Torbay and South Devon NHS Foundation Trust

RA9

Community health inpatient services

Quality Report

Lawes Bridge
Torquay
Devon
TQ2 7AA
Tel: 01803 614567
Website: www.torbayandsouthdevon.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RA952	Ashburton and Buckfastleigh Hospital	Ashburton and Buckfastleigh Hospital	TQ13 7AP
RA954	Brixham Hospital	Brixham Hospital	TQ5 9HN
RA955	Dartmouth Hospital	Dartmouth Hospital	TQ6 9BD
RA956	Dawlish Hospital	Dawlish Hospital	EX7 9DH
RA957	Newton Abbot Hospital	Newton Abbot Hospital	TQ12 2TS
RA958	Paignton Hospital	Paignton Hospital	TQ3 3AG
RA959	Teignmouth Hospital	Teignmouth Hospital	TQ14 9BQ
RA979	Totnes Hospital	Totnes Hospital	TQ9 5GH

This report describes our judgement of the quality of care provided within this core service by Torbay and South Devon NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Torbay and South Devon NHS Foundation Trust and these are brought together to inform our overall judgement of Torbay and South Devon NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Requires Improvement l

During the inspection, we visited eight out of the nine community hospitals. At the time of our inspection, Bovey Tracey hospital inpatient beds were temporarily moved to Newton Abbott hospital. We reviewed surgical services at Teignmouth hospital day surgery unit.

Our inspection team included two Care Quality Commission inspectors and seven specialist advisors and an expert-by-experience. Our Pharmacist looked at medicines management in three community hospitals, Teignmouth, Paignton and Brixham. We spoke with approximately 60 staff, 25 patients and 7 relatives.

We rated safety in the community inpatients to require improvement. We found there were good systems in place for reporting, investigating incidents and sharing learning from them. Medicines were not consistently managed and stored in a way that would keep people safe from avoidable harm. The ward environments across all community hospitals were clean and tidy. Patient records were completed to a high standard. They were detailed, up to date and showed evidence of multidisciplinary team input. There were reliable systems in place to prevent and protect people from a healthcare associated infection and staff followed appropriate infection control procedures. Staffing levels, skill mix and caseloads were not effectively planned and reviewed to ensure people received safe care and treatment at all times. Staff of varying seniