of life care we spoke with had the skills, knowledge, experience and integrity that was needed.
- At the time we inspected two organisations had merged four months previously with a two year lead in. It was clear that with few exceptions leaders had encouraged appreciative, supportive relationships among staff delivering end of life care. What was not clear was how the next step to an integrated end of life care service would happen or who would set out the strategy and timescales or shape of end of life care services.
- Staff we spoke with said leaders were visible and approachable. The chief executive had visited the mortuary, the chief nurse, the end of life executive lead attended appropriate meetings. The clinical lead for the hospital specialist palliative care team worked regularly on wards. The community and hospital teams were beginning some work together but the strategic lead for end of life care in the community was not enabled to fully engage with acute staff. It was not clear if this was an agreed action or how this would happen.
- The leadership and culture of staff who delivered end of life care and that of the specialist palliative care team reflected the vision and values of the trust, and encouraged openness and transparency.

Culture within the service

- Staff we spoke with felt respected and valued. We saw evidence of action taken to address performance that was inconsistent with the vision and values of good end of life care. End of life care was centred on the needs and experience of patients and those close to them and encouraged candour and honesty.
- We saw evidence that members of the specialist palliative care team and others involved in end of life care had delivered good care and were enthusiastic to move end of life services on. However they appeared to be waiting for some structures to be in place that they could identify with as part of the integrated care organisation. This had resulted in some delay in acting on the outcome of audits.

Public engagement

- We saw evidence that patients and those close to them and their representatives had been actively engaged and involved in decision-making about their care and what happened after death. The specialist palliative care team were aware that gaining the views of patients receiving end of life care and those at end of life could be difficult.
- Patient's views and experiences had been gathered. In the palliative care patient survey 2014-15 (survey end date 31st March 2015) six patients were asked a number of questions relating to end of life care and satisfaction. These included what three symptoms cause you the most trouble, have you found it easy to communicate with the specialist palliative care team (six answered yes), have you been involved in decision about your treatment (six answered yes).
- The end of life care was good according to those receiving it but beyond the small survey response the trust was not able to demonstrate whole system performance or potential.

Staff engagement

- Staff we spoke with in the specialist palliative care team felt actively engaged with end of life care provision. Their views were reflected in the delivery of day to day services but planning and further development had not yet been integrated in the new organisation.
- Staff and leaders in the team were clear that they would raise incidents or issues of concern when they arose and felt that action had resulted when they had.

Innovation, improvement and sustainability







- We saw evidence that the trust was innovative. Bereavement officers had instigated a project to reduce the time that death certificates took to be issued. This had increased the efficiency of the process and reduced some of the emotional impact on relatives at a stressful time. Bereavement officers gave out feedback cards to bereaved relatives which were discussed with line their manager. Feedback resulted in the trust enabling bereaved relatives to park free. They also contact the relatives six weeks after bereavement to identify any other concerns or comments which is then fed back to clinical teams.
- We also saw evidence that the trust was improving resources for palliative and end of life care. A business

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plan had been submitted and funding had been agreed by Macmillan to employ another full-time nurse which was to be funded for three years by them. This was going to be either a developmental post or Band 6 and would be dependent on the applicant's experience of palliative care.

- However, it was not clear how the Trust had assessed the impact on the sustainability of palliative and end of life care following the recent significant organisational change. The change had involved 6000 staff, the formation of a new care organisation providing acute, community health and social care.

Outpatients and diagnostic imaging

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

Information about the service

Torbay and South Devon NHS Foundation Trust provided outpatient services at Torbay Hospital and eight other non-acute hospitals throughout the region. At Torbay Hospital, there was a large dedicated outpatient department. Outpatient services were split into a number of service lines (broken down into specialties) which sat within one of four divisions. There was a dedicated oncology outpatient department, breast care department, and a number of specialist dedicated outpatient clinics including dermatology, ophthalmology and cardiology. The diagnostic imaging service provided inpatient and outpatient services for plain x-ray, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine and non-obstetric ultrasound. The breast care unit provided mammography imaging. Between January 2014 and June 2015 633,126 outpatient appointments were provided across the region by the trust, with 548,604 of them held at Torbay Hospital.

During our inspection, a team of inspectors, specialist advisors and experts by experience visited: the main outpatients department, the ear, nose and throat (ENT) clinic, trauma and orthopaedics, ophthalmology, oncology, urology, cardiology, dermatology and breast care outpatients departments. We also visited the therapies department (including physiotherapy). We visited CT, plain x-ray, nuclear medicine and fluoroscopy in the diagnostic imaging department at Torbay Hospital.

We spoke with 26 patients, carers and relatives. We also spoke with 86 members of staff including managers, clinical (doctors, nurses, allied health professionals and health care assistants) and non-clinical staff.

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Summary of findings

Torbay and South Devon Foundation Trust outpatient and diagnostic services were over all rated as requires improvement, although there were many areas of good practice.

- The systems in place for the prevention of healthcare associated infections, including hand hygiene, were not being followed throughout the whole outpatient and diagnostic imaging department.
- Systems were in place for the safe administration and storage of medicines, but recording and monitoring of fridge temperatures used for the storage of medicines was not consistent in the outpatients department and there were no records of stock rotation in some areas.
- Infection prevention and control protocols were not being followed in dermatology who carried out minor surgical procedures in rooms that were not adequately ventilated or maintained with visibly unclean air vents and dusty surfaces. We did not see evidence of any cleaning logs or records of emergency oxygen checks.
- The design, maintenance and use of facilities and premises did not keep people safe at all times. Lots of small concealed waiting areas throughout outpatients and diagnostic imaging meant staff could not observe patients waiting in their departments.
- Aging equipment was preventing staff from providing safe and effective services in trauma and orthopaedics, ultrasound and speech and language therapy, however, this was being addressed in the future capital funding project.
- External training courses were available to some staff, but not all, and in some departments, staff were carrying out specialist procedures without formal qualifications, and were starting to train other staff in those procedures.
- Staff were very competent in their roles, and we saw National Institute of Health and Care Excellence (NICE) guidelines were embedded in policies throughout many clinics. However, we saw patients called for follow-up mammograms at one, three and

five years, which is not in line with best practice, and there was no metastatic breast care nurse in post, but there were triple assessment clinics in breast care for symptomatic breast referrals.

- Staff struggled to maintain patient privacy and confidentiality in the physiotherapy and diagnostic imaging departments, mainly due to the lack of space, and design of the departments.
- Staff told us in some outpatient clinics, chaperones were only provided in some clinics if patients asked for them.
- We found that due to a follow up backlog, and the capacity of clinics, people were frequently not able to access 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.
- The hospital identified a problem with the surgical follow up outpatients booking system, which missed patients off follow up lists. The hospital investigated, and changed procedures to prevent it happening again. This was also the case in ophthalmology.
- The hospital appointment cancellation rate was 8.8% and the patient cancellation rate was 10.1%, which was above the England average, however, no analysis of the reasons for this had been done.
- Service plans were reliant on increasing staffing, especially at consultant level; however, plans were in place to increase clinic facilities throughout outpatients, to help meet increasing service demands.
- There were governance processes in place, but these were inconsistent throughout outpatients and diagnostic imaging.
- Dermatology services were split over two locations, and the services based in general outpatients were confused as to who was responsible for the day-to-day running of the service. However, oncology staff had regular multi-disciplinary team (MDT) governance meetings, and we saw evidence of shared learning available in an operational policy folder.

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- The dietetics department had raised the issue of the lack of an adult eating disorders service to the Clinical Commissioning group (CCG), and were monitoring its progress.
- Not all staff felt supported by their immediate managers and said some managers were not visible to their teams. Some teams did not have an overall manager, and senior staff were not very supportive or visible. However, medical records staff felt much supported by senior managers, and were very proud of their clinical engagement in their projects.

However;

- We saw detailed monitoring and analysis of patient outcomes in the Physiotherapy department.
- Seven-day services were established as part of a normal working week in some specialities, but not in others, because capacity was meeting the current demand.
- Diagnostic imaging reported the lowest report turnaround times in a recent benchmarking exercise of 78 departments in England.
- Feedback from patients and their families was very positive and described staff as helpful, efficient and polite, and we saw genuine compassionate care where patients were spoken to patiently, kindly and politely. We saw carers and relatives actively involved in decision-making.
- The Friends and Family Test produced good results, and 96% of patients who responded recommended the outpatients department at Torbay Hospital.
- The radiology department reported 93-99% of all imaging, for all patient types, across all modalities, within one week of the examination. 97% of inpatient reports were returned within 24 hours.
- The physiotherapy service provided a direct referral system, with the majority of patients receiving appointments within 72 hours, with no need for GP involvement, and a virtual triage system in fracture clinic had reduced the number of patients called back to fracture clinic unnecessarily by 15%.
- The DNA rate was 6.1%, which was below the England average.

- Oncology provided a delivery service for some types of oral chemotherapy, which meant some patients did not have to attend hospital appointments regularly.
- We saw evidence that complaints were being discussed both in department and at monthly 'learning from complaints' meetings, and we saw evidence of shared learning.
- The majority of staff we spoke with felt the culture was open and that staff strived to make sure the experience for the patients was outstanding in line with the trusts vision and values.

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Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated safety in the outpatients and diagnostic imaging services to requires improvement because:

- There were inconsistencies in hand hygiene compliance throughout the outpatient and diagnostic imaging departments, with very few departments carrying out regular compliance checks, and few records kept.
- There were inconsistencies in the recording of fridge temperatures used for the storage of medicines and records of stock rotation, with some fridges not having any written records of temperature checks. Other fridges had gaps in the records.
- Dermatology carried out skin flap procedures in treatment rooms without sufficient ventilation.
- Dermatology carried out cautery procedures in treatment rooms without smoke extractors or the use of masks.
- The emergency oxygen in the general outpatients department was not regularly checked, and there were no written records.
- We saw visibly unclean air vents and dust on surfaces in procedure rooms.
- We found that the design, maintenance and use of facilities and premises used to keep people safe was inconsistent throughout outpatients, diagnostic imaging, physiotherapy and dermatology as design flaws, age and lack of space were having a negative impact on patients safety, wellbeing, privacy and dignity.

However:

- In January 2016, 98-99% of patient records or notes were available for clinics.

Incidents

- The diagnostic imaging and outpatient departments had a mixed approach to incident reporting, which was reflected in the number of incidents reported. Between January 2015 and December 2015, 20 incidents were reported in the general outpatients department, and

177 incidents were reported in diagnostic imaging. Overall, the entire outpatient department reported 145 incidents between November 2014 and November 2015, 53 of these were in ophthalmology.

- The hospital reported all incidents using an electronic system that tracked and investigated all reported incidents, and was available on computers throughout outpatients and diagnostic imaging, which were easily accessible to staff. The hospital acted upon significant incidents and investigated them using the Serious Incident Framework 2015.
- In January 2015 there was an ophthalmology never event where a surgical procedure was carried out on the incorrect eye. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death. An internal review team carried out an incident investigation. The root cause analysis of this incident showed that it occurred due to human error. The investigation identified several administration and consenting errors. Including a lack of awareness of the mental capacity of the patient. There was evidence of lessons learnt from the investigation, and staff in ophthalmology were able to describe the incident, and showed a good understanding of the learning from it.
- The investigation also showed that locum doctors working in the ophthalmology department did not receive the same level of training as permanent doctors. Staff told us that since the investigation, all locum doctors who worked in the department had to complete a training checklist, and get sign off from a permanent consultant.
- In April 2015, a serious incident was reported in ophthalmology, where a patient was found to have had the wrong strength intraocular lens fitted in January 2015. An internal investigation was undertaken, and a failure to follow agreed checking procedures and a lapse in the surgeon's concentration was found to be the cause. As a result, the department improved its checking process and extended it into the operating theatre, where a modified World Health Organisation (WHO) surgical safety checklist was introduced, and we saw this on display in the outpatient procedure rooms. The department also updated the cataract pathway documentation. However, staff told us that doctors carrying out laser procedures did not mark patients' faces to show which side was for treatment.

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- Staff understood their responsibilities to raise concerns, and to record safety incidents and near misses. They understood to report them internally and externally and staff we spoke to were confident to report incidents through the electronic system and could give examples of when they had used it. Staff told us they were actively encouraged to report incidents. Senior staff were confident to investigate and analyse the cause of incidents through this system as well.
- We did not see any evidence of a process for staff to receive feedback from incidents, and most staff we spoke to said they did not hear about outcomes from incidents. Senior staff showed us each division had a key lessons learned action database, which described lessons learnt from each incident, but staff said they had not heard of it. Staff in general outpatients discussed recent incidents at the morning safety briefing, including a recent incident of a patient fall in a car park.
- In the diagnostic imaging and outpatient departments, there was a good reporting culture. It is a requirement for certain radiology incidents to be reported to the Care Quality Commission and we saw that in the radiology and radiotherapy departments those such incidents had been reported correctly. Since June 2014, there had been 13 reportable incidents. The trust managed these appropriately. Staff said they understood their responsibilities to report any incidents where the radiation dose to a patient had been 'much higher than intended', and staff could clearly describe how they would report an incident and who to.
- Staff told us that they had recently changed their patient identification procedure from a two-point check to a three-point check, in line with the Society of Radiographers 'pause check' guidance (2015). Staff told us of an incident where a patient did not have an adequate identification check. The patient had an x-ray, and it was noticed that it was the incorrect patient. The patient had the same x-ray that had been requested for them, but the member of staff immediately explained what had happened to the patient. Staff reported the incident to a senior member of staff for investigation.

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 be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.

- There was a culture of openness and transparency, and staff understood their duty of candour to be open and transparent in their practice and to give an explanation and apology if an error was made that caused harm and required reporting. Staff were supported to speak up about errors, and managers were supportive when things went wrong. Staff told us that duty of candour was covered as part of their mandatory training.

Cleanliness, infection control and hygiene

- During our inspection, we found Torbay Hospital to be visibly clean and tidy in all of the areas we visited, with the exception of the dermatology outpatient procedure rooms, which were visibly dusty and had unclean air vents. Patients in the general outpatient waiting areas said the hospital looked clean and tidy. We saw green 'I am clean' stickers on various pieces of equipment throughout general outpatients, including patient examination couches, notes trolleys, Echocardiograph machines and examination chairs.
- Hospital policy stated that if the 'Saving Lives Hand Hygiene score' in any outpatient clinical area was less than 100%, the area should perform weekly hand hygiene audits until 100% compliance was reached. Regular infection control audits, including hand hygiene audits, were not taking place and in December 2015, general outpatients, radiology and heart and lung outpatients did not submit any hand hygiene compliance data. Staff were not aware of any on-going audits of hand hygiene, and could not tell us where results from them were stored. The ophthalmology department carried out regular hand hygiene audits and uploaded results to the intranet shared drive (matrix), but the recent data was not available to see. In radiology, we were shown data from December 2015 and January 2016, showing 96% compliance and 100% compliance respectively; using an observational tool. Staff told us that regular hand hygiene monitoring was going to continue on a monthly basis.
- Staff told us hand hygiene formed part of their mandatory training, using a 'Globex'. The use of a

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'Globox' assesses the quality of an individual's hand washing technique, and some staff thought this was sufficient to comply with hospital infection prevention and control policy.

- Staff could explain what good hand hygiene was, along with the limitations of alcohol gel, and we saw that staff in the areas we visited were bare below the elbow following the hospital's infection prevention and control and uniform policy. However, we saw three members of staff with hair below their collar and we saw staff drinking hot drinks in covered cups in a clinical area where blood samples were collected.
- There was mixed availability of infection control measures for members of the public, including alcohol gel. Gel dispensers were available in the main outpatient reception area, but not in radiology. We were told dispensers were removed because patients had drunk the gel. Oncology reception staff told us they had not had dispensers for a number of months.
- In most clinics, we saw treatment rooms had cleaning logs. These were up to date and complete. This showed us that regular cleaning was taking place to reduce the risk to people from healthcare-associated infections. We saw monthly cleaning audits, including high and low surfaces.
- The general outpatients department sent out information leaflets to patients with their outpatient appointment, asking them not to come in to hospital if they had diarrhoea and vomiting or flu like symptoms. There was a phone number for patients to call if they had symptoms.
- Between January 2015 and December 2015, 344 patients had lesions removed in the dermatology clinics held in general outpatient department, and 11 skin flaps were carried out in the general outpatient procedure rooms in October and November 2015, but data was not available for the rest of the year.
- The dermatology department had undertaken two post-procedure infection audits. Results in 2013 showed an 11% infection requiring antibiotics rate (10% is benchmark). Results in 2014 showed a 10% infection requiring antibiotics rate. The studies recommended the wearing of scrubs, shoes and theatre hats in line with National Institute of Health Care Excellence (NICE) Clinical Guideline 74: Surgical site infection: prevention and treatment of surgical site infection (October 2008). Staff wore scrubs and gloves for procedures, but did not wear any aprons, so there was no barrier between them and the patients.
- Staff were not aware of post procedure infection rates, because patients went back to GPs for follow-ups and dressing changes. Staff told us they did not audit outcomes of procedures. Staff did not report post-operative infections as incidents, and patients were offered ad hoc follow up appointments instead.
- Staff told us there was a problem with cleaning of minor surgery rooms, and we saw a visibly unclean air vent in one of the procedure rooms. There were no cleaning logs in either procedure room, and staff did not know if it had been reported or to whom, and were not sure whose responsibility it was.
- Patients were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) during some first appointments in the outpatient departments.
- There were some infection control measures in place for infectious patients to attend a department for a test. Staff said they would arrange for those patients to attend at the end of a list or clinic, and close the room for cleaning. Staff told us that due to the design of the department; there was no way to isolate a bed bound infectious patient, so they took these patients straight into examination rooms where possible. Personal protective equipment was available for staff, and they could describe how to use it.
- Staff told us that there was a deep cleaning team available 24 hours a day, who responded to requests quickly. Out of hours, in CT, there were two scanners, and staff told us they could close one unclean scanner, and use the other in an emergency.
- We saw two water fountains in radiology and staff told us the department flushed taps twice weekly, to prevent Legionella, but did not keep written records of this.

Environment and equipment

- The design, maintenance and use of the general outpatient and diagnostic imaging departments was not sufficient to keep people safe from harm at all times. The general outpatient department was arranged into corridors, with clinic rooms off the corridor. There were multiple sub-waiting areas off these corridors, which were not very visible to staff. Staff told us that they did walk rounds to check on patients, but could not visibly monitor patients all the time.

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- We saw that the general outpatient environment varied from clinic to clinic. The main entrance was light and well signposted, but this was temporary due to building works in the normal main entrance area. There was a large reception desk with a number of administration staff. Patients moved forward in turn so that they could speak to the reception staff without being overheard by other patients. The oncology department had a dedicated reception desk, which had good visibility of the main waiting area. There were comfortable wipe clean chairs, and the area was bright and colourful. However, nuclear medicine and MRI had no reception desk for patients to report to, instead, oncology reception staff directed patients round to the departments.
- In the diagnostic imaging department, waiting rooms lined the corridors, broken up by small partition walls, which meant that some seats were not visible. Out of hours, patients waited in the closet part of the waiting room to the emergency department, which had CCTV coverage. In waiting area three, the radiographer in charge told us that there were pull cord alarms, but on the day of the inspection, these had been taken down to repaint. Since the inspection, the alarms had been replaced. We saw two patients, one in a wheelchair on oxygen, and one on an ambulance stretcher, left in the inpatient waiting area, with no escorts, and pull cord alarms out of reach.
- The general outpatients clinic was quite dark, and the sister in charge told us that she did not feel the environment was very dementia friendly, as the flooring “looked like water.” However, the ophthalmology clinic had good lighting, with clear signs, but was accessed through the general outpatient department.
- The audiology and ear, nose and throat (ENT) outpatients clinics, were hot during our inspection. It was also hot in the waiting area outside the phlebotomy clinic, and staff told us that pregnant patients attending for fasting glucose blood tests frequently felt faint.
- In the physiotherapy department, there was a locked door between the waiting area and treatment areas, and a patient told us they thought this was good, as it stopped people from walking past cubicles. There were four curtained cubicles and one quieter treatment room. We heard conversations about treatment in the curtained cubicles. This issue was on the divisional risk register.
- There was a dedicated children’s outpatients department, with special waiting areas for children depending on their age. There was a good selection of clean toys, and we saw written cleaning schedules for them. We saw several small areas throughout the general outpatients and diagnostic imaging, which had been adapted for children. However, they were in the same areas as the adult clinics. In fracture clinic, there was a children’s waiting area separate from the adult areas, but staff told us that children had to go through adult areas to access it.
- Staff told us they had problems with patients in beds and wheelchairs, waiting in corridors, and we saw two beds and an ambulance trolley blocking one section of the corridor outside the ultrasound room. The ambulance team told us it was difficult to manoeuvre patients on trolleys, because there was not enough room for beds and trolleys to pass one another in the corridors in radiology west. Staff also told us that it was very hard to keep inpatients and outpatients separate, because of this lack of space.
- In the diagnostic imaging department, there was a dedicated cannulation bay in between two patient waiting areas, separated from the corridor by a disposable curtain. The resuscitation trolley was kept in this area, covered by a large red cloth cover. This had previously been stored in the centre of the department in the viewing area, but because the access corridor to this area was also the storage area for wheelchairs, the trolley had been moved. Staff checked and signed the trolley, but there was no tamper proof tag. All of the resuscitation trolleys we looked at in the outpatient departments were clean and had all documentation signed and in date. Trolleys were locked with a breakable seal and, of those we checked, this number was recorded as part of the checking routine. This demonstrated the trolley had not been opened or equipment used or tampered with since it was last used. In one clinic, we saw that the resuscitation trolley had two electronic items waiting for maintenance with medical electronics. We saw a dedicated paediatric resuscitation trolley in the ear, nose and throat (ENT) department. The resuscitation trolley in radiology east was unchecked on the day of the inspection, but had been checked consistently since the beginning of the record for 2016.
- All the staff we spoke to could tell us how to summon help in an emergency, and where their nearest

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resuscitation trolley was. Staff also told us about a panic button in the trauma x-ray room, which would summon help from the emergency department next door. They also told us this was tested regularly, although not always intentionally.

- We saw fire extinguishers throughout the outpatients and diagnostic imaging departments, which had in date check tags on them.
- The trust had a medical devices policy and procedure documents, and reviewed it every two years. The policy told staff how to report broken equipment for repair or disposal. The hospital target for 70% of scheduled equipment maintenance to be done within one month had not been met between April 2015 and December 2015. Staff told us medical electronics were responsible for checking equipment.
- The trauma and orthopaedic department had a piece of equipment used to diagnose carpal tunnel syndrome. The staff told us this piece of equipment was over 15 years old, and was no longer a reliable way of diagnosing carpal tunnel syndrome, but that a replacement was due for delivery in the next month. This issue was on the trust risk register.
- We saw two electrolysis machines in the ophthalmology department that were out of date for their electrical safety testing in June 2015. We also saw a cautery machine that was out of its maintenance date in May 2014. Staff responded immediately by taking them out of use.
- There were measures in place to control and restrict access to areas where ionising radiation and high power lasers were used. Staff showed us that all lasers used in ophthalmology procedures were inside their maintenance dates, and had a record of this. Warning lights were at the entrance to the laser procedure rooms. In radiology, we saw warning signs, light boxes and notices on all x-ray room doors. However, we saw two of these rooms with their main doors held open directly opposite a patient waiting area, without a member of staff in the room. We saw that in the urology outpatient department, there was a cystoscopy room with an air filtration system and a dedicated cystoscopy cleaning room. However, the cleaning log was not available for us to see.
- The dermatology outpatient procedure rooms were not maintained or used in a way that kept people sufficiently safe from the risk of healthcare associated

infections. There were two minor procedure rooms used for removing skin lesions. In the first procedure room in the general outpatients department, we saw no best practice guidance displayed for scrub technique, surgical attire or swab checking. There was very little ventilation in the first room, and no ventilation or air changing equipment. The sink for scrubbing was small with a mixer tap, but had restricted space for scrubbing. We saw wires across the floors in the rooms, and saw a sharps bin used for general waste disposal. In the second procedure room, we saw in/out trays and a staff member's handbag. We saw a visibly rusty trolley and another with flaking paint. There was no ventilation in room two, except one ventilation outlet, which was visibly unclean, and the staff nurse did not know why it was there. Some procedures in this room used cautery, but there was no smoke extraction, and staff did not wear masks for these procedures. Staff we spoke to could not show us any risk assessments for the cautery procedures.

- In the speech and language therapy department, the fibre optic endoscopic evaluation of swallowing (FEES) flexible scope used in complex swallow assessments, had been escalated to the therapies divisional risk register, because it was old and had started to break down. Funding was turned down for a replacement, but swallow assessments could continue with the use of video fluoroscopy.
- Equipment was stored safely. Flammable products were in locked steel cabinets. Products deemed as hazardous to health were in locked cupboards and often in sluice or clinical rooms that also had key code or swipe card locks and were only accessible to approved staff.
- In Nuclear medicine, the radio pharmacy was not meeting current standards according to the British Nuclear Medicine Society (BNMS) guidelines. Staff told us work was due to start in February 2016 to improve the radio pharmacy laboratory. During the building work, staff told us that specially trained couriers would deliver radiopharmaceuticals ready made from another radio pharmacy.
- Senior staff told us that the ultrasound equipment at Newton Abbott Hospital, used for foetal ultrasound, had been removed, as it was too old and could not be used for some types of foetal scans. The trust had pulled the service back to Torbay Hospital, but a replacement machine was being included in the trust's capital replacement allocation for the next financial year.

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Medicines

- Patient Group Directions (PGD) are written directions that allow the supply and/or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition. In outpatients, we found that the PGDs were in date and signed by all staff authorised to supply and administer the medicines specified.
- We saw signed PGDs in the ophthalmology, urology and physiotherapy departments, all in date and authorised for use. In the urology department, it was not clear if the PGD had been authorised by the trust, as the original authorisation could not be found.
- There were arrangements to ensure that access to storage of controlled drugs was restricted to trained nurses who were permanently employed by trust. Trust policy stated that the keys for medicines cupboards should remain with a designated registered nurse. On inspection, we found that most clinics had rooms with either swipe card access or key code locks. The general outpatient department always kept these doors closed. We did not see any expired medicines. However, in the ENT department, we saw tubes of an ointment that had been opened but not marked with a new expiry date, and in ophthalmology, we saw eye drops stored in unlocked drawers in the clinic rooms.
- The systems and processes used to monitor refrigeration of medicines were not always followed. Whilst current maximum and minimum temperatures were recorded on the correct register in the majority of areas, there were deviations from the recommended storage range (2 to 8°C) seen and actions were not always recorded. In dermatology, we saw two unlocked fridges, one with an up to date temperature register and one without. The general outpatients temperature register was not completed from 1 to 17 January 2016 but current records were not showing deviations. The temperature register in the urology outpatients department was not maintained or up to date. We did not see any evidence of stock rotation.
- A change in processes for recording refrigerator temperatures had not been communicated to staff well, but additional training had taken place and was on-going to ensure proper temperature recording. Staff understood their responsibilities to report when a fridge was outside of its temperature range, and could explain how they would escalate a problem, and who to.
- We saw two members of staff in the general outpatients department undertaking a stock inventory, checking expiry dates of medicines, and rotating stock and equipment held in the department.
- There were arrangements in general outpatients to ensure the safe storage of FP10s (NHS prescriptions) which were stored securely in locked drawers. Pharmacy issued and monitored FP10s direct to doctors, who were the only staff who held them. The majority of prescriptions were internal forms and individual departments managed them well.
- Resuscitation trollies we saw were new, and their contents checked on a daily and weekly (full check) basis. They were clean and well maintained. All of the contents we saw were in date. Staff told us that once an emergency box was opened pharmacy replaced it.
- The nuclear medicine department followed the Medicines (Administration of Radioactive Substances) Regulations 1978 (MARS). The manufacturer signed all radioactive material in and out of the hospital.
- The nuclear medicine department carried out daily contamination checks and tested all equipment regularly. During the planned refurbishment of the radio pharmacy, senior staff told us that supply of radiopharmaceuticals would be from another radio pharmacy, and would be delivered directly to the department, where staff would check and sign for them.

Records

- Systems and processes in place meant that medical records were consistently available for clinics. In January 2016, 99% of records were available for clinics when requested before the cut-off. They supplied 20,670 sets of notes to 2440 clinics across 24 specialities. Staff produced figures monthly, and monitored the number of temporary folders. In February 2016, 2698 sets of notes were prepared across all specialities, with five temporary folders created.
- Medical records ran a seven day, 24 hour service, from their on-site medical records library. Outpatient clinics requested notes one week before the clinic date, and they were prepared for the clinic the day before. The cut off for requesting notes in the acute hospital was 2pm the day before the clinic. After this time, staff emailed or called through to the service desk in the medical records library, or spoke directly to the team leader in clinic preparation.

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- There was a system in place to ensure medical records were available for clinics, where notes were pulled from the library seven days before the clinic date, and staff checked the notes 24 to 48 hours before the clinic to identify any missing notes. Staff showed us that they produce daily activity figures for all 24 specialties, and the clinical preparation department monitored missing sets of notes. Between November 2015 and February 2016, staff prepared 496 sets of notes for clinics at short notice.
- If notes were not available, a temporary folder, which contained all of the patient's recent letters, printed from the electronic archiving system, was sent instead. Staff printed care plan summaries from the new electronic notes system. Staff monitored missing notes, and investigated each case individually. Staff told us that they recorded the chain of events to try to identify a cause for a missing set of notes. The temporary notes were married back up in the medical records library, and the numbers of temporary folders were monitored by staff.
- Plans were in place to change the notes tracking system to use radiofrequency tags, which would provide a live location of all notes at any time, and would alert staff when a set of notes left the hospital site. Staff currently tracked missing notes using a computer tracking system or contacted the secretary or department the notes were in. They also contacted consultants directly. Staff told us they ran a notes amnesty with a 'no blame' guarantee, to encourage the return of any missing notes.
- Notes were delivered to clinics in blue boxes, which had tamper proof tags if they were being sent off site to community clinics.
- Staff in oncology told us they had two sets of notes for each patient. The second set of notes were held in a library within the oncology centre. Oncology reception staff were responsible for pulling oncology notes, and pairing up both sets when the medical notes were delivered.
- Staff told us they had a high number of sets of oncology notes not available for clinic, because they did not have enough staff to pull them, but it did not affect the running of the clinic, because all of the information that the doctors and nurses needed was also contained in the regular medical notes. Staff told us that there was a current business case to recruit an additional band 2 post to improve the oncology notes preparation.
- Staff told us doctors dictated their clinic letters onto the electronic system, and could update both sets of notes at the same time by printing documents direct from the computer system.
- In the outpatients department medical records were stored securely in roller-fronted filing cabinets or behind manned reception desks with no direct access from public areas. We did not see any unattended notes or records.
- Medical records delivered notes for clinics daily, and collected them at the end of the clinic. If notes needed to remain in the department overnight, staff showed us that they were stored in locked offices, and that access to the department was controlled overnight.
- Staff told us if the patient's notes were not available for the clinic, because of the electronic systems and the temporary notes, doctors still saw the patient in clinic. However, there were no records kept of the numbers of notes not available.
- In the general outpatient department, staff told us they monitored the quality of the note preparation, and sent a list to the practice manager of the area affected. Staff told us they also filled out an online incident form. Most un-prepped notes were short notice requests, and the senior sister told us that they received feedback from these incidents at the band 7 nurses' meetings.
- Staff told us that they took responsibility for the notes for their clinic, and checked them before the clinic started.
- We looked at 19 sets of notes, and found them to be complete and legible, with clear signatures and all relevant documentation filled out.
- Processes were in place to ensure people's individual care records were written and managed in a way that kept people safe, and staff in medical records had set up an action plan around note keeping, and learning had been set up and sent out to other departments. A recent audit of note keeping had shown an improvement in dating, identification and usage of black ink.

Safeguarding

- There were systems, processes and practices in place, to safeguard adults and children from abuse, and there was good compliance with safeguarding adults and children level one training, in diagnostic imaging, therapies, women's, children's and diagnostics, breast care and surgical outpatients, who had all met the trust target of 85% compliance. However, there was mixed

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compliance with safeguarding adults and children level two training, with all outpatient departments and diagnostic imaging not meeting the trust target of 85% compliance. Safeguarding update training took place on the online training system, but one member of staff thought face to face training would be more useful as they 'could question and challenge' in a classroom.

- Staff we spoke to understood their responsibilities under the safeguarding of both children and adults policies, and were able to tell us where they would look for guidance, and who they would contact. There was a trust wide 'see something, say something' campaign, which staff thought was good because it was simple
- Staff understood their responsibilities to follow safeguarding policies and procedures, but there was some confusion around the availability of the safeguarding team. One member of staff said there was a safeguarding team available 24 hours, but was not sure. Several other staff said this too, but were unsure who they were, or if there was a safeguarding lead in their departments. Staff said if they had a concern about a patient or if a patient disclosed something, they would speak to the senior nurse in charge of their clinic.
- In the ophthalmology department, staff told us there was a specific clinic for patients with safeguarding issues, but this was doctor led.
- There had been a never event in the ophthalmology department where a patient had a procedure performed on the incorrect eye. An investigation took place, and found that the patient did not have capacity to consent for the procedure. The investigation did not class this as a safeguarding incident, but the senior staff involved in the investigation could not tell us how this decision was made
- A member of staff also told us that they had witnessed a poor consent procedure in the dermatology outpatient department, and as a result, spoke with the dermatology consultants, and organised some specific adult safeguarding training.
- Staff in the breast care outpatient department, had contacted the safeguarding adults team, as they had concerns about a patient who attended for a mammogram. However, they did not know what had happened to the patient after their appointment. Staff

also told us that they had contacted the safeguarding children team when a patient who was having surgery came to the unit, and there were concerns for the child whilst the patient was in hospital.

- The hospital had a safeguarding adults board, which met every six weeks, and who oversaw the delivery of the safeguarding service and Mental Capacity Act 2005 across Torbay.

Mandatory training

- The hospital target for compliance in mandatory training had not been determined at the time of this inspection. However, the trust was using a RAG (red, amber, green) traffic light system to highlight any areas on concern, with 90% compliance being the benchmark for a green rating.
- Staff received mandatory training in nine core areas, including information governance, manual handling, and infection control.
- All outpatient departments had met this at the time of the inspection, except therapies and diagnostic imaging.
- Hospital policy stated that 85% of hospital staff should have infection prevention and control mandatory training. Breast care, diagnostic imaging, obstetrics and gynaecology and women's, children's and diagnostics departments met this target but the therapies and radiology departments had not with 83% of staff receiving infection control training in both departments.
- Senior staff in the therapies department could not tell us why staff were not undertaking their mandatory training, and did not have any plans in place to address it.
- Staff we spoke to could confidently tell us where to find policies and procedures. Staff felt confident to ask line managers for help if they could not find something, or were unsure of anything.
- The sister in charge of the general outpatient department told us that she kept an eye on staff mandatory training, but each member of staff got reminder emails as well.
- Staff in the general outpatient department were encouraged to book training six weeks in advance, to allow it for it on the rota.
- Staff told us that they thought the safeguarding adults e-learning package was too long at three hours. It was difficult to be allowed be away from clinic for that long.

Outpatients and diagnostic imaging

- Staff in cardiology outpatients told us mandatory training was staggered over 12 months, so everyone could attend.
- Most individual clinics we visited told us that they had met the hospital target for mandatory training compliance.

Assessing and responding to patient risk

- Patient risks were assessed and evaluated, and staff could tell us how they identified and responded to changing risks to people including identifying deteriorating patients and medical emergencies.
- Reception staff knew what to do if a patient collapsed in the waiting room. All reception staff said they would shout for a nurse or doctor. The resuscitation council recommend that all staff, including non-clinical staff receive basic life support training, and staff told us their mandatory training covered this. All staff were able to tell us where the nearest resuscitation trolley was, but some were unsure where to go for a paediatric resuscitation trolley.
- In the general outpatient department, staff told us they sometimes had pregnant women attending for fasting blood tests. Staff told us that it was quite common for these patients to become faint, and that there were a high number of band 2 healthcare assistants trained to use the blood glucose machine to help assess these patients.
- In the fracture clinic, there was an outreach team, who routinely visited all primary hip and knee replacement patients at home after six weeks, instead of bringing the patients back into the clinic. A patient told us they had been told of a support service, but that nobody had been in touch with them to arrange a home visit.
- In the diagnostic imaging department, a radiologist or advanced practitioner radiographer vetted all electronic imaging before patients attended for their appointment. Staff highlighted to us a problem with the electronic system, when patients rang the radiology bookings office before the request had been vetted. This had led to the cancellation or delay of appointments where the request was not adequate or justified.
- Staff could describe the procedure for checking the possibility of pregnancy before an x-ray. They told us if there was any doubt, they would not do the x-ray, and would ask the accident and emergency staff to perform

a pregnancy test. There were signs in patient waiting areas telling female patients to tell the radiographer before the x-ray if there was a chance they could be pregnant.

- Staff in CT checked estimated glomerular filtration rates (eGFRs) for all patients having iodinated contrast, along with checks for allergies and asthma, in line with NICE guidance CG169. If a patient, had an eGFR below the threshold, staff told us they would seek advice from a radiologist.
- Staff said patients drank lots before the scan, but they did not give them any advice about fluid intake after they had contrast, unless their eGFR was low.
- Staff told us they gave out questionnaires before cannulating patients for contrast administration, and explained the risk of extravasation before the procedure. Staff compliance with the questionnaires was being audited.
- There were warning signs, light boxes and notices on all x-ray room doors, warning people about ionising radiation, however we saw two of these rooms with their main doors held open directly opposite a patient waiting area, without a member of staff in the room.

Nursing staffing

- There were safe staffing levels throughout the outpatient departments and planned staffing levels were the same as the actual staffing levels, with the exception of Torbay Hospital outpatients department, which had a 1.22 whole time equivalent (WTE) shortfall.
- Staff told us that they thought there was a good mix of different grades of staff.
- The ophthalmology nurse numbers had increased from 40 to 60 to accommodate Saturday working, including 10 band 6 posts.
- In the breast care department, between July 2014 and June 2015, agency and bank staff made up approximately 4% of the workforce per week, except in December 2014 where this went up to 7%, and in April and June 2015, where it went up to 6%. This was below the trust target of 12%.
- We spoke to a bank member of staff in the breast care department who had a good understanding of their safeguarding responsibilities, and told us they had to undertake the same mandatory training as permanent staff.

Outpatients and diagnostic imaging

- Staff in the general outpatient department held a morning safety briefings, to discuss the staffing and skill mix for the day, and to make sure the right staff were in the right place depending on what was going on in the clinics that day.

Allied healthcare professional staffing

- In the dietetics department, there was a 3.0 WTE shortfall of dietitians. In the occupational therapy department, there was a 4.1WTE shortfall of occupational therapists.
- Senior staff told us that they had a vacancy rate consistently around 8%, because of a high turnaround of band 5 and 6 staff, especially in the physiotherapy department.
- Staff in the physiotherapy and occupational therapy departments rotated, so vacancies were never in the same place. Senior staff told us that the current vacancies were not having an impact on the services, but there was on-going recruitment to band 5 and 6 posts across the whole therapies division.
- In the occupational therapy department, senior staff told us there were not enough hand specialists, so a band 7 had been recruited, and was working with the rheumatology outpatient team to develop the service, which included training two further part time occupational therapists.
- Staff told us these vacant posts made up part of cost savings.
- The cardiology department had one WTE physiologist vacancy and another member of staff was due to retire, but they had been unable to recruit, and there were currently two locum physiologists in post.
- In the diagnostic imaging department, there was a 3.17 WTE shortfall of radiographers, but the senior staff said this was not affecting the delivery of the services.
- The hospital had a target of 12% for its maximum percentage usage of bank staff in any given week. In the diagnostic imaging department, between July 2014 and June 2015, agency and bank staff made up approximately 1% of the work force per week, except in December 2014 and January 2015, where this went up to 3%.

Medical staffing

- The levels of medical staffing were having an impact on the backlog of follow up appointments, as the capacity to see urgent new patients had been the priority in the breast care, upper gastrointestinal surgery, urology and colorectal surgery outpatient departments.
- The ophthalmology department had appointed a new consultant to deal with the backlog of patients, and two further medical retina ophthalmic consultants had been appointed, to replace the locums previously used. In the cardiology outpatient department, there were six consultant cardiologists, who had brought the current waiting list down from 20 weeks to between nine to 11 weeks. The urology outpatient department had recruited a fourth consultant to help clear the backlog of follow-up patients.
- In the radiology department, there was a seven-day on-call service, shared between the consultant radiologists and the specialist radiology registrars. On a weekend, the consultant radiologists covered 9am to 5pm, and the specialist registrars covered from 12:30pm to 9pm. Out of hours from 9pm, both at weekends and during the week, CT reporting was provided by radiology registrars with consultant support. This was managed across local trusts, on a rotational basis, whereby the registrar was sited at one trust, but through a computer image sharing process, reported all out of hours CT imaging for all included trusts.
- The interventional radiology department provided consultant cover 24 hours from Monday to Friday. At the weekends, Torbay radiologists maintained an on-call service between 5pm to 8am Friday to Monday, which alternated between Torbay radiology cover and cover from another NHS Trust.
- In the breast care outpatient department, there had been a reduction in the number of breast radiologists, due to maternity leave, sickness and locum contracts ending. This had led to a reduction in the availability of radiologists to undertake breast imaging and reporting, resulting in a reduction of one-stop clinics for urgent new patients, and an increased wait for results for routine patients.
- At the time of the inspection, there were three fulltime radiologist vacancies, but there had been no applications to fill the role. Staff told us that a full time locum radiologist was due to start on 1 April 2016 to cover general reporting, which would release the remaining interventional and breast radiologists.

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- The current and future staffing issues in the diagnostic imaging department were not having an effect on the report turnaround rate, which remained consistently between 93-100% within one week across all modalities and areas of the hospital. However, radiologists were undertaking additional funded reporting sessions to maintain this. The diagnostic imaging department was using advanced practitioner radiographers with reporting qualifications and advanced practice ultrasonographers to free them from two reporting sessions and two general ultrasound sessions, so that they could undertake more specialist work, such as in breast care.
- Radiologists were considering outsourcing of some general reporting to help with the situation as a short-term solution until staffing issues were resolved.

Administrative staff

- In the cardiology and respiratory medicine outpatient departments, there was one medical secretary for two consultants with a secretarial assistant providing general help.
- Staff told us there was a trust target of four day clinic typing, but did not include diagnostic tests, which made up 50% of the workload.
- Clinic letters in the cardiology outpatient department took between three to five days to type.
- In the respiratory medicine outpatient department, there was currently a 13 day delay for respiratory consultant letters, which was on the divisional risk register, but we did not see any evidence of plans to improve this.

Major incident awareness and training

- We saw major incident plans clearly displayed on the office wall of the sister in charge of the general outpatient department. Staff we spoke to were aware of their role in a major incident, and knew where the policy and quick reference guide was kept.
- In the diagnostic imaging department, staff showed us that there was a contingency plan if an x-ray room or CT scanner broke down. Staff knew whom to contact in a major incident, and were aware of their role in helping the flow of patients through the hospital.
- Whilst we were on site, the hospital called an internal incident, which did not affect the outpatient department, and staff were unaware of it.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients will not be rated due to insufficient data being available to rate outpatients effectiveness nationally at present.

- We saw National Institute for Clinical Excellence (NICE) guidelines embedded in policies in the cardiology, ophthalmology and oncology outpatient departments that were accessible to all staff via the shared intranet, and were all in date, with clear review dates.
- Staff told us about triple assessment clinics in breast care for symptomatic breast referrals, which allowed imaging and diagnosis of the patient by a specialist radiologist in the same clinic.
- We saw detailed monitoring and analysis of patient outcomes in the physiotherapy department using a RISQ questionnaire.
- We found that seven-day services were established as part of a normal working week in some specialities, but not in others.
- Radiology turnaround reporting times were the lowest in a recent benchmarking exercise; however, extra funded reporting sessions were helping keep the turnaround times down, until more staff were recruited.

However:

- In some departments, some staff were performing specialist procedures without formal qualifications.
- Staff in some departments had to volunteer to cover extra clinics put on to clear waiting lists.
- Staff said patients had follow-up mammograms at one, three and five years, which is not in line with the yearly follow-ups set out by NICE guideline CG80.
- There was no metastatic breast care nurse in post, as recommended by NICE guideline CSG1.

Evidence-based care and treatment

- Outpatient services ensured they identified and implemented relevant best practice guidance, by including it in their departmental policies. In the ophthalmology outpatient department, we saw

Outpatients and diagnostic imaging

multiple folders containing up to date local guidelines, and we saw evidence of National Institute for Clinical Excellence (NICE) guidelines within the protocols. We reviewed one policy on the internal internet, and it was named, dated and had a clear review date.

- Staff told us for every new procedure or treatment they started doing in the department, staff would draw up new guidelines. Staff also told us because of new guidelines in 2008 for the treatment of macular degeneration, the department had seen a large increase in referrals. Staff told us the trust had been very supportive in the provision of more equipment and medical staff to help with the additional patients
- In the cardiology outpatient department, a rapid access chest pain clinics ran twice weekly in line with NICE guidelines CG95.
- We saw that the British School of Echocardiography accredited all echo cardiographers and physiologists, and all scans performed by them were reported the same day.
- In the oncology department, we saw current NICE guidelines used to develop the departmental operational policies. We looked at the lymphoma policy on the shared intranet drive, and saw that it was past the review date of April 2015. Several other policies were all in date.
- In the heart and lung outpatients department, there was an open tuberculosis (TB) clinic. Staff told us that when they saw these patients, they took them straight into a consulting room with an open window. Staff told us that they are aware of the new NICE guidelines (NG33) for inpatients with drug resistant TB, but that no guidelines currently existed for outpatient review of patients.
- The diagnostic imaging department used diagnostic reference levels to identify the amount of dose required to perform an optimised X-ray. Staff told us each x-ray had a numerical value called an exposure index, which would indicate to them if their image had been under or over exposed. Staff we spoke to told us they always checked this value when assessing an x-ray image.
- The radiology department recorded and monitored the amount of radiation a patient was exposed to, but this was dependent on the radiographers entering the dose when they processed each patient.
- In the mammography department, patients had follow-up mammograms one, three and five years after their diagnosis, instead of yearly as recommended by

NICE guideline CG80. Staff told us this was because of funding issues, and had been discussed with the Clinical Commissioning Group (CCG), who had made the decision not to commission annual follow ups for certain breast care patients. Staff were aware that they were not fully compliant with all of the requirements of the guideline, but said it was not their decision.

- There was not a metastatic breast care nurse in post, as recommended by NICE guideline CSG1, improving outcomes in breast cancer.

Pain relief

- In fracture clinic, staff asked patients to rate their pain using a simple scale. Staff also told us they did not administer pain relief very often, but doctors assessed patients if necessary. In radiology, staff told us if a patient was in pain during a procedure, they would seek advice from a consultant or registrar, who would come and see the patient if required.

Nutrition and hydration

- We saw water fountains and vending machines in most outpatient areas for patients to get hot and cold drinks. In radiology, staff informed us that due to a patient accident, they had to remove their hot drinks vending machine.
- Patients arriving by ambulance transport had 'snack boxes', and staff told us they could get cold food for patients from the on-site canteen.

Patient outcomes

- Processes were in place to monitor performance and maintain standards and in the physiotherapy department. Information about the outcomes of people's care and treatment was collected using a revised impact of symptoms questionnaire (RISQ), given out when they attended for their follow up appointment. The questionnaire gathered outcomes about the patients work, hobbies, social life, relationships and everyday activities. The department gathered all of the data, and used it to assess the positive and negative impact of the patient's treatment on their lives.
- Staff told us they planned to continue to use the questionnaire, but using a bigger sample of patients to assess if there were different outcomes for different body parts, and if there were different outcomes for acute conditions compared with chronic conditions.

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- In the urology department, a previous problem with cystoscopy follow up appointments had meant the multi-disciplinary team (MDT) had taken over responsibility for the coding of follow-up appointments, with sign-off from the clinical specialist nurses.
 - In the fracture clinic, patients were given a capturing patient experience questionnaire, which covered all aspects of the patients care in the fracture clinic. Staff told us that the results of these questionnaires were online for staff to access.
 - In the ophthalmology department, because of a patient complaint, consultant outcome letters were moved onto the digital dictation system with a tick box to indicate a follow up appointment, which had to be completed before the system would allow sign-off of the letter.
 - In the general outpatient department, staff told us that patient outcome letters are always sent to the patient's GP, and to the patient if they wanted a copy.
 - In the breast care department, staff monitored patient outcomes with the number of 'thank you cards' they received.
 - The diagnostic imaging department undertook an extensive benchmarking exercise, run by the NHS Benchmarking network. Seventy eight trusts took part, and looked at activity, report turnaround, outsourcing, waiting times, workforce and finance. The radiology department had the lowest report turnaround time out of all 78 participants, and the departments waiting times were in lowest 25 % of participants.
 - The audiology department had Improving Quality in Physiological service (IQIPS) accreditation. IQIPS is a national programme which promotes and recognises good quality practice in physiological diagnostic services.
- Competent staff**
- The hospital had an on-going commitment to training and development, and had set a target for 90% of staff to have received an annual appraisal. We found that by September 2015, 94% of staff in the breast care department had an appraisal, 84% in obstetrics and gynaecology, 76% in radiology and imaging, 88% in therapies and 89% in women's, children's and diagnostics. Staff had all received an appraisal, and said that they found it useful.
 - Staff said they felt comfortable to discuss further training with their direct line manager, and did not feel pressured to do things before they were ready, and they felt confident to discuss their training needs with their manager. There was a dedicated room for continual professional development in radiology, which staff used for online training.
 - In the general outpatient department, all staff had to read the standard operating procedures and be assessed as competent before using equipment, or working in a new clinic. Each clinic had its own standard operating procedures folder, and staff knew where to find them. Staff told us they were also on the intranet shared drive. In the diagnostic imaging department, standard operating procedures were available in the viewing area for each room, and staff showed them to us on the shared intranet drive.
 - Doctors and registered nurses were supported to revalidate with their professional bodies. Although individuals were responsible for revalidating with their professional body, they were reminded this was required and appropriate managers approved supporting documentation.
 - Learning needs had been identified in CT, and a competency based training programme, and a mentoring system for all new staff was developed following a radiation incident in CT when an unsupervised training CT radiographer carried out an incorrect scan.
 - In the general outpatient department, the senior sister, told us staff were encouraged to book extra training, and she factored it into the rota, six weeks in advance.
 - Staff showed us they had a written folder for revalidation, which was stored in the sister's office. Staff told us they had regular team meetings with the senior staff to discuss any issues affecting them or the department, and staff used minutes from these meetings as evidence for the revalidation process.
 - In the diagnostic imaging department, new staff had a written three month training plan. Staff signed off each training area as staff moved through the training. Staff said that they had good communication with managers, and plans could be adapted to meet training needs of each radiographer.
 - In the nuclear medicine department, the staff told us that until recently, there had not been a clear succession plan for the Radiation Protection Advisor (RPA). A senior medical physicist was now working closely with the current RPA to take over the role.

