Torbay and South Devon NHS Foundation Trust

Torbay Hospital

Quality Report

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Date of inspection visit: 11 February 2019
Date of publication: 14/03/2019

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

Urgent and emergency services

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focussed inspection of the emergency department at Torbay Hospital on 11 February 2019.

We did not inspect any other core services or wards at this hospital or any other locations or services provided by Torbay and South Devon NHS Foundation Trust. During this inspection we inspected using our focussed inspection methodology. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Torbay Hospital (unscheduled care) provides an emergency medicine service through a Type 1 Emergency Department (ED) including trauma. There is a minor injuries service provided by the emergency nurse practitioner service with consultant-led support.

Our key findings were:

- There were appropriate processes for the initial assessment, triage and streaming of patients who presented via the front-door. Patients conveyed to Torbay Hospital via ambulance received timely initial assessments before being transferred to the rapid assessment and treatment area for subsequent clinical management.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists.
- Care and treatment was planned and carried out in a timely way.
- The leadership team had worked to reduce the total nurse vacancy factor so that by the end of April 2019 there will be approximately 1.5 whole time equivalent vacant Band 5 posts. Departmental leaders reviewed the competency and skill mix of staff to ensure sufficient numbers of staff were deployed across the department.
- Compliance against constitutional standards remained a challenge. However, new models of care and the introduction of well-rehearsed escalation protocols were starting to show signs of some incremental improvement.
- The department had a strategy to ensure patients were managed as safely and effectively as possible, especially during times of surge activity.
- Professionals from across the hospital took responsibility for the delivery of the emergency care pathway. Strong team working and a multi-disciplinary approach was evident. A "Can do" attitude was present with staff reporting good morale across the department and wider hospital.
- Risks were identified and well managed. The trust acknowledged areas for improvement which they were responsible for delivering.
- Staff reported some concerns over the commissioning arrangements for some cohorts of patients, including those who presented with mental health conditions. Staff recognised more needed to be done to address a perception of health inequality for this group of patients.

However:

- The environment in which patients received care and treatment remained a challenge. Staff acknowledged the constraints of the department and had developed plans to improve the department through a new build which had received capital investment.

Whilst we do not consider the provider to be in breach of regulations we have identified some areas which require improvement. Specifically, the provider should:

Ensure the mental health assessment room continues to meet national service specifications at all times.

Ensure children are directed to an appropriate waiting area in accordance with national service specifications.

Summary of findings

Dr. Nigel Acheson
Deputy Chief Inspector of Hospitals (South)

Torbay Hospital

Detailed findings

Services we looked at
Urgent and emergency services;

Detailed findings

Contents

Our inspection team

The team included a CQC inspector and three specialist advisors: a clinical fellow who specialised in neurology and acute stroke management; an emergency care consultant; and an experienced emergency care nurse.

The inspection was overseen by Mary Cridge, Head of Hospital Inspection for South West England.

Urgent and emergency services

Safe	
Responsive	
Well-led	
Overall	

Information about the service

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. Acute services are provided at Torbay Hospital located in Torquay.

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.

Torbay Hospital (unscheduled care) provides an emergency medicine service through a Type 1 Emergency Department (ED) including trauma & cardiology. There is a minor injuries service provided by the emergency nurse practitioner service with consultant-led support.

The department has:

- 16 majors' cubicles (including side rooms) of which 3 cubicles were assigned to ambulance triage and rapid assessment.
- Four bedded resuscitation room where both adults and children are seen
- A separate children's assessment area
- A designated mental health room
- A clinical decision unit

Torbay Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

We previously inspected the emergency department at Torbay Hospital in May 2017 to determine whether improvements had been made following an inspection we undertook in February 2016. We rated it as good overall.

Urgent and emergency services

Summary of findings

This was a focused inspection so we have not inspected the whole of each key question. Therefore there is no rating.

- There were appropriate processes for the initial assessment, triage and streaming of patients who presented via the front-door. Patients conveyed to Torbay hospital via ambulance received timely initial assessments before being transferred to the rapid assessment and treatment area for subsequent clinical management.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists.
- Care and treatment was planned and carried out in a timely way.
- The leadership team had worked to reduce the total nurse vacancy factor so that by the end of April 2019 there will be approximately 1.5 whole time equivalent vacant Band 5 posts. Departmental leaders reviewed the competency and skill mix of staff to ensure sufficient numbers of staff were deployed across the department.
- Compliance against constitutional standards remained a challenge. However, new models of care and the introduction of well-rehearsed escalation protocols were starting to show signs of some incremental improvement.
- The department had a strategy to ensure patients were managed as safely and effectively as possible, especially during times of surge activity.
- Professionals from across the hospital took responsibility for the delivery of the emergency care pathway. Strong team-working and a multi-disciplinary approach was evident. A "Can do" attitude was present, with staff reporting good morale across the department and wider hospital.
- Risks were identified and well managed. The trust acknowledged areas for improvement which they were responsible for delivering.
- Staff reported some concerns over the commissioning arrangements for some cohorts of patients, including those who presented with mental health conditions. Staff recognised more needed to be done to address a perception of health inequality for this group of patients.

However:

- The environment in which patients received care and treatment remained a challenge. Staff acknowledged the constraints of the department and had developed plans to improve the department through a new build which had received capital investment.

Urgent and emergency services

Are urgent and emergency services safe?

As this was a focused inspection we have not inspected the whole of this key question therefore there is no rating.

- There were appropriate processes for the initial assessment, triage and streaming of patients who presented via the front-door. Patients conveyed to Torbay hospital via ambulance received timely initial assessments before being transferred to the rapid assessment and treatment area for subsequent clinical management.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists.
- Care and treatment was planned and carried out in a timely way.
- The leadership team had worked to reduce the total nurse vacancy factor so that by the end of April 2019 there will be approximately 1.5 whole time equivalent vacant Band 5 posts. Departmental leaders reviewed the competency and skill mix of staff to ensure sufficient numbers of staff were deployed across the department.

However:

- The environment in which patients received care and treatment remained a challenge. Staff acknowledged the constraints of the department and had developed plans to improve the department through a new build which had received capital investment.

Environment and equipment

- The emergency department had a triage area which was located at the main reception area; 16 major's cubicles of which space was also allocated to ambulance triage and rapid assessment; a dedicated minor injuries area; and a four-bed resuscitation area with one bay designated as a children's resuscitation bed space although could also be used to manage adults. In addition, the department had a five bed children's assessment area which also included a separate children's waiting area.
- The emergency department was not designed to accommodate the number of patients who attended the department and there was frequently not enough physical space to accommodate all patients in a safe and appropriate environment. We had previously raised this as an area which required improvement. Staff told us flow across the emergency pathway had improved but accepted it had not been entirely resolved. Nursing patients along the corridor was reported to be the "Norm" for the department, in part due to the poor footprint. Following the Department of Health's announcement that the trust was to benefit from funding of up to £13m to improve urgent and emergency services for local people, plans were being developed to improve the urgent care environment to meet modern healthcare requirements.
- We observed staff working dynamically to ensure there was sufficient clinical space to assess and review patients. This meant there was no requirement for patients to be actively treated in the main corridor. However, we noted patients experienced multiple moves to different parts of the department during their assessment and treatment.
- Where we observed patients being held in the main corridor, a nurse had been allocated to meet the ongoing needs of patients. We spoke with three patients who were receiving care whilst being accommodated on the main corridor. Each patient reported nursing and medical staff had been responsive to their needs; patients were aware of the treatment plans and anticipated waiting times.
- We observed the resuscitation room to be operating at full capacity during the inspection. Additional capacity had been identified as an escalation area in the event a fifth bed space was required. We observed medical and nursing staff undertaking risk assessments to establish whether patients still required treatment within the resuscitation area or whether they were sufficiently stable to be transferred to the major's department.
- We previously reported the department had created a mental health suite which was used to assess and treat vulnerable patients. At this inspection we observed the room to be well utilised. However, we noted a door in the mental health suite which led to the breakout area (used by staff in the event of an emergency) was unlocked. This door led to an office which contained multiple ligature points. We raised this with the trust at the time of the inspection following which action was taken to resolve the issue.

- There was a separate children's area which was secure and not overlooked by adult patients or visitors. However, during the inspection we observed one child who was waiting for treatment who had been asked to wait in the main waiting room alongside adult patients. This was despite the children's waiting area being empty and thus able to accommodate the child. We raised this with staff at the time of the inspection who provided assurances that this would be addressed as a priority.
- There was sufficient equipment such as adult, infant and paediatric pulse oximeters, blood pressure machines, thermometers, oxygen and suction for the number of patients requiring these. Patients had access to call bells to call for staff if required.
- Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys which were sealed with a tamper evident tag. Safety checks were carried out daily.

Assessing and responding to patient risk

- National standards require 95% of patients to have had an initial assessment within 15 minutes of arrival to the department. For patients who presented via ambulance, the trust reported a median time to initial clinical assessment of zero minutes since November 2017. Our observation of the process suggested minimal waits were encountered by ambulance crews when they arrived at the department. A nurse was allocated to the ambulance triage area which was observed to be staffed at all times. Nurses had access to a screen which provided real-time information on any ambulances currently en-route to the hospital. On arrival, nurses received a handover from the ambulance crew, carried out an initial set of physical observations on patients and determined whether the patient was stable or required immediate escalation to a clinician. Once assessed by the nurse, the patient was then placed in a corridor queue until there was sufficient capacity for the patient to be seen by the rapid assessment team where further diagnostics and assessments were undertaken.
- The department had a safe triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours.
- Patients who presented to the emergency department independently (walk-in) were first booked in by a member of the administration team. Once checked in, staff told us patients would then be triaged by a nurse and this was observed during the inspection. Triage nurses undertook timely assessments of patients using a range of criteria; for example patients presenting with head injuries were assessed against the Glasgow Coma Scale to determine their neurological status. There was an escalation protocol which allowed patients presenting with specific conditions to be prioritised and moved from triage to either the resuscitation bay, majors or the rapid assessment area. For example, if a patient appeared seriously unwell or who presented with time-critical symptoms such as those with symptoms of stroke or heart attacks.
- As part of their induction all reception staff had received training on 'red flag' presenting complaints and the deteriorating patient. Red flags are signs and symptoms that indicate the possible or probable presence of serious medical conditions that can cause irreversible disability or untimely death unless managed promptly.
- The department operated a range of clinical protocols for the management of specific conditions. For example, staff had access to a sepsis care bundle for those patients at risk of or who presented with sepsis indicators. We reviewed 10 patient records which confirmed staff consistently used the relevant early warning tools and sepsis assessment forms. Patients at risk of pressure damage or who were identified as being at risk of malnutrition or venous-thrombo embolism (VTE) were risk assessed with appropriate mitigations put in place to reduce the risk of harm.
- Staff used an electronic patient record which prompted them to complete all relevant risk assessments including the completion of early warning scores, safeguarding and mental health assessments. The national early warning score (NEWS) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). We looked at 10 NEWS/PEWS charts and saw that they were completed correctly and regularly. NEWS is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. On the charts reviewed, clinical observations were

repeated in line with the previous score and escalated when scores were elevated. Due to the configuration of the software used by the department, we noted that whilst it was possible for nurses to review the trends of NEWS scores for adults, this function was not present for paediatric patients. This meant nursing staff were required to individually review and retrospectively review individual PEWS scores to help them identify any trends.

Nurse staffing

- Staffing had been reviewed using recognised acuity tools. Safe staffing levels and staff to patient ratios had been defined and increased since our inspection of 2016. This included an increase in the nurse cover for the resuscitation area, which had increased from one to two nurses. The department had also employed a band seven nurse coordinator to manage patient flow from 8am to 11pm, seven days a week. The assessment of staffing continued throughout the day to ensure sufficient numbers of staff were always deployed. We observed a "Control Room" meeting at 4pm during which staffing levels, department activity and residual risk scores were considered to ensure there were appropriate numbers of staff to support the night shift.
- The emergency department was consistently staffed with appropriate numbers of suitably skilled and experienced staff to ensure people always received safe care and treatment. The leadership team had worked to reduce the total nurse vacancy factor so that by the end of April 2019 there will be approximately 1.5 whole time equivalent vacant Band 5 posts.
- At all times throughout our inspection, we found the skill mix of staff to be suitable for the needs of the emergency department, with actual staffing levels meeting the planned levels. Senior staff had oversight of the staffing within the department and moved staff around to ensure all areas were safe and they were able to manage surges in demand.
- The department had both bank staff and agency staff who were used regularly. All the bank and agency staff we spoke with had completed an induction and were familiar with the department. These staff were able to cover some of the short notice issues such as sickness and likely increased demand.
- The children's emergency department was staffed with a qualified children's nurse 24 hours a day, seven days a week. In addition to children's nurses, the department had one paediatric practitioner who had been trained to undertake advanced skills including cannulation and phlebotomy. This individual worked under the auspices of delegated responsibility and so nursing staff remained responsible for the practitioner's actions. Nursing staff reported some challenges with recruiting qualified children's nurses. This meant only one children's nurse could be deployed at any one time to support the children's emergency department. To mitigate against any risks, nurses working in the adult emergency department undertook competencies to enable them to assess and manage the acutely unwell child; this was consistent with national best practice recommendations.

Medical staffing

- There was a consultant present in the department for 14 hours a day, seven days a week, with a registrar (ST4) available 24 hours a day. Current staffing and job plans allowed for two consultants to be present Monday to Friday from 8am to 10pm and for one consultant to be present from 8am to 10pm at weekends. One consultant was available on-call out of hours to support the specialist trainee and other junior doctors, as well as responding to trauma calls and any paediatric cardiac arrest scenarios.
- At the time of the inspection, the department had 10 substantive consultants who worked full time, one locum consultant (full time) and one part time consultant. The department did not have any paediatric emergency medicine consultants; however, this was recognised as an area for development.
- During the working week, one consultant was allocated as the consultant in charge and oversaw the rapid assessment area as well as supporting junior doctors. A second consultant facilitated emergency care clinics as well as reviewing x-rays to determine if any fractures or other conditions had possibly been missed requiring patients to be recalled to the department or referred to other specialities.
- Consultant led board-rounds occurred three times a day at 8am, 2pm and 10pm. This allowed both nursing and medical staff to review all patients in the department; to consider staffing levels; to review the residual risk score of the department and to develop any necessary

actions. Escalation of patients also happened because of the consultant board-round to ensure patients were progressed through the emergency care pathway with as little delay as possible.

- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of a patient's treatment when shifts changed. Handovers between different teams of doctors was well-structured and detailed. Junior doctors were present at board rounds so they could update the lead consultant.
- Since December 2018, the trust had introduced acute physicians direct into the emergency department to help support patient flow and to enable early decisions to be made about medical patients. Predominantly supporting the emergency department Monday to Friday between 9am and 5pm, acute medical physicians worked collectively to review all medical patients who were in the emergency department, either with a decision to admit but no bed being available or where patients were requiring extended care but not requiring admission to hospital. Specialist trainee medical doctors and junior doctors were observed to be in the department reviewing blood results and other diagnostic tests and ensuring regular medicines were prescribed for patients. These interventions helped support early decisions about the care for patients, including the discharge of patients from the emergency department with appropriate safety-netting advice and mechanisms to ensure patients were discharged safely.

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

As this was a focused inspection we have not inspected the whole of this key question. Therefore there is no rating.

- Compliance against constitutional standards remained a challenge. However, new models of care and the introduction of well-rehearsed escalation protocols were starting to show signs of some incremental improvement.

Access and flow

- There was a greater proportion of ambulance handovers delayed over 60 minutes in January 2019 than in December 2018. From 7 to 20 January 2019, 1.1% of ambulances had handover delays over 60 minutes. 0.8% From 21 January to 3 February 2019, 0.8% of ambulances had handover delays over 60 minutes. This was similar to the England average performance.
- The total time (median) in A&E for all patients was 0.8 of an hour in November 2018. This was similar to the England average of 1.1 hours, but worse than the previous year (0.7 of an hour in November 2017).
- Most patients spent less than four hours in the trust's type 1 major A&E department in December 2018 (82.5% of patients). This was worse than the England standard of 95% but marginally better than the England overall average of 79.3%.
- In December 2018, four patients waited more than 12 hours from a decision to admit being made to admission. This was much worse than the England average, and worse than the trust's performance in December 2017.
- The trust's time to treatment in November 2018 was 60 minutes. This is an increase of the hospitals previous time to treatment performance which was reported as being between 36 and 43 minutes for most of 2018. It is important to note the 60 minute performance time was in line with national performance.
- We had previously reported the design and layout of the emergency department was no longer suitable to meet the growing demands of the service. During this inspection we noted the department to be under operational pressure; the trust was reported to be operating at Operating Pressures Escalation Level (OPEL) 3. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; The local health and social care system capacity is such that organisations can maintain patient flow and are able to meet anticipated demand within available resources, to OPEL 4; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care.
- We observed patients being held along the main corridor of the emergency department and within the minor injuries unit; some patients had been in the department for extended periods due to a lack of beds

across the hospital. We noted the bed position improved during the inspection resulting in patients being discharged across the hospital. This allowed patients in the emergency department to be admitted to inpatient beds.

- There were systems in place to manage the flow of patients through the emergency department to discharge or admission to the hospital. The operations control room and clinical site team could see on the computer system the length of time patients had been in the emergency department, along with who had been referred and required admission. The system allowed them to have an overview of bed availability and the flow of patients coming into the emergency department. The trust used a risk-based scoring system to help them identify peak times or when the acuity of patients in the emergency department had reached a critical point. We observed medical physicians supporting the emergency department during peak times, as well as speciality doctors responding in a timely way to review their patients and support emergency care staff to develop treatment plans. The departmental risk score was discussed at regular "Control Room" meetings throughout the day and plans made. The general manager worked closely with the nurse in charge of the department to facilitate communication to the operations team. We saw evidence of this during our inspection.
- The clinical site team provided cover 24 hours a day, seven days a week. They had an oversight of acute and emergency flow, along with ensuring capacity was maintained.
- To help improve flow across the department, and therefore enhance the safety and effectiveness of the emergency department, developments to the ambulatory care pathway had been trialled. However, at the time of the inspection this trial had been halted due to the need for additional in-patient bed capacity within the 'emergency village'. In-patient bed occupancy had also been reported to be higher in part due to an unexpected reduction in the availability of packages of care within the community. This had been reviewed by the trust and remedial action taken to ensure appropriate intermediate care hours were more readily available. It was not possible to assess the impact of the proposed interventions at the time of the inspection.

Are urgent and emergency services well-led?

As this was a focused inspection we have not inspected the whole of this key question. Therefore there is no rating.

- The department had a strategy to ensure patients were managed as safely and effectively as possible, especially during times of surge activity.
- Professionals from across the hospital took responsibility for the delivery of the emergency care pathway. Strong team-working and a multi-disciplinary approach was evident. A "Can do" attitude was present, with staff reporting good morale across the department and wider hospital.
- Risks were identified and well managed. The trust acknowledged areas for improvement which they were responsible for.
- Staff reported some concerns over the commissioning arrangements for some cohorts of patients, including those who presented with mental health conditions. Staff recognised more needed to be done to address a perception of health inequality for this group of patients.

Vision and strategy for this service

- At the time of our focussed inspection, the department was operating at an escalated state. Whilst an internal major incident had not been declared, the trust's 'emergency department full' protocol had been implemented. Operational leads were present in the department to help improve flow across the hospital. Staff told us they now considered the trust escalation protocol to be an effective process. Improvements were reported in terms of speciality doctors supporting the emergency department during times of surge.
- Regular "Control Room" meetings meant plans could be developed to manage the risk within the emergency care pathway; quality issues and patient experience concerns were discussed and actions identified to resolve any identified problems. Actions were reviewed and closed if appropriate or alternative plans identified to ensure on-going challenges were resolved. These meetings were facilitated by members of the executive team and supported by leaders from community and in-patient services.

Urgent and emergency services

Governance, risk management and quality measurement

- There was a consensus across the wide range of health and operational professionals we spoke with that management of risk within the emergency care pathway was a trust-wide responsibility. At a local level, a triumvirate including a clinical lead, matron and business manager co-ordinated the day-to-day management of the department, including the completion of audits, reviews of risk registers, staffing challenges, quality and patient safety. However, it was apparent representatives from across the hospital had worked to help address quality, operational performance and patient safety agenda items. The introduction of new models of care, including the introduction of acute medical physicians to the emergency department, confirmed this concept of joint ownership of risk.
- Junior staff told us they could escalate any concerns to the leadership team and were confident action would be taken. There were no contradictory ideas or perceptions of "learned helplessness" in the department in regards to having to provide corridor care to patients. Staff were committed to providing the best possible care and as positive a patient experience as was possible within the existing footprint of the department. Staff were heavily critical of the requirement to bed patients within the minor injuries unit during times of surge as they recognised the environment was far from suitable. We observed staff working hard to free-up bed capacity across the hospital to ensure the minor injuries unit was decongested of bedded patients.

Culture within the service

- In 2017 we reported the culture of the department was "one of pride and optimism for the future". There was a consensus amongst staff that this was still the case, despite the challenges of working in a department which was not fit for purpose. Staff were optimistic and excited by the recent announcement that the trust had received funding to improve the urgent and emergency care service. Staff reported even greater team working across specialities; the concept of the hospital owning the emergency care pathway and the risks associated with it were testament to the team approach.
- There was a sense more could be done to improve patient experience. Staff were committed to ensuring patients received safe care. Staff were able to provide examples of where they had escalated their concerns to senior managers who then acted to resolve those concerns. Commissioning challenges and variation to the access of services was raised during the inspection, specifically in relation to patients requiring support from specialist mental health teams. Staff described an almost "post-code lottery" in terms of the services available to some patients. Staff told us there was some level of health in-equality for some patients. This was because the responsiveness of some externally commissioned services to provide timely care and assessment to patients presenting in a mental health crisis was variable. It was clear from our discussions with staff this was a pressing concern for the department and led to some staff feeling frustrated by the challenges of "the system". Senior staff could describe the escalation actions they had taken with commissioners and external providers to ensure such barriers were addressed. However, some staff considered little had changed and felt this impacted on the morale of the team when there was a perception patients suffered from poor care provision.

Outstanding practice and areas for improvement

Outstanding practice

During the inspection we observed staff going the extra mile to support a patient who was registered blind. Staff were available to support the individual through the emergency care pathway, including escorting the patient from another department in the hospital. Staff were patient, provided clear explanations to the patient and organised appropriate onward transport for the patient.

The presence of acute physicians within the emergency department was considered by staff as being an exceptional benefit for patients. Acute physicians were present across the day to help support emergency staff to develop care and treatment plans for patients who were subsequently discharged; staff reported these patients may have previously been admitted for periods of up to one day whilst they were diagnosed and subsequently treated during medical ward rounds.

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure the mental health assessment room continues to meet national service specifications.
- Ensure children are directed to an appropriate waiting area in accordance with national service specifications.

These two areas are something that is required as part of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to the suitability of the premises. It was considered it would not be proportionate for these two findings to result in a judgement of a breach of the Regulation overall at Torbay Hospital.