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- In the diagnostic imaging department, all radiation protection supervisors attended regular training and meetings to maintain their skills and practice, and had certificates to show their continual professional development.
- The diagnostic and imaging department had Administration of Radioactive Substances Advisory Committee (ARSAC) accreditation and there were several radiologists in the diagnostic imaging department who held ARSAC certificates, clearly showing which radiopharmaceuticals they could give, and there were clear guidelines for which radiographers and medical technical officers (MTO) could administer these radioactive substances, under a delegated system of work arrangement.
- The majority of staff in the general outpatient departments had the right qualifications, skills, knowledge and experience to carry out their jobs. In the urology outpatient department, clinical specialist nurses led cystoscopy clinics. There was currently one nurse who had been fully trained in house, and a second was being trained.
- In the dermatology outpatient department, a nurse practitioner carried out punch biopsies; however, they did not hold a nationally standardised surgical care practitioner qualification, but was training others.
- In the oncology outpatient department, there was a nurse led peripherally inserted central catheter (PICC) line service, and a nurse practitioner was qualified to carry out minor invasive procedures such as taking abnormal fluid from the lungs or abdomen. The nurse practitioner was training to prescribe certain medicines. In the ophthalmology outpatient department there was an in house training programme to train nurse practitioners. There was one qualified and six training at the time of our inspection.
- In the breast care department, patients who had a symptomatic referral were given access to delivery of co-ordinated care through a triple assessment clinic, where a specialist consultant radiologist imaged and performed diagnostic tests for the patients referred from the surgeons list for that day.
- In the urology department, specialist nurses told us they had tried to set up a one-stop urology clinic, but found that the diagnostic imaging they needed was not available. Staff told us they would need ultrasound and fluoroscopy support, but the services did not have capacity to help them.
- In the ophthalmology department, staff told us that a review of the patient journey was being undertaken, to try to provide a smooth flow for the patient through the clinic from diagnosis to treatment of certain conditions.
- The audiology outpatient department used a clinic room for a transient ischaemic attack (TIA) clinic. A one-stop clinic operated from 1.30pm to 5.30pm on Monday to Friday, where patients were referred directly from their GP, or the emergency department, for same day assessments.
- In the therapies outpatient department, there were joint MDT clinics between physiotherapy, occupational therapy and rheumatology, with the most senior member of staff providing clinical supervision for that clinic.
- In the dietetics department, staff told us there should be an MDT approach for the adult eating disorders service, as recommended by NICE guideline CG9. Staff told us senior dietician saw patients who were referred, and until recently, all referrals had triggered a safeguarding incident, to highlight the lack of service. Senior staff told us the Clinical Commissioning Group (CCG) was aware of the need for a service, but staff felt they have taken the issue as far as they could. Senior staff told us the issue had been raised consistently over the past two years, and the CCG had started to look at funding and staffing, but had not made it a priority. The head of dietetics was in contact with the CCG on a monthly basis.
- Staff in the gynaecology department, told us they had an excellent service provided by radiology and they could get urgent scans seven days a week, and could always speak to radiologist for advice. Staff told us they thought the service was proactive, flexible and accessible.
- The diagnostic imaging department service made use of previous imaging by encouraging radiographers to

Multidisciplinary working

- We saw evidence that staff worked professionally and cooperatively across different disciplines to ensure care was coordinated to meet the needs of patients.
- The outpatient services had access to a range of therapies such as physiotherapy, occupational therapy, dieticians, and speech and language therapists. In fracture clinic, there was a specialist hand clinic, with occupational and physiotherapy specialists.

Outpatients and diagnostic imaging

check all previous imaging before taking an x-ray or scan. The hospital was part of a southwest picture archiving and communication (PACS) system, so images from other hospitals in the region were easy to share and access.

Seven-day services

- We found that seven day working was being considered as part of the outpatients and radiology services future strategy.
- In the ophthalmology department, the staffing had increased from 40 to 60 nursing staff, to accommodate Saturday working as part of the normal working week. The increase in staff numbers had meant that there had been no knock on effect to the weekday clinics.
- CT and MRI had implemented seven-day services, and an advanced practitioner radiographer held a dedicated reporting session every Sunday morning to clear reporting of x-rays from the emergency department over the weekend.
- The oncology outpatient department provided less complex chemotherapy on a Saturday, because junior medical staff were less available at the weekend to supervise the more complex chemotherapies.
- Staff in fracture clinic told us that to include a Saturday in the working week, they would need to increase the staff by another five nurses. Staff told us that thanks to the virtual triage system, the clinic was running well, with no capacity issues now, so it was felt that a move to seven day working was not necessary yet.

Access to information

- Information was available to clinical staff either in the patient's notes, or through systems on the intranet, with key patient documents, including care plans, available on computer. The trust had a PACS for the storage of radiological images and reports, for the use of clinical staff throughout the trust and the southwest of England, so all hospitals in the region could share and access each other's images.
- Pathology, microbiology and other blood results were provided electronically through various computer systems.
- The diagnostic imaging service had arrangements in place where radiologists prioritised x-ray reporting and turned reports around quickly, with 98-99% reported within one week. 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. All GP reports were sent back electronically, and urgent results followed up with a phone call.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In many outpatient departments and in diagnostic imaging, consent to a procedure or radiological examinations was implied or verbal, omitting the use of a formal consent form.
- Staff had a varied working knowledge of the Mental Capacity Act 2005 (MCA). Some staff in the diagnostic imaging department were unaware of their roles and responsibilities in applying the act to keep people safe. Staff told us they had to complete an online training module as part of their safeguarding adults training.
- Patients' mental capacity to consent to treatment was assessed in pre-assessment clinics and specific MCA consent forms were used. In the ophthalmology outpatient department, we saw them in use, and staff could explain when they would use them and why. The use of these forms, and the quality of the data written on them, was being continually monitored after being identified as an area for improvement following the never event in ophthalmology.
- Staff told us they tried to identify patients in the pre-assessment clinics, but also worked closely with the learning disabilities link nurse, who provided a weekly list of all patients in the hospital or coming into the hospital, but staff did not know where the information on the list came from.
- An ophthalmology patient liaison officer was available to provide individual help to people, and we saw easy read information leaflets.
- Staff in the radiotherapy department told us they used consented self-restraint for some procedures, and gave us an example of where it had been used on a patient with Parkinson's disease.

Are outpatient and diagnostic imaging services caring?

Outpatients and diagnostic imaging

Good



We rated caring in the outpatients and diagnostic imaging service to be good because:

- Patients we spoke with were very positive about the quality of care provided by the outpatient and diagnostic imaging departments.
- Patients described staff as helpful, efficient and polite. Health watch Torbay had undertaken a review of the hospital services between December 2014 and December 2015, and staff attitude and quality of care came out as the highest scoring categories patients rated.
- We saw genuine, compassionate care and patients were spoken to patiently, kindly and politely.
- We saw good practice where relatives and carers were included in patient's decision-making, and patients were encouraged to bring relatives and carers into their consultations.
- According to the latest friends and family test data, 96% of patients who responded would recommend the outpatients department at Torbay hospital.

However:

- A recurring theme identified in the Health watch Torbay report, was that patients were becoming increasingly unhappy with referral times for appointments in ophthalmology, audiology and neurophysiology, with some being promised an appointment in one to two weeks, but actually waiting over six weeks to be seen.
- We saw that there were problems maintaining privacy and dignity within the physiotherapy and diagnostic imaging departments, which were due to the lack of space and appropriate consulting and waiting areas.
- Staff told us chaperoning was inconsistent in the general outpatients department, and in some clinics, they were only provided if the patient asked for one.

Compassionate care

- According to the latest friends and family test data, 96% of patients who responded would recommend the outpatients department at Torbay Hospital, with a total of 474 responses.
- Staff in both the outpatient and diagnostic imaging departments showed encouraging, sensitive and

supportive behaviours towards patients and we saw that staff spoke appropriately, kindly, patiently and politely to patients and their families, and communicated at their level, by making the effort to bend down to make eye contact with the patients. We heard staff asking patients what they preferred to be called, and if this had not been determined, staff addressed patients by their title and surname.

- We saw a member of staff calling a patient with learning difficulties into an examination room. The member of staff called the patient from the doorway, but did not approach the patient, whose wheelchair was facing away from the staff member. They stood by the examination room, until the patient had manoeuvred their wheelchair and made their own way to the room.
- We saw staff informing patients verbally of clinic delays, and addressing patients individually to answer any specific questions. In most clinics, there were white boards with estimated delay times displayed.
- Several patients told us they would feel confident to raise a concern if they were not happy with their care, but added they had not had a reason to do so.
- 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 patients 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.
- One patient told us the physiotherapy department was "the best department in the hospital", because the physiotherapist listened to the patient and showed them what to do so they understood. They had also diagnosed something that their GP had missed.
- Staff responded well to patients who experienced pain, discomfort or emotional distress after an appointment. We saw a patient have a panic attack after having some treatment in one ophthalmology clinic, and a nurse immediately sat with them in a quiet part of the department, and calmed them by speaking to them and making them a drink.

Chaperoning

Outpatients and diagnostic imaging

- Policies to ensure patients were offered chaperones for procedures involving intimate personal care were not followed consistently throughout the outpatient departments. In the general outpatient department, staff told us chaperones were always provided when doctors were providing intimate or personal care to patients of the opposite sex. Patients attending heart and lung outpatients and ophthalmology laser clinic were not offered chaperones, unless they requested one.
- A senior staff member in the ophthalmology department told us they were going to be offering chaperones to all patients, and allowing the patient to refuse rather than having to request one, and documenting the reason in the patient notes.

Understanding and involvement of patients and those close to them

- The oncology outpatients department ensured patients knew whom to contact if they were worried about their condition or treatment after they left the clinic. We spoke with four patients who were all currently receiving some form of treatment, and three of them told us there was 24-hour helpline, manned by the oncology ward, which was extremely helpful and reassuring. One patient had called up in the early hours of the morning for advice when they were on chemotherapy, and found the staff member they spoke to was very helpful and able to answer their questions.
- Staff in the general outpatient department told us they had a list of patients with additional needs displayed in a locked room, for them to check every day before their clinic started.
- Staff communicated with patients so they understood their care, and a patient's relative told us the staff in general outpatients were "brilliant with their parent" and were aware of their limitations. They told us they had been involved at all stages of their parent's care, and staff adjusted their language so that their parent could understand.
- The outpatient departments send copies of clinic letters to the patients as well as their GP. Some patients we spoke to knew their GP got a copy of their clinic letters, but some did not. Some patients had copies of clinic letters sent to them, but some did not know this was offered.
- The diagnostic imaging department ensured that patients knew when and where they would get their x-ray results. We saw a member of staff tell a patient to contact the person who asked for their x-ray if they had not heard anything within two weeks. The staff member then checked the patient knew who had asked for their x-ray.
- The general outpatient department recognised when patients needed additional support to help them understand and be involved in their care and treatment. Staff told us they had a patient whose child had power of attorney for their parent, and they had actively involved both patient and child in all decisions relating to the patient's care.

Emotional support

- The outpatient and diagnostic imaging departments used information leaflets both before and after appointments, to help patients understand the tests and treatment they would be having. We saw information leaflets in all outpatient areas, which advertised support groups for patients, relatives and carers, and we saw staff hand these out to patients and point to and explain some pages.
- The hospital had a dedicated chaplaincy team, who provided non-judgmental, inclusive care for those of any faith or none. The chaplaincy staff establishment is 2.3 WTE, which had been determined in line with the latest NHS Chaplaincy Guidelines (2015). A team of 50 volunteers and a small number of honorary Chaplains supported these staff. In addition, voluntary contacts from a broad spectrum of other faiths were available to contact or consult if needed.
- Torbay Hospital had a traditional Anglican chapel and a quiet room, which were both open 24 hours. Information about the service was available online, and patients could be referred by staff, relatives or refer themselves.
- One patient in the oncology outpatient department told us that as well as being given the 24-hour helpline number, they had also been given a named nurse. They told us that they found this very comforting.
- Patients were given appropriate and timely support whilst in clinic, and in the breast care department, we saw dedicated 'bad news rooms', where patients could take as much time as they needed to understand and cope with their care, treatment or condition.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated the responsiveness of the outpatients and diagnostic imaging service to require improvement because:

- We found that due to the scale of a follow up backlog, and restrictions in the capacity of clinics, people were frequently not able to access services in a timely way for follow up appointments.
- At the time of the inspection, 9756 patients were in breach of their see-by date, across all specialities. The biggest backlog was in the ophthalmology department, with 3980 patients past their to-see by date.
- Incomplete pathway referral to treatment targets in the pain management, gastroenterology, trauma and orthopaedics, colorectal surgery, ophthalmology, clinical neuro-physiology and upper gastrointestinal surgery outpatient departments, were not being met.
- A problem with the trust's surgical follow-up outpatients booking system had been identified, which allowed patients to be missed off follow up lists. The hospital investigated this and found three patients had been harmed as a result, and a fourth died, out of the 2,858 patients investigated.
- In the ophthalmology outpatient department, a patient complained they had not received a follow up appointment, and as a result, introduced a tick box on the outcome form on the computer system.
- The Hospital had around a 10.1% patient cancellation rate, which was above the England average, and an 8.8% hospital cancellation rate, which was also above the England average.

However:

- Cancer wait targets were being consistently met across all specialities.
- The diagnostic imaging department turned around between 93-99.9% of reports within one week for all imaging modalities.
- The hospital had a 6.1% 'Did not attend' (DNA) rate, which was below the England average.

- The physiotherapy service provided a direct referral system, with the majority of patients receiving an appointment in 72 hours.
- A virtual triage system in fracture clinic has reduced the number of patients called back to fracture clinic unnecessarily.
- The oncology and pharmacy departments provided a delivery service for some types of oral chemotherapy.
- There were monthly 'learning from complaints' meetings, which involved representatives from the trust, community and other key organisations.

Service planning and delivery to meet the needs of local people

- The outpatient department involved commissioners and other providers in service planning, and in the ophthalmology department, consultants had fortnightly meetings with the Clinical Commissioning Group (CCG), which helped to ensure good links with the community and GP surgeries.
- The services provided by the outpatient and diagnostic imaging departments reflected the needs of the population.
- The physiotherapy department provided a self-referral system where patients could bypass their GP for treatment. Patients usually got an appointment within 72 hours. In the oncology outpatient department, there was a telephone consultation service and special courier service by pharmacy, for home delivery of certain chemotherapy medicines.
- The facilities and premises were not appropriate for some of the services that were currently delivered in the general outpatient department. However there was an on-going project looking at room availability and usage within the general outpatient department. Any non-essential services such as consultant and secretary offices had already been moved out of the department, and the project was looking to change the usage of some rooms. This project was also looking at facilities available in other hospitals, to make the best use of the clinic rooms available there. This project formed part of the trust overall 'Integrated Care Organisation' programme, which was working to bring all of the facilities in the other community hospitals together, to provide joined up care.

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- The majority of patients and staff we spoke to told us car parking was a big problem, and signs confused one patient who paid for parking despite having a blue disabled badge. Staff told us there was not a park and ride service.
- The outpatient and diagnostic imaging department offered weekend appointments in some specialties, and in the ophthalmology outpatient department, Saturdays had been incorporated into the working week. Evening clinics had also been used to reduce the waiting lists.

Access and flow

- The outpatient and diagnostic imaging departments offered direct patient access to hospital appointments through an electronic referral and a choose and book system. The Devon referral support system (DRSS), triaged all referrals, and allocated appointments. Patients rang to confirm their appointment, and DRSS made the consultant clinic appointment.
- The consultants could then adjust the priority of the appointments, which could lead to cancellation of routine appointments to make way for urgent referrals. However, staff told us they telephoned patients if this happened.
- The hospital provided timely access to appointments using the patient services centre that took around 40,000 calls a month, of which 95% were answered in less than 30 seconds.
- In January 2016, there were 9756 patients on the follow-up pending patients waiting list and 5291 (54%) had been waiting over six weeks past their follow up date. The biggest backlog was in the ophthalmology outpatient department, with 3980 patients past their to-see by date. Out of these patients, 2357 (59%) had been waiting over six weeks past their follow up date.
- In the ophthalmology outpatient department, the group of patients at risk of most harm was the macular degeneration patients. In July 2015, there were 546 patients in this group. A macular coordinator monitored these patients, and two additional consultants had been recruited to manage the backlog.
- The dermatology outpatient backlog was also highlighted, but staff told us a regional skin cancer awareness campaign in 2015, had seen a 30% increase in referrals, which had remained at this level. Staff told us capacity and consultant vacancies were the reason for the backlog.
- Between September 2014 and September 2015, the trust reported a rate of referral-to-treatment (RTT) within 18 weeks, which was greater than the national standard of 95%, (which meant more patients were being seen within 18 weeks, compared to other hospitals in England). At the time of the inspection, all RTTs were between 96-97% of patients seen within 18 weeks.
- In cardiology, patients referred for echocardiograms, were seen within the six-week standard, but 12-month follow up appointments were being booked seven to eight months after the patient's to be seen by date. At the time of the inspection, there were 366 patients past their to be seen date.
- The percentage of incomplete pathways had been below the England average, and above the national standard of 92% of patients starting treatment within 18 weeks, since November 2014 to October 2015 (which meant patients were starting treatment sooner, when compared to other hospitals in England). In December 2015, the trust did not achieve the 92% target for incomplete pathways in the pain management (92%), gastroenterology (91%), trauma and orthopaedics (87%), colorectal surgery (82%), ophthalmology ((80%), clinical neuro-physiology (75%) and upper gastrointestinal surgery (72.%) outpatient departments.
- The percentage of cancer patients who saw a specialist within two weeks had been consistently higher than the national average from April 2014 to January 2016, and higher than the national target of 93%. In December 2015, the trust had met all of the cancer standard waiting times. Seven hundred and two, two-week wait patients were seen, with 14 breaches, nine of which were at the patient's request. The national targets for patients receiving their first treatment or radiotherapy session were also consistently met up to December 2015.
- The percentage of cancer patients receiving their first treatment within 62 days after their two week wait referral was consistently above the national target of 85% between November 2014 and December 2015 (which means more patients were seen within two weeks of being referred, compared with other hospitals in England). However, haematology, lower gastrointestinal (GI), lung, upper GI and urology, had not met this standard for more than five months (not consecutive) between November 2014 and November

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2015. Staff told us this was because the tests, procedures or surgery needed for some of these patients happened in other trusts, so their pathways were often longer as a result.

- The diagnostic imaging department had consistently not met the national standard for 99% of patients to have their imaging within six weeks between November 2014 and September 2015. However, the standard had been met in October 2015, and November 2015, but not in December 2015.
- In CT, MRI and non-obstetric ultrasound, between 22-24% of patients had their scan within one week, 72-75% of patients were scanned in under five weeks, and the remainder over six weeks.
- The diagnostic imaging department had consistently not met the national standard to see 93% of two-week wait patients within two weeks between December 2014 and October 2015. Staff told us this was because demand was greater than capacity, and one member of staff said that they were under constant pressure to try to meet these targets.
- The nuclear medicine department had a 15 week waiting list for myocardial perfusion scans, but a training plan for two additional doctors to oversee this was underway, to bring the waiting list down and minimise the time patients had to wait for treatment or care.
- The hospital had a 6.1% 'Did Not Attend' (DNA) rate, which was below the England average, between January to December 2015. The hospital allowed patients to cancel their appointment twice, and recorded the reasons, but had not analysed this data recently. The hospital had a cancellation rate of 8.8%, which was above the England average (which meant the hospital cancelled more appointments compared with other hospitals in England).
- In the dermatology outpatient department for the year 2014-2015, 3902 clinics were held. Seven hundred and eighty nine (20%) were cancelled, 605 with less than six weeks notice, six were cancelled on the day. In ophthalmology, for the year 2014-2015, 16280 clinics were held, with 1149 (7%) cancelled, 387 with less than six weeks notice, and seven cancelled on the day.
- The hospital found a problem with the trust's surgical follow up outpatients booking system, which allowed urology patients who had a cystoscopy to be missed off follow up lists. The hospital investigated this and found 24 patients had not been given an appointment. Three patients had been harmed as a result, and a fourth died. Staff told us that they had gone back through over 2,858 patients since 2012, to see how many had been affected. The hospital found that the process for identifying follow-ups used three different computer systems. Because of the investigation, clinical staff had taken over coding of the follow-up patients. Staff downloaded a spread sheet of follow-up appointments from the clinical record software. Staff were happy that they had done everything they could to prevent this happening again.
- In the ophthalmology outpatient department, a patient complained they had not received an appointment, and the hospital found they had been missed off the follow up list. As a result, the department introduced a tick box when consultants typed letters on the computer system, which did not allow the consultant to complete the letter without ticking the box.
- The hospital had a four-day target for the typing of clinic letters, which was not being met in the cardiology, or respiratory medicine outpatient departments. Staff monitored typing backlogs, and there was a floater secretary assigned to areas with backlogs.
- The diagnostic imaging department collected data over a six-month period to show the waiting times of patients attending for examinations. Over 44 % of patients were imaged before their appointment time, 40% within 30 minutes, 9% over 30 minutes, and 6% were delayed over an hour although the system used assumed that any wait over one hour must be because a staff member had not processed the patient's examination on the computer system.
- The outpatient and diagnostic imaging departments kept patients informed of clinic delays verbally or used whiteboards to display delay times.

Meeting people's individual needs

- Patients were treated as individuals with treatment and care being offered in a flexible way which was tailored to meet their needs.
- The trust had an electronic flagging system to alert staff to a patient's individual needs, but not all staff were aware of it. The hospital assessed patients with learning difficulties by taking information from GP coding and history, health and social care databases, and by having discussions with patients and carers. The hospital had a full time specialist learning disability nurse who received a daily email of all flagged patients. Staff told us senior

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nurses in charge of clinics were on the weekly email, and we saw the list on display in a secure, staff only area of the clinic. We saw at a morning safety briefing, the senior sister reminding staff to check the list before their clinics started. In most clinics we visited, there was a named learning disability nurse.

- Processes were in place to allow vulnerable patients to bypass queues, and in fracture clinic, we saw a simple coloured plain sheet of paper attached to the front of notes, to indicate fast track patients.
- The hospital had a dementia nurse specialist who provided staff with additional skills to care for patients with dementia and staff knew how to contact her. All staff, including non-clinical staff, received dementia awareness training, and there were dementia champions to promote good practice around dementia. Hospital mandatory training covered dementia awareness, but staff said more detailed training was available.
- Services were planned to take account of patients with complex needs, and staff told us they made reasonable adjustments for patients on an individual basis. Some examples given to us were patients being given double appointments or being placed first or last on outpatient appointment lists. We saw a patient with dementia fast tracked straight through to the doctor in an ophthalmology clinic, and we saw a dedicated liaison officer in another ophthalmology clinic offering help to patients with visual impairment by offering letters and information in braille and easy read formats.
- The trust had a translation and interpretation service which was available to staff, patients, carers and relatives. Staff told us services could be provided face-to-face (which was always preferable) or over the telephone. There was also a document translation service, which was used to support the information shared at appointments and when communicating with patients, carers and relatives (for example, appointment letters could be translated). Staff told us the telephone-based service was a national service, but the face-to-face translators were from Devon and had a good understanding of the area, including an understanding of how some patients in rural areas could become socially isolated. In addition, frontline teams (such as the Patient Access Centre for centralised bookings) had received training on the use of translation and interpretation services, and staff told us interpreters were nearly always booked before the patient came for

their appointment. The outpatient department also had the support of Total Communication Now (an internal service supported by speech and language therapists to address communication needs for patients not able to communicate). However, not many staff we spoke to had heard of this.

- The hospital had an accessible information policy, together with a working protocol and a training video, which were available on the internal staff website, and some staff we spoke to had completed this training.
- Staff said they were aware of bariatric patients before they attended clinic because patients' body mass indexes (BMI), were stored on the computer system. Staff explained how they would order specialist equipment ready for the clinic.
- Wi-Fi was available for patients and visitors to allow them to use internet facilities on their tablets and smart phones.
- Signage in the hospital was good and used zones to differentiate between areas. There were also coloured lines on the floors in each clinic to help patients find their way through the clinic. In the ophthalmology outpatient department, the signage was not adapted for visually impaired patients.
- In the outpatient clinics we visited, the environment was patient centred and the waiting areas had plenty of seating, which was clean and well maintained. There were magazines and water fountains for patient use. We did not see any bariatric seating, wheelchairs or trolleys, but staff told us they could order it from a central store. There were children's play areas in most of the clinics we visited, but there were variations in their suitability due to space and department design.
- In the outpatient and diagnostic imaging departments, wheelchairs were accessible to patients if they needed one, and we saw volunteers assisting patients. We did not see any dedicated wheelchair or trolley waiting areas. In diagnostic imaging, patients in wheelchairs and beds were positioned along the corridors where other patients were waiting.
- We saw good disabled access to the outpatient departments we visited, including the temporary main entrance to general outpatient department.
- According to the latest friends and family test data, 96% of patients who responded would recommend the outpatients department at Torbay Hospital, with 474 responses. However, we did not see any of this feedback displayed.

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- Information leaflets were available in most outpatient areas, and staff knew how to request leaflets in other languages and formats. We saw leaflets in languages other than English in waiting areas throughout outpatient. Senior staff in general outpatients told us that a review of all the information leaflets had taken place after the merger. However, they did not know if patients had been involved in reviewing the leaflets. In the breast care department, staff audited patient advice leaflets, and developed and improved them using the audit results, and direct patient involvement.
- The hospital did not provide an adult eating disorders service in line with current best practice guidance, which advocated a multi-disciplinary approach, involving mental health support. Staff thought this was due to a lack of funding.
- The outpatient and diagnostic imaging departments tried to deliver services that took into account individual needs of patients, for example, staff in the heart and lung outpatients department, told us that if patients requested a female doctor, the hospital tried to book them with the only female cardiologist. Staff said her clinics were very full, and were concerned about what might happen if she left.

Learning from complaints and concerns

- The Patient Advice and Liaison Service (PALS) was advertised throughout the outpatient and diagnostic imaging departments, with leaflets about their services available for relatives to take away. Staff told us that should a patient wish to make a complaint they would attempt to resolve any concerns within the unit first before involving the PALS team. Staff in general outpatients and fracture clinic told us that dissatisfied patients were given a 'How do you think we are doing' leaflet before they were referred. Staff told us they did not encourage patients to complain formally, and they had not really thought about it being helpful to the department.
- We were told lead clinicians or senior nurses investigated complaints. The investigation and feedback process included the complainant and staff members, with meetings arranged to enable good communication and understanding throughout the process.
- The trust had tried to survey complainants by sending a questionnaire to a random sample of complainants, six

weeks after the outcome of their complaint, and tried sending out the questionnaire to another group, with the final outcome. Neither approach gave many responses.

- Patients told us they would be happy to complain if something about their care had not gone well.
- The trust had a patient experience and community partnership that met every month and provided scrutiny to the processes around complaints. From this partnership, the trust received a quarterly patient services report and an annual patient experience report. Each division had an action database, and key actions were identified in the quarterly patient services report. However, staff said they had not heard of this.
- Staff told us acute services aimed to provide a response to a simple complaint within six weeks, and complex complaints were discussed with the complainant and aimed for an eight-week response. If a delay occurred, the hospital sent a letter of explanation about the delay to the complainant.
- We were told most complaints were answered within six weeks (42 days), and this was reviewed every month. Between October 2014 and October 2015, the general outpatients department received 35 complaints, which accounted for 7% of all complaints received across the hospital. Nine complaints (26%) were responded to within 30 days, 16 (46%) within 60 days, six (17%) within 90 days, one (3%) over 91 days, and three (9%) had not been responded to.
- The trust upheld five of these complaints, 19 were not upheld, and eight were partially upheld. Investigations into three were on-going at the time of our inspection.
- The trust had a 'learning from complaints' group, which included the community, CCG, patient representatives, and all heads of services with responsibility for dealing with complaints. These meetings took place on a monthly basis with the purpose of sharing learning from complaints across the whole organisation.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We rated the leadership in outpatient and diagnostic imaging services to requires improvement because:

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- Service plans were reliant on increasing staffing, especially at consultant level and radiologist staffing levels were beginning to affect service delivery, however there were plans to minimise the impact on other services.
- The dietetics department had escalated the lack of an adult eating disorders service to the CCG, as patients were not getting access to all of the services recommended by NICE guidelines.
- The dermatology services were split over two locations, and the services based in general outpatients were confused as to who was responsible for the day-to-day running of the service, and senior staff were not visible to staff working in the annexe dermatology clinics.
- Cardiology had no overall manager, and the senior leadership was not very visible to staff, and did not hold regular staff meetings.
- The hospital did engage with staff and patients through the staff survey and Friends and Family Test; however, we did not see these results displayed and staff were not aware of them.

However:

- There was a good strategic vision for outpatient and diagnostic imaging services, and plans were in place to increase clinic facilities throughout outpatients, to help meet increasing service demands
- There was committed leadership in some areas and staff showed dedication to their patients and their responsibilities throughout most of outpatients and diagnostic imaging.
- Medical records staff felt much supported by senior managers, and were proud of the engagement they had with clinical staff in the development of some of their projects.
- Oncology staff had regular MDT governance meetings, with evidence of shared learning was available in an operational policy folder.

Vision and strategy for this service

- The values of the trust were that everyone counts, respect and dignity, commitment to quality of care, compassion, improving lives and working together for people, and staff had a good understanding of these values.
- The hospital had a clear vision for the future of its services, called the Integrated Care Organisation (ICO), which involved and utilised the community hospitals in

service delivery, as well as Torbay Hospital. Staff had a good understanding of this vision and could explain how it was going to affect their department. However, some staff from the community said that it still felt like a takeover rather than a merger of two organisations.

- There was an on-going project to reorganise the room usage in the existing outpatient department, with the programme of building to extend the ophthalmology clinic area due to finish soon. There was also an online 'live' availability system for clinic room and staff availability, which was 'going live' in the next two to three months, which would show available clinic rooms. In the diagnostic imaging department, the senior management team told us of their vision to create imaging hubs on several community sites, to reduce the number of aging standalone single x-ray room departments, and focus more resources in several larger, better-equipped departments.
- Consultant radiologist staffing levels were a factor in the development of the diagnostic imaging service, and the future planning was dependant on increased recruitment. However, senior radiology management told us they were considering other options such as outsourcing some reporting temporarily, to ensure specialist services were not affected by vacancy rates.
- Dermatology senior staff told us that there was a business plan to relocate all dermatology services to the annexe John Parkes Unit, and staff were aware of these plans, and thought it would be good as the current department felt divided.

Governance, risk management and quality measurement

- There was a clear governance structure in some outpatient departments and in diagnostic imaging. There were consultant and senior nurse leads for governance that oversaw and managed the governance processes for their departments. Regular meetings took place in some specialities, and there was evidence of business planning, and reporting structures between the specialties, division and trust board. However, some outpatient specialties did not have a clear view of the governance of their departments. Dermatology staff told us monthly meetings took place, but were unable to tell us what was discussed or to show us any minutes or learning from the meetings. In the oncology department, six governance meetings were held a year, and involved oncology, haematology, palliative care

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consultants, and senior nursing staff. Staff told us that process mapping had been discussed at the most recent meeting, and staff had created an action plan with a training element, to help reduce oral chemotherapy treatment delays. Echo-cardiographers said they had regular governance meetings and checked random samples of reports for quality and accuracy.

- The directorate divisional risk registers were well used. Aspects of outpatient care sat mainly in the surgical division, therapies and diagnostic imaging. On the surgical division risk register, trauma and orthopaedics outpatients referral to treatment times were flagged as a red risk, because the equipment used to diagnose patients with carpal tunnel syndrome, was no longer fit for use. The trust had approved funding to purchase new equipment, and it was due for delivery at the time of our inspection.
- Senior staff in the general outpatient department escalated a risk to board level about the inappropriate storage of liquid nitrogen. As a result, the chemical was moved to a safe storage area.
- Ophthalmology follow up patients, in particular those with macular degeneration, had been identified as a risk on the divisional register. We were told that that a macular coordinator had been appointed to manage the list, along with two additional specialist consultants. Consultants had categorised and prioritised the outstanding patients based on the length and severity of their condition, and the macular coordinator and clinical appointments were monitoring this, by giving patient's their appointments at recommended regular intervals.
- The majority of incidents reported in ophthalmology were due to delays in glaucoma follow up, and a number of patients who had delayed appointments, resulting in deteriorating vision. All of these patients were placed on an ophthalmology incident tracker.
- The diagnostic imaging department had its own risk register, with the radiologist staffing levels appearing on the surgical divisional risk register. Other risks on the diagnostic imaging register included the radio pharmacy in nuclear medicine. The radio pharmacy was not compliant with the British Nuclear Medicine Society

(BNMS) best practice guidelines, and the Radiation Protection Advisor (RPA) had escalated this to board level. The hospital had approved funding, and building was due to commence in mid-February 2016.

- Staff in the therapies division expressed concern over the lack of a suitable adult eating disorders service. Senior staff told us that the current service did not give patients all of the support that NICE guidelines state they should have. This issue was on the therapy risk register, and the Clinical Commissioning Group (CCG) was aware. However, staff felt they had escalated this as far as they could. Staff had raised the issue with the CCG consistently over the past two years, and the CCG had started to look at funding and staffing for the service, but had not made it a priority. The head of dietetics was in contact with the CCG on monthly basis.
- The dermatology outpatient department was carrying out minor surgical procedures in two procedure rooms that may involve cautery. Both rooms had little or no ventilation and no smoke extraction equipment. Staff we spoke to could not produce risk assessments for these procedures.
- Staff in medical records set up an action plan around note keeping, and learning had been identified and sent out to other departments. A recent audit of note keeping had then shown an improvement in dating, identification and usage of black ink in patients' medical notes.

Leadership of service

- Most of the managers we spoke to had a good understanding of the challenges facing their services, and had already identified actions to address them, which were evident from the divisional risk registers.
- There was some confusion in the general outpatient department as to who was responsible for the day-to-day running of some clinics. Senior staff in charge told us they were responsible for the allocation of staff and rooms, but that the responsibility of running the clinic lay with the specialty. Senior staff in the dermatology outpatient department told us all aspects of running a specialist clinic or list, lay with the sister in charge of outpatients, including room cleaning, emergency equipment checks and fridge temperature monitoring.

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- Cardiology staff told us there was no formal head of the department, since the early retirement of the last post holder five years ago, and a new head had been “talked about”, but nothing had happened. Staff told us the senior leadership did not hold any staff meetings.
- Staff in diagnostic imaging said they felt well supported by their managers, and said they were happy to approach them with problems, as did the medical records team who said they had a good team with strong leadership, and felt valued by their senior managers, with good support from the top down. Staff said the senior management met with the team once a month and provided support and knowledge, and gave the team confidence. Staff also told us they saw members of the trust board of executives in the departments, who were always approachable and friendly.
- The cancer waiting list team, told us they had very strong leadership within the service. However, they had identified a risk around sickness and annual leave when the head of the service was off, so a business case had been put forward to increase resources to strengthen the service.
- Staff spoke highly about their managers in some areas, and specific comments, both positive and negative were made to us about some service leads. In most of the outpatient departments and in diagnostic imaging staff said they were well supported by the senior executives, their managers and team leaders. Dermatology staff said they had been told what to say to Care Quality Commission inspectors when we visited their departments, and told us that they did not feel valued by the senior staff or management. Staff in cardiology said that there was a high turnover of staff, because there was no chance of career progression, or clear management structure. They said they believed this was the reason that they could not recruit staff.
- Senior staff in the general outpatient department used the vision and values of the organisation to evidence behaviours of staff. If staff did not follow these behaviours, the departmental sister spent time with the staff member to understand problems and issues.
- The trust gave out achievement recognition awards for outstanding practice, and we saw several of these displayed in CT and general outpatients. The non-executive chairperson presented the awards annually.
- Staff in the oncology outpatient department told us they had an operational policy folder in the department, which contained all the governance information in relation to the department. Staff also told us the department ranked the highest in terms of patient experience, in the South west, and these results along with thank you cards and letters, were in the operational policy folder.
- The hospital had a staff sickness target of 3.5%. In August 2015, all outpatient departments were under this, except the therapies department, who had a 4% staff sickness rate.

Public engagement

- Staff told us about a web channel that the hospital had been developed for staff, visitors and patients, which they thought was very useful.
- The breast care outpatient department had also involved patients directly in the updating and development of its patient information leaflets.

Staff engagement

- Staff in cancer services told us they were very proud of their engagement with clinical staff, and as a result, they did not meet any resistance when administration staff had to escalate patients on the waiting list to clinical staff.
- As part of the development of the Integrated Care Organisation (ICO), the hospital appointed a number of ICO champions from the staff, to share their views and tell other staff about the vision for the services in the future.
- Staff in the general outpatient department told us they had started having regular group discussions where

Culture within the service

- Staff in the dermatology outpatient department held clinics in an annexe building called the John Parkes Unit. Staff who worked in this unit told us the lead consultants “hardly ever visited” and the senior leadership did not visit the unit at all. Staff said the service felt spilt into two teams, and was “a bit of a mess”.

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they could talk about any aspect of their job. Senior staff attended these meetings and kept a record of the group discussions for evidence to help staff with their revalidation.

- The senior staff in the general outpatient department, told us they had created a quiz for staff that combined the trusts values and the CQC inspection, to help staff feel involved in the preparations.

Innovation, improvement and sustainability

- The trust had developed strong partnerships with other trusts that had led to a financial risk sharing agreement.
- The hospital had invested in the development of the Horizon Institute, in particular the virtual clinics for the

trailing of paper light computer systems. Clinical staff could experience using software before its roll out. Staff told us this was a good way of answering problems and keeping staff calm in the face of change.

- The trust had worked with education providers to deliver programmes of education and training and the development of a web channel had made accessing education and training easier.
- The trust had undertaken a benchmarking exercise in diagnostic imaging, and had performed well in the National Cancer Patient Experience Survey.
- The physiotherapy department had a well established direct referral service. Staff told us whilst this was not unique to the trust, it was well established and the department was often approached by other physiotherapy services for advice.

Patient transport services (PTS)

Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Outstanding	☆
Overall	Outstanding	☆

Information about the service

The patient transport service at Torbay and South Devon NHS Foundation Trust is registered to provide transport services and triage and medical advice provided remotely. The service had a fleet of 20 vehicles including ambulances that could cater for stretchers and wheelchairs, patient transport cars, bariatric ambulances and a four wheel drive ambulance.

The patient transport service undertook over 42,000 patient journeys from April 2014 to March 2015. Plans were to complete over 45,000 patient journeys from April 2015 to March 2016. The service had 72 full and part time staff and provided a transport service from 7.30am to midnight Monday to Friday and 9am to 10pm on a Saturday and Sunday. The majority of ambulances were based at Torbay hospital, with one vehicle based at Brixham and one at Newton Abbot.

Summary of findings

We rated this service as good with a number of outstanding features. We found the service to be well led with a stable and dedicated workforce that had been trained and supported appropriately. Systems were in place to repair and maintain the ambulances and the good governance structure enabled managers to have oversight of the whole service.

The patients we spoke with all gave positive feedback about the staff. We heard and observed staff going above and beyond what they were contracted to do. We found the service to be responsive to the patients' needs.

Patient transport services (PTS)

Are patient transport services safe?

Good



We have rated the patient transport services as good for safe because:

- There were processes in place to report unsafe incidents and we saw evidence that learning took place to prevent similar incidents from happening again.
- Staff had received their mandatory training, which included first aid, resuscitation, conflict management, infection control and safeguarding.
- Staff were aware of their role within safeguarding and gave us examples of where they had helped to safeguard vulnerable adults by following the trust policy.
- The ambulances we inspected were clean and tidy with appropriate and in date equipment. The provider had good systems in place for ensuring all the vehicles were serviced and maintained appropriately. We saw checklists that staff completed at the start of each shift were completed consistently and that any defects were repaired in a timely way.

However:

- We found some out of date fire extinguishers that were replaced immediately when we raised this with the managers of the service.
- We had concerns that the sluice was not fit for purpose and posed a risk of cross-contamination when cleaning the vehicles.

Incidents

- We saw evidence of learning from incidents. In one incident, two patients were waiting for discharge on the same ward. Because the patient details had not been checked adequately, one patient was taken to the wrong location. This incident was quickly rectified and processes put in place to prevent it happening again with staff double checking a patient's details with the patient themselves and the nurse looking after them on the ward.

- Incidents and learning were shared with staff via a variety of methods including one to one meetings with individual staff, team meetings, memo's displayed in the crew room and via the team newsletter.

- Staff understood their responsibilities to raise concerns and record incidents. Staff gave us examples of when they reported incidents to their team leaders or directly to the control room. Staff told us they were given feedback back from the managers or team leaders when necessary and appropriate.

- The staff we spoke with understood the '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, provide reasonable support to the relevant person in relation to the incident and offer an apology

- They were aware of the principles and gave examples of how and when it was put into action. Staff told us they always maintained an open and transparent approach when things did not go to plan. As an example, we saw where staff had apologised to a patient when confusion surrounded the discharge. This was also reiterated in the subsequent investigation and explanation to the patient.

Mandatory training

- Staff received mandatory training when they started work for the patient transport service as part of their induction.
- Every driver completed a comprehensive driver assessment before they were allowed to drive patients. These assessments were completed by a specialist instructor from the local authority. Where drivers were involved in accidents they were retrained and reassessed before being allowed back on the road.
- We looked at the training records for the patient transport service. The records showed that staff (including the team leaders) were up to date with all their mandatory training. The records showed 100% of staff had completed their mandatory clinical training (which included moving and handling, infection control, resuscitation and fire training, oxygen training, conflict resolution, information governance, equality and diversity and first aid), against a trust target of 90%.

Patient transport services (PTS)

- The staff had yearly mandatory training in core skills (health & safety, fire safety, equality and diversity, information governance, moving and handling, conflict resolution, infection control, resuscitation and safeguarding for adults and children). The administration staff within the patient transport services department maintained a training course tracker. This tracker highlighted each member of staff's training needs prior to the expiry of their current certificates. We were shown this tracker and we found it to be comprehensive and up to date.
- Staff were suitably trained, assessed and equipped to do their role safely.

Safeguarding

- Training records confirmed that 96% of staff had received adult safeguarding training, against a trust target of 90%. The patient transport service also conveyed a small number of children. Staff were undertaking children's safeguarding training at the time of our inspection. Only staff who had completed the children's safeguarding level two training were used to convey children.
- Staff had a good understanding of the different types of abuse and were aware of when to report concerns and who to report concerns to. They were aware of the trust policy for safeguarding and where to seek additional advice if they needed it.
- There were systems, processes and practices in place to help safeguard children and adults from abuse. Staff knew their responsibilities around safeguarding and would have no hesitation in reporting concerns. Staff gave an example; one crew noticed one of their regular patients was not their usual self. It was identified that the patient might have been experiencing abuse. Referrals were made to the appropriate services in line with trust policy. This meant the patient received the help and support they needed.

Cleanliness, infection control and hygiene

- The patient transport service had its own sluice that was used for cleaning the vehicles and disposing of the dirty water. We raised concerns with the managers because the sluice was not in a condition where it could be kept clean and this increased the risk of cross-contamination. Our concerns were responded to immediately by the

service managers. Plans were put in place before we left the inspection to replace the flooring, walls and ceiling, install additional shelves and a new hand wash basin for staff. The managers had worked with the estates department and the infection control team to make sure the changes would be fit for purpose. We were told this work would start immediately following our inspection.

- Systems were in place to protect patients and staff from healthcare-associated infections and the risk of cross-infection. The crews were responsible for keeping their vehicle clean. This involved cleaning equipment and the vehicle between patients, and a more comprehensive clean at the end of their shift (which included the outside of the vehicle). A cleaning schedule was in place and being followed at the time of our inspection was awaiting approval from the trust's infection control team.
- Each vehicle was equipped with hand sanitizer and personal protective equipment, such as gloves and aprons. We observed staff using this equipment appropriately.
- We looked at eight vehicles during our inspection. All but one of these vehicles were clean and tidy. The one vehicle we observed that was dirty had just returned from use and was due to undergo its daily clean. This vehicle did not present any risk to patients and staff confirmed it would not be used again until it had been fully cleaned. The following day we subsequently observed patient care on the vehicle and it had been prepared for use to a high standard.
- Equipment was available on each of the vehicles to contain and clean spillages, such as blood and bodily fluids. Staff were able to describe how they would clean equipment or the ambulance, including using the appropriate personal protective equipment.
- Where specific patients had problems that might be an infection risk to others, this information was obtained on booking and passed onto the crews. The information was communicated via the electronic communication system and/or via mobile phones.

Environment and equipment

- The patient transport service team had good systems in place for the maintenance and repair of their vehicles. Vehicles were serviced in accordance with the manufacturer's instructions. Each September, the

Patient transport services (PTS)

planners booked each ambulance in for their routine servicing at specific times for the year ahead. This meant the team leaders knew exactly when each vehicle was going to be off the road and could plan the crew and vehicle allocation against patient demand accordingly. In between the yearly routine servicing each vehicle underwent six monthly safety checks. These checks included all the equipment on that vehicle such as stretchers, wheelchairs and ramps. The administration team kept an up to date database which showed the details of each vehicle, Ministry of Transport (MOT) expiry dates, servicing and safety checks. This showed us that each vehicle was roadworthy and up to date with its servicing and safety checks.

- The patient transport service was accredited by the Fleet Transport Association to have successfully passed the 'van excellence' audits four years in a row. The service commissioned these yearly audits to be undertaken. This was an industry-led initiative that aimed to enhance the standards of van operator compliance and celebrate excellence. At the time of our inspection, the patient transport service at Torbay Hospital was one of only five ambulance services in England to commission this audit for its vehicle fleet. We saw that the service had successfully achieved high scores for the past four years. The audits covered driver competencies, the checks carried out on the ambulances, the maintenance, risk assessments, insurance and MOT (Ministry of Transport) testing. Each year the service was shown to have robust systems in place.

- We were told that all ambulances were to be replaced between December 2016 and April 2017. The vehicles had been specified with stair climbers (specialist equipment to help staff move patients up and down stairs safely and effectively) on each vehicle. Additionally, several vehicles were being adapted to make sure they were suitable for new developments and initiatives within the service, such as the development of a high dependency transport service.

- During our inspection we found several fire extinguishers on the ambulances to be out of date. We raised this with the managers. Within five minutes the fire safety company had been contacted and they arrived

later in the day to replace the extinguishers. We were told that the vehicle checklists would be changed to incorporate an expiry date rather than just the fact the extinguishers were present on each vehicle.

- Before the start of each shift, crews had to complete a number of checks on their vehicle and equipment to make sure it was safe to use. Checks included lights were working, tyres were in good condition, all the necessary equipment was in place and the vehicle was fully fuelled. Completed checklists were reviewed by the team leaders and either signed off as correct or followed up where issues had been identified. If any defects were found, these were noted on the checklists. The administration team would then update the checklists to show when the defects had been fixed. We inspected 40 checklists and found they were completed appropriately. We checked the defects that had been identified on a number of vehicles and saw they had been resolved quickly. As an example, a side indicator light was not working on one vehicle and was repaired within 24 hours. In another example, one tyre was reported to have a low tread. It was assessed by a specialist tyre provider who replaced the tyres as appropriate to ensure the vehicle was roadworthy.

- We asked how staff and managers knew when vehicles should be taken out of service if defects were serious. We were told that advice was always sought from their specialist providers who maintained their vehicles. If they recommended a vehicle was taken out of service until a repair could be made, the advice was always followed. The records we saw relating to vehicle maintenance confirmed this. The provider did not have onsite mechanics available, but had systems in place with local transport companies to repair and maintain the vehicles.

- The patient transport service had a range of vehicles at its disposal including ambulances able to take stretchers, a bariatric ambulance for larger patients, ambulances able to accommodate wheelchairs and a four wheel drive ambulance for adverse weather conditions. Each vehicle carried first aid kits, defibrillators and oxygen. We found these to be correctly stocked and in date on the eight vehicles we inspected. Seat belts and/or and stretcher restraints were fitted to all vehicles.

Medicines

Patient transport services (PTS)

- There was no separate policy for the use of oxygen within the patient transport services and no mention of patient transport services within the trust's medicines management policy. However, staff were aware they could only administer oxygen in the event of an emergency situation. If a patient was to be transported using oxygen, staff followed the guidance and prescription of the clinical staff caring for the patient. Competencies in the use of oxygen were assessed during the mandatory training for resuscitation and first aid.
- Oxygen was available on all vehicles used in the patient transport service. Cylinders were checked on a daily basis and following our inspection, expiry dates would be checked and recorded on the vehicle check sheets. Oxygen was obtained from the main hospital stores when necessary.
- Staff confirmed they did carry TTAs/TTOs (medicines issued by the hospital for patients to take home) but did not administer patients' own medicines.
- Staff told us they would remind patients before leaving home to check they had any necessary medicines with them, together with any other belongings they needed.

Records

- Each patient transport vehicle was fitted with a satellite navigation, communication and tracking system. This was linked to the control room and allowed instant messages to be both sent and received in the vehicle. Changes to journeys and additional journeys could all be notified to the crew via this secure system. Mobile telephones and paper booking sheets were also available as a back-up as necessary.
- The booking sheets and the electronic system had all the details the crew needed to safely convey each patient. This included any special information on access that the crew might need. It informed the crew of any special needs each patient might have such as needs a wheel chair, or help with mobilising.

Assessing and responding to patient risk

- At the time of booking, the patient's weight was obtained. This allowed staff to assess whether any additional equipment was needed. As an example, powered stair lift carry chairs were used to make it easier for chair bound patients to be helped up and down stairs.

- Staff told us they had received first aid training. This gave them the basic grounding to assess whether a patient needed more care than they could provide. Staff gave us examples of when they had used these skills. For example, picking up a patient referred by a GP that had deteriorated since accepting the call. If a patient had deteriorated, staff would contact their control room, and the GP informed and an emergency ambulance contacted.
- Staff told us that when they took a patient back to their own home, if they were not happy to leave them they would discuss with the patient and the control room to decide on the best course of action. As an example, the heating and electricity was not working in one patient's home. The staff did not feel it was suitable to leave the patient and after discussions agreed to return the patient back to the hospital. This showed that staff assessed the patient safety even when they had fulfilled their responsibilities in transporting the patient to their destination. A number of staff told us that if they were not happy with the safety of a patient, they would not leave them.
- We were told of a number of specific risk assessments which had been completed, and staff knew about the action plans. For example, one patient lived in a bungalow with a very steep driveway so the team leader had visited the property and assessed the risk. Action was taken to minimise the risk with the patient agreeing to the removal of surface moss. Advice for staff to use appropriate moving and handling equipment, especially in adverse weather, was then circulated.
- Patients' needs were assessed by the call centre staff as part of the booking process. This allowed the planners and control room staff to allocate the most appropriate crew and vehicle for that patient's needs. As an example, a patient who needed a stretcher would require a suitable ambulance and a two-person crew.
- Staff we spoke with told us it was routine for them to undertake dynamic risk assessments of their patients when they arrived. This was a visual risk assessment primarily looking at the patient's mobility, but also whether there were other health needs which meant they needed the specialised care of a paramedic crew.
- If a patient deteriorated during the journey, the crews were able to call for assistance from the emergency

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services or take other appropriate action. The staff we spoke with gave examples of the actions they had taken. As an example, a patient had been discharged from the emergency department and was found to be bleeding in the patient transport ambulance. The staff used their first aid knowledge to put pressure to help stop the bleeding and returned the patient to the emergency department.

- Crews were alerted by the control room staff if a patient was not for resuscitation and confirmed this with staff when they collected the patient.

Staffing

- The sickness rates for the patient transport had risen to 12% in May 2015 and had been consistently above 7% from April 2015 to September 2015. However, this had started to reduce as staff had returned to work. In November and December 2015 the sickness rates had dropped to 3% against a trust target of 4% or below.
- At the time of our inspection, the patient transport team had a very stable workforce and a low turnover of staff. The staffing consisted of 6.9 whole time equivalent (WTE) administration staff, 41.6 WTE patient transport service crew, 5.5 WTE team leaders and 2 WTE managers. We were told by staff that it was an excellent service to work for and they did not have any problems in recruiting new staff. At the time of our inspection there were 0.88 WTE admin vacancies and 1 WTE team leader vacancies. Staff within the service worked to cover additional shifts as required for annual leave or unexpected sickness. We did not see any evidence that agency staff were used.
- The patient transport staff worked as two or single person crews depending on the patient's needs.

Anticipated resource and capacity risks

- We saw that each vehicle was fitted with external facing cameras. We saw evidence that since these had been fitted, the number of insurance claims by third parties as a result of minor accidents had reduced by over 50 thousand pounds in one year. This made sure the service was not needlessly paying inappropriate insurance claims from accidents.
- At the time of our inspection the control room opened from 7.30am until 6pm. This meant that out of those hours, the hospital bed management team took on the role of managing transport services. It was recognised this was not a good use of resources because the bed

managers needed to focus on patient flow throughout the hospital. The patient transport service was looking to extend the control room until 10pm to manage demand for transport services more effectively.

- We saw evidence of where additional training was provided to staff when risks had been identified accessing a patient's property. As an example one patient had a very steep drive down to their house. When the risk had been identified, team leaders visited the property and asked for measures to be taken to reduce any risk. This advice included any specialist equipment that could be used or any actions the patient needed to action, such as cleaning the moss from the drive which would reduce the chance of slipping.
- We spent time in the call centre planning and control room. We saw the planners only planned the first few journeys of the following day. After that point, all the planning was 'live' and altered in response to changing demands. Usually, patient transport services were planned for the whole day; however, this system worked locally for Torbay hospitals and made the system more responsive to the demands of the service.
- To support the patient transport service crews, voluntary care services were used. There was a pool of 20 voluntary drivers that were able to take individual patients on their journey to the hospital or back home.
- We saw the service had plans in place to manage demands from the main hospital and changes relating to adverse weather. The service had a specialist four wheel drive ambulance which could be used in the event of floods/snow. The control room kept in contact with the local ferry companies and could re-route ambulances as necessary where the sea state affected the ferry sailings.

Are patient transport services effective?

Good



We have rated the patient transport services as good for effective because:

- All relevant information about individual patients was taken by call centre staff during booking. This information was passed to staff on vehicles so they were able to provide the best possible care for their patients.

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- The service performed well against key performance indicators for picking patients up from home and from the wards.
- The patient transport service had competent staff who provided good care to patients and were encouraged to develop their skills both for their current role and future career.
- All staff had received their appraisals and team leaders had protected time where they could complete administration tasks. For the remainder of their week, team leaders were able to travel alongside the crews and perform observations, risk assessments and additional training. We observed good working relationships internally between road crews and planning and control, and externally with all the wards and departments within the trust as well as commissioners, GP's and care homes.

Evidence-based care and treatment

- The Department of Health and NHS England set the eligibility criteria for patient transport services across England. We saw evidence that these criteria were used to determine which patients could access the transport service. We observed staff in the call centre asking appropriate questions to assess a patient's eligibility. Where patients did not meet the criteria, other options were offered such as voluntary cars, community transport or a hospital transport service that patients could pay for.
- Yearly audits were commissioned by the service and carried out by an external organisation, which focused on the systems the provider had in place to manage its fleet of ambulances in line with best practice.

Assessment and planning of care

- Patient transport services provided non-emergency transport for patients who were either attending hospitals for an appointment or being discharged.
- All relevant information, such as individual patient needs, do not resuscitate orders, escorts and end of life care plans were taken by the call centre staff when booking the transport. This information was passed onto the crews manning the ambulance.
- Team leaders would attend patients' homes when necessary to carry out additional risk assessments where access was a problem or staff needed additional support.

- Staff kept in regular contact with the control room if traffic conditions meant they would arrive later than expected. Patients were also contacted to confirm the ambulance was on its way or if any delays were expected.
- During our observation of the control room, we saw how they communicated with the crews out on the road. As an example, one crew reported a road traffic accident had closed a particular road. The control room staff were able to send one message to all the road crews alerting them to stay clear of the area. This was done via the electronic navigation system. This saved time because the control room did not have to phone each individual crew separately.

Nutrition and hydration

- The patient transport service staff did not routinely provide nutrition or hydration to their patients because the journey times were low. When they needed to carry out a long journey out of area, arrangements were made to make sure the patient had water and a snack box ready for the journey.

Patient outcomes

- Patients must meet the Department of Health (DH) national guideline for patient transport service eligibility to use the service. This was assessed by experienced call takers for eligibility on either medical, mobility or access issues. The service had seen an increase in the number of patient journeys completed each year. In 2013/2014 the service completed over 40,000 patient journeys. This rose to over 42,000 patient journeys in 2014/2015 and was projected to be over 45,000 for the current financial year (2015/2016).
- We looked at the key performance figures which showed overall the patient transport service was performing well. In December 2015 the call centre took 3,187 calls and answered the calls on average within 70 seconds. The service made 2,897 patient journeys during December with 12% (348) of those being same day bookings.
- The service had two primary key performance indicators: one for dropping off patients for their admission or outpatient appointment; the other for picking patients up from wards and departments to transfer them home. In December 2015, 99.9% of patients arrived at the hospital no more than 60 minutes before their appointment time (against a target of 90%). Over the

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five month period September 2015 to January 2016, the service consistently scored above 99% for this target. Ideally, patients should arrive just before their appointment and the patient transport service achieved this in 91% of its journeys (against a target of 95%) over the same five month period.

- On discharge, patients should be picked up at their agreed discharge time. The patient transport service achieved 77.6% for picking up patients within an hour of their agreed time, against a target of 90%. Over the five month period September 2015 to January 2016, the service achieved between 69% and 91% for picking patients up within an hour of their agreed time. Another performance indicator was for picking patients up within 90 minutes of their agreed time. The target (set by the commissioners) was 95% and over the five month period the service achieved between 84% and 95%. We looked at the performance figures for four months. This showed the patient transport service was consistently achieving similar performance month on month. None of the patients we spoke with during this inspection waited longer than 30 minutes for their transport to arrive either to collect them from home or the hospital.

Competent staff

- Combined trust compliance rate for appraisals as of September 2015 was 84%. For the patient transport service team it was 100%. We saw examples of where additional training was discussed and encouraged with staff during their appraisals.
- Staff told us they were supported to undertake additional training, whether this was for their role, to enhance patient care or for career development. This included training in customer care and dementia. Staff were also given the opportunity to have extended training such as dementia so they could be champions in that particular area. Additional training was being organised at the time of our inspection in the care of children because of the increase in the number of children the service expected to see being transported in the future.
- The provider carried out annual checks on all their drivers to make sure they were fit to drive. These checks included whether drivers had points on their licence or had medical conditions that might affect their driving ability. All drivers received a driving assessment. This

training was provided before the drivers were allowed to transport patients. No follow-up driving assessments were carried out unless an accident had taken place or the team leaders had decided it was necessary following observation.

- The four operational team leaders provided cover from Monday to Friday 7.30am to 8pm and evenings / nights 6pm to 7.30am with an on-call arrangement at the weekends. Their role was to provide on the road observation and feedback, which supported staff development. The team leaders themselves had completed a level two leadership course and were completing training to level three in the national vocational qualifications in management. The team leaders were given two days' protected time to complete office based tasks. For the remainder of their time they worked with their crews to complete individual observations and assessments.
- All new staff completed the trust induction and a period of two to three weeks where the staff would accompany a more experienced crew. During this time their competencies would be assessed and mandatory training completed. Crews were not allowed to care for patients until they had completed their training and passed the relevant competencies.

Coordination with other providers

- The patient transport service worked closely with all the departments across the trust, as well as with external providers such as nursing homes, social services and other NHS trusts.
- Approximately six months before our inspection, the service had started transporting suitable GP admissions. This meant a close working relationship was established with the local GPs. GPs were able to book transport for their patient if they were medically suitable, reducing the need for an emergency ambulance.

Multidisciplinary working

- The standard operating procedures for the patient transport service were clear about the actions staff needed to take when a patient was not for attempted resuscitation. This included obtaining the necessary

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forms signed and dated by the doctor. The staff we spoke with during this inspection were all aware of their role and responsibilities surrounding 'do not resuscitate' instructions.

- We saw evidence of good multidisciplinary working. As an example, a staff member from the patient transport service control room attended the daily bed meeting every weekday morning. This meeting was attended by senior clinical staff and managers to look at capacity and demand across the trust. The patient transport service fed into this so they knew the demand for discharges and could plan accordingly. Also, trust staff knew what resources were available to accommodate timely discharges from the wards.
- The patient transport service had good links with other agencies, such as social services. The ethos of the department was that as long as it improved the patient experience, they would do what they could to help. 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.

Access to information

- Staff were provided with patient information (including name, address and any special information the crews needed to be aware of) via their secure vehicle data terminals. Paper versions of the booking form were also available as a back-up. Updates could be sent via the terminals or via the mobile phones in each vehicle.
- Ward staff would relay any necessary information to the ambulance booking staff who would pass it onto the appropriate crews. Any additional information would be passed directly from the ward staff to the crew when they arrived to collect the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff asking patients for their consent prior to transporting them in the ambulance. Staff explained what was happening to patients. All staff had received additional training to care for patients with dementia.

Are patient transport services caring?

Outstanding



We have rated the patient transport service to be outstanding for caring because:

- The feedback we received both from patients and other health care staff was all extremely positive.
- We heard numerous examples of where staff went 'above and beyond' what was expected from them in order to make their patients as comfortable as possible.
- The priority for staff was to make the patient's experience of transport as good as it could be.

Compassionate care

- During our inspection we spent time on the ambulances observing how staff cared for their patients.
- We saw and heard of a number of examples where staff went above and beyond in the care they provided to their patients. The crews were proud of the care they provided. As an example, they would make sure the patient's home was warm on their return and that adequate welfare resources were in place, such as milk where there was none. One member of staff told us that for one patient, they made sure their phone was within reach when they left so they felt secure. Staff told us it was these little things they did that made a big difference to their patients. Another example was for a patient who had an automatic alarm system to summon help should they need it at home. When the staff brought this patient back home, they pressed the alarm button to make sure the system was working and that the company knew the person was back in their own home. This helped the patient to feel safer when returning home alone.
- We spoke with 19 patients during this inspection and all of them had very positive comments about the transport and the staff. Their comments included "the staff are always polite and professional", "The service I have received has been good and I always feel safe with the staff", "I can't speak highly enough of the service, the pleasant staff go the extra mile", "The staff always help, I can't think of anything they could do better", "I use the

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service three times a week and I could not ask for more, they treat me very well”, “I am very pleased with the service, they even take care going over pot holes, nothing is too much trouble for them”.

- Staff told us that a priority for them was to maintain the dignity of patients. As an example, a frequent occurrence that staff dealt with was continence of patients. To maintain the patient’s dignity, if possible the ambulance would divert to the nearest community hospital so the patient could use the facilities. When this was not possible, blankets could be used to maintain the privacy of the patients when using disposable toilet facilities on the ambulance.

- Occasionally, crews were asked to help end of life patients to go home to be with their families. Staff told us they had special vacuum mattresses available to make the journey as comfortable for the patient as possible. Staff told us of one patient who 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.

- In another example of where staff went above and beyond, we observed a patient who was conveyed to their outpatient appointment. The staff made sure the patient was seated and that the outpatient staff were aware of their arrival. At this point the duty of care had transferred to the outpatient department. As the crew were leaving the department they noticed the patient trying to make their way to the toilet. The crew escorted the patient and made sure they were safely seated again.

Understanding and involvement of patients and those close to them

- Patients were able to contact the call centre to book, cancel or amend their transport booking. Bookings could also be made by hospital staff, care home staff or GPs as necessary.
- We observed staff involving patients and their families in the transport journeys.

- The patients we spoke with told us they were kept informed of any delays either in being picked up or during the journey. Patients also confirmed that staff would phone them when they were on their way.

- Satisfaction surveys were kept on each vehicle and given out to patients with a pre-paid envelope for them to return the completed surveys to the hospital. At the time of our inspection, 93% of patients who completed the survey were extremely likely or likely to recommend the patient transport service of Torbay hospital.

Emotional support

- We observed staff supporting patients before, during and after their journey. One patient told us they were a very nervous passenger, but the staff made the journey as easy as possible for them and made them feel safe. This was a view shared by other patients we spoke with during this inspection.

- Staff had been trained in conflict resolution techniques and were able to use distraction techniques where necessary to support individual patients.

Supporting people to manage their own health

- We observed how staff listened to patients and their individual needs. Patients were encouraged to use their own mobility aids where possible. For example, using a patient’s own wheelchair which would be more comfortable for them. Staff also reminded patients about their own property or medicines that they needed to take with them.

Are patient transport services responsive?

Good



We have rated the patient transport service as good in responsive because:

- The service operated seven days a week and had the resources to adapt to the changing demands of the trust.
- Journeys were planned until 11am the next day, after which journeys were booked as they came in. This meant the service could respond to changing demands in the hospital, discharging patients to improve patient flow throughout the trust.

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- The service was able to convey suitable GP admissions direct to the ward, which meant an emergency ambulance did not have to be used and the patient did not have to wait in the emergency department.
- The service had a vehicle that could take specialist patient transfer trolleys for surgical patients and babies from the special care baby unit.
- The patient transport service provided the vehicle and driver, and the clinical staff from the ward would escort the patient. This meant timely transfers could take place without the need to book an emergency paramedic ambulance.
- We saw the service had systems in place so that patients could raise complaints if they needed to. These were investigated appropriately and lessons learnt where applicable.

Service planning and delivery to meet the needs of local people

- The service operated from 7.30am to 11.59pm Monday to Friday and at the weekend between 9am and 10pm. There was a very good understanding between the patient transport service and the wards and departments within the hospital. Crews understood the reasons why patients were sometimes not ready when they arrived and liaised with the ward team to make sure the patient did not wait unnecessarily.
- One new initiative that had been in operation for approximately six months before our inspection was conveying GP admissions. GPs were given the eligibility criteria and if they needed to admit patients that did not require a paramedic crew, they could book transport to the hospital. This meant that patients did not have to use an emergency ambulance and did not have to be admitted via the emergency department.
- During our inspection we observed the planning and control room. Planned patient journeys were planned up until 11am on the following day. After this time journeys were planned depending on capacity and the needs of the hospital and the patient priority. A member of the control room staff attended the bed meeting every morning. This made them aware of the capacity issues within the hospital and which wards would need to be prioritised for their discharges.

- The control room used live satellite tracking for all of their vehicles. This allowed for last minute changes to be made in response to the hospital needs. It also allowed journeys to be rerouted because of traffic conditions, roadworks or accidents.
- Patient journeys could be booked in advance or booked on the same day, depending on the patient needs and demand within the hospital.

Meeting people's individual needs

- Interpreting facilities were available for all staff to use within the trust, including those within the patient transport service. Face to face interpreters and a telephone interpreting service were available. The staff we spoke with knew how to access the service should patients need it, but also told us that they had never had cause to use it. As an example, one crew told us they had conveyed one patient who did not speak English, but they had an escort with them from the residential home who acted as interpreter.
- During our observation on the patient transport journeys, we saw staff changed their processes depending on the individual needs of each patient. As an example, one patient had been booked as needing a wheelchair. When the crew arrived at the patient's house, the patient had their own wheelchair and it was agreed with the patient this is what they would use. This meant the patient was a lot more comfortable on their journey in their own wheelchair.
- In another example, we saw how well staff communicated with patients who had difficulty with their speech. The staff took time to communicate using careful listening and observing the patients non-verbal communication. This showed staff had a good understanding of the communication difficulties some patients faced.
- The booking process captured important information that was relevant to each patient, such as if they needed to travel alone, if they had an escort with them, if they had mobility issues or if they were not for attempted resuscitation.
- A specially adapted bariatric ambulance was available for larger patients. Staff had received training in moving and handling which meant they had the necessary skills to support larger patients.

Patient transport services (PTS)

- All staff had been trained in conflict management which gave them skills to deal with potentially violent or aggressive patients.

Access and flow

- The patient transport service at Torbay hospital had started transferring stable GP admissions instead of the patient having to wait for an emergency ambulance. This made sure that suitable patients were conveyed to hospital as quickly as possible without taking up emergency resources that might be needed for more serious patients. This resulted in a reduction of approximately four to five patients a day being seen in the emergency department via an emergency ambulance. Instead, the patients that were assessed by the GP were picked up in a non-emergency patient transport ambulance and taken directly to their admission ward.
- Where possible staff would phone patients to indicate an arrival time. We saw this took place during our observations on the ambulances.
- Eligibility criteria for patient transport was determined by the commissioners of the service and based on national guidance for the non-emergency transport of patients. Additional services had been developed in conjunction with the commissioners, such as the GP urgent admissions. Referrals were made via the call centre where details were recorded directly into the patient transport management system. These appeared live on the planners' and control room staff computers to allow easy confirmation of the transport, and scheduling of the journey. Callers were given their booking reference numbers to confirm the journey.
- One vehicle 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 surgical ward or special care baby unit. The new fleet due later in 2016 was planned to have more vehicles to take specialist patient care trolleys to improve transfers from the hospital to other NHS units. The service was responsive to the ward and patient needs and reduced the need to call on emergency vehicles from the NHS ambulance trust.

Learning from complaints and concerns

- The patient transport service followed the trust's complaints policy. Staff told us they tried to resolve any concerns patients might have as they arrived. If a complaint was received, it was investigated appropriately and a response provided. We saw examples of where actions had been taken as a result of complaints. As an example, when the clinical commissioning group requested that the eligibility criteria be applied, the number of complaints rose. The patient transport team worked with the Patient Advice and Liaison Service (PALS) to revise the wording and delivery of the criteria to be more supportive. Following this change and improved training, the complaints reduced.
- Data provided by the trust before our inspection showed that 12 complaints were received since April 2015. These mostly related to timeliness. Complaints were shared with staff where appropriate. Any learning identified was shared with staff via team meetings and memo's displayed in the crew rest room.

Are patient transport services well-led?

Outstanding



We have rated the patient transport service as outstanding for well-led because:

- The service had good governance structures in place, and the staff, services managers and divisional managers knew the service very well.
- The provider had sought external accreditation for its vehicle fleet for the past five years.
- When we raised concerns to the managers about out of date fire extinguishers and the suitability of the sluice, the response was immediate. The management resolved one of our concerns instantly and put plans in place to resolve the second.
- All the staff we spoke with about the patient transport service were very proud of the service they provided. They were not complacent and were continually looking at how to improve the service and the overall patient experience.
- We found the culture of the service to be one where the patient was the priority. We saw this culture reflected in the day to day care the staff were providing.

Patient transport services (PTS)

- New initiatives were being planned in response to patient and trust needs. Other acute trusts had also been in contact with the patient transport services to see how the service was provided and whether it was something they could replicate in their own organisation.

Vision and strategy for this service

- The trust had a vision and the staff within the patient transport service were aware of this and the role they played in helping the trust to achieve it.
- The staff and leaders of the patient transport service had a vision that the service would be an all-encompassing transport service. Managers told us this meant their aim was to be as responsive to their patients' needs as possible, to respond to any gaps identified within patient transport and to make the experience of their local patients as best as it can be. The development of the service, such as transporting GP admissions, was part of the vision. Future developments that were being considered included a high dependency and intermediate care transport service. The service was also looking to advise other trusts about how they could develop their own patient transport service.

Governance, risk management and quality measurement

- The patient transport service had good systems of governance in place. Performance indicators and any concerns were escalated to the patient flow group, which reported to the trust board via the senior business management meeting. The patient transport service team sat within the corporate operations service directorate and reported to the head of operations and chief operating officer.
- We saw documents that showed key performance indicators were reported monthly to the local clinical commissioning group. The managers met regularly with the team leaders and the head of operations. The team leaders worked very closely with their teams and were able to feedback information from the trust directly to staff.
- Patient flow meetings were held monthly, which fed into the trust board via the monthly senior business management team meeting.
- Regular monthly meetings took place between the patient transport service and the clinical commissioning

group. We saw minutes of these meetings. These showed eligibility criteria, funding and new initiatives were discussed. The service also participated in other meetings, such as the Devon health transport forum.

- A risk register was in place. At the time of our inspection there were three risks, which managers and staff were all aware of. The risks were reviewed regularly and updated when necessary. As an example, one of the risks related to the long term suitability of the fleet. The outcome was to replace the fleet of ambulances with new vehicles from December 2016.

Leadership of service

- Staff felt supported by their immediate team leaders and the managers of the service. The managers told us they were very well supported by the divisional directorate managers and the director responsible for the service.
- The managers of the service were proud of the patient transport service and the staff and spoke highly of them. We also saw this pride replicated in the senior managers that we spoke with during this inspection.
- Two operational managers were responsible for overseeing the day to day management of the patient transport service. Four team leaders were then responsible for overseeing a number of crew.
- All staff had a designated team leader. Staff were aware of who their team leader was and who the managers of the service were. We were told the team leaders and managers of the patient transport service were always visible and approachable. Staff said they were able to raise issues and concerns if necessary and had confidence they would be listened to. Staff told us they felt reassured that their managers would resolve any issues or concerns raised with them.
- The team leaders themselves had completed a level two leadership course and were completing training to level three in the national vocational qualifications in management.

Culture within the service

Patient transport services (PTS)

- The staff we spoke with told us they felt part of a strong, close-knit team. During our inspection this was evident. Staff worked well together and we saw that communication was good between crews and control room and planning staff.
- Staff told us they felt proud to work for the service, and whilst they felt like an important part of the patient transport team they also felt like part of the overall trust. They felt the trust let them get on with their jobs and believed this reflected the confidence senior managers had in the service.
- Staff felt respected by their colleagues and managers and told us the service was open and honest both towards staff and patients.
- The culture of the patient transport service was one that put patients at the heart of what they did. During our inspection we heard a number of comments from staff which illustrated this culture. Comments included: “our patients are people not numbers”, “patients are out priority, we try to go above and beyond for them”.

Public and staff engagement

- The patient transport service handed out satisfaction surveys to patients as part of the friends and family tests. The response rate was low and staff felt that patients had already been asked the same questions for the ward or other departments and felt reluctant to answer them again for the transport service. Prepaid and addressed envelopes were provided to make it easier for patients to return the forms. From April to October 2015, 105 completed questionnaires were returned from patients. Of the patients who returned the questionnaires, 98 (93%) were extremely likely or likely to recommend the service to others.

- We saw evidence that staff were involved in decisions that affected the service. As an example, a consultation was held with staff about extending the control room opening hours until 10pm. Staff had a chance to ask questions and raise any concerns. We were also told that staff were involved in discussions about the specifications for the new ambulance fleet due later in 2016.
- Systems were in place to provide feedback to staff, such as through one to one meetings, team meetings, memos that all staff could refer to and via the internal staff newsletter.

Innovation, improvement and sustainability

- Torbay and South Devon NHS Foundation Trust is one of the only acute trusts in the country who provide their own in house patient transport services. At the time of our inspection two other large acute hospitals in the south west were looking at Torbay’s patient transport service to see if they could model similar services at their own hospitals.
- The service was looking to see how it could improve and develop services without detracting from the quality care provided to patients. New innovations included the transportation of intermediate care patients and high dependency patients.
- Intermediate care patients (patients being moved from their home to another care setting such as a nursing home) were transferred using emergency ambulances. The patient transport service was investigating how they could assist with transferring these patients on the same day using their non-emergency vehicles, which would free up emergency resources and provide a more timely transfer for the patient.

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 their care.
- In the middle of the surgery recovery 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 innovative 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 medicines. 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.

- One vehicle 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 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 system 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 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

Outstanding practice and areas for improvement

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.

Areas for improvement

Action the hospital 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 hours a day, seven days 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.

Outstanding practice and areas for improvement

- 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.
- The trust should ensure that sharps bins are used correctly and are not accessible to the public.
- Staff should be aware of consistent management of paediatrics through the emergency department and ensure children's safety.
- The damaged areas of the emergency department should be repaired to ensure the safety of patients and reduce any risks of cross-infection.
- The trust should ensure staff are supported with sufficient training for the risks associated with mental health patients spending long periods of time in the emergency department.
- The trust should ensure staff are supported with sufficient training for the safeguarding of patients and protect them from avoidable harm
- The trust should ensure hand hygiene audits are completed for the emergency department.
- Staff appraisal rates for staff in the emergency department were low and the trust should ensure these are completed.
- The trust should ensure information communication is known consistently by all staff. This included the alerting of patients with a learning disability to the wider hospital.
- The trust should ensure doctors complete patient records with legible signatures, designations and the use of the General Medical Council stamp.
- The trust should ensure adequate stock control policies and procedures are in place to ensure expired clinical products are disposed of in a timely manner.
- The trust should ensure clinicians are aware of infection control procedures and comply with hand-washing guidelines when assessing and treating patients.
- The trust should ensure nurses and other staff working in clinical areas are offered a robust and timely response to concerns they raise and incidents they report.

Action the hospital SHOULD take to improve

- The trust should ensure that the privacy and dignity of patients in the resuscitation area of the emergency department is maintained and not overlooked from the adjacent corridor.
- The trust should review the security of injectable medicines on trolleys that are widely accessible in the emergency department.

Outstanding practice and areas for improvement

- The trust should consider the provision of practical de-escalation and breakaway training for ward-based staff, particularly on the EAU units and care of the elderly wards.
- The trust should consider providing staff on medical wards with de-escalation and breakaway training to support them in caring for people who present with dementia-related violence.
- The trust should do all that is reasonably possible to reduce the numbers of patients waiting over 18 weeks for treatment.
- The trust should reduce the numbers of operations being cancelled.
- The trust should improve the completion of care planning summaries within 24 hours
- The trust should ensure that record keeping for emergency equipment checks are done in line with trust policy and therefore in line with national guidance from the resuscitation council.
- The trust should improve access into the surgical assessment unit to allow for stretchered patients to be assessed in that facility.
- Intravenous fluid storage in the critical care unit should be improved to ensure these cannot be tampered with.
- The recording of mandatory training compliance in critical care should be improved so that this is easily accessible and reportable.
- The trust should ensure plans to relocate the antenatal and gynaecology clinics and as a result, improve the privacy and dignity issues for women attending fertility clinics and the early pregnancy clinics, continue.
- The trust should continue to consider plans around delivering the Day Assessment Unit service to ensure women receive an effective service with adequate staffing levels and reduced waiting times when using the service.
- The trust should continue to consider the best arrangements for ensuring screening blood tests taken from babies reach the external laboratory in time for the sample to be read and that staff are all trained to complete the blood spot card effectively. This would mean fewer babies are called back for a repeat test.
- The trust should work with partners to eliminate unnecessary delays in accessing the Children's and Adolescents Mental Health Services, particularly out of hours and at weekends.
- The trust should review facilities for parents on the special care baby unit to ensure sufficient chairs to enable mothers to nurse their babies appropriately.
- The trust should review access to the treatment room on the paediatric ward
- The trust should ensure clarity and consistency around care planning for children and young people on Louisa Cary ward.
- The trust should ensure the quiet room is maintained to an appropriate standard to provide a clean and pleasant environment for patients and their families.
- The trust should ensure incidents associated with end of life care are able to be collated to ensure the palliative care team are alerted and can access the incident reports.
- The trust should ensure palliative and end of life assessment of need, care planning and recording is consistent and utilises personalised end of life care planning documents available.
- The trust should ensure that recording of nutrition and hydration needs is consistent and utilises the trust tools provided for example the malnutrition universal screening tool.
- The trust should ensure clarity around key strategic roles for end of life care cross the organisation
- The trust should ensure there is an appropriate level of staffing available for mortuary services.
- The trust should ensure accurate audit data is available which can be used to support delivery of end of life care across an integrated organisation.

Outstanding practice and areas for improvement

- The trust should ensure a coherent strategy is identified, disseminated and actions in place to deliver effective end of life care across an integrated organisation.
- The trust should ensure the mortuary staff and others such as specialist palliative care team have regular training in major incident awareness to ensure the trust can respond if required.
- The trust should ensure medicine fridges in outpatient areas are kept locked at all times.
- The trust should ensure medical records remaining in clinics overnight are locked away securely.
- The trust should ensure staff undertaking procedures have appropriate skills and knowledge to do so.
- The trust should ensure staff understand their role and responsibilities when holding clinics in generic rooms, with regard to cleaning, emergency equipment and medicine storage and monitoring.
- The trust should ensure all staff adhere to the uniform policy and cross infection guidance with regard to long hair below collar length.
- The trust should ensure staff do not eat or drink in areas where blood samples and other chemicals are found.
- The trust should consider CCTV for the monitoring of isolated patients in the radiology west department.
- The trust should consider improving the environment for children in the outpatients department as the mixed environment means it is not child-friendly.
- The provider should consider having a separately policy for the use of oxygen within the patient transport services.
- The provider should make sure the sluice area for the patient transport service is fit for purpose.

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
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>12(1) Care and treatment must be provided in a safe way for service users</p> <p>12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –</p> <p>(a) assessing the risks to the health and safety of service users of receiving the care or treatment</p> <p>(b) doing all that is reasonably practicable to mitigate any such risks.</p> <p>(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.</p> <p>(g) the proper and safe management of medicines.</p> <p>(h) assessing the risk of, preventing, detecting and controlling the spread of infections, including those that are healthcare associated.</p> <p>(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.</p> <p>Urgent and emergency care</p> <p>Patients on corridors waiting to be seen needed to be reviewed and monitored to ensure their safety.</p> <p>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.</p>

Requirement notices

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 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.

Requirement notices

The trust needed to review how staff were trained in fire safety on wards ensuring a named, competent fire wardens were 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.

Regulated activity

Treatment of disease, disorder or injury

Regulation

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.

Requirement notices

The premises used for the delivery of minor surgical procedures in dermatology general outpatients did not have adequate ventilation or extraction.

Regulated activity

Treatment of disease, disorder or injury

Regulation

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:

(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

(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

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.

This section is primarily information for the provider

Requirement notices

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

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.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

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.

(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 must have a full understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and ensure that patients subject to these are appropriately assessed, supported and authorised.

Regulated activity

Treatment of disease, disorder or injury

Regulation

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

Urgent and emergency care

Requirement notices

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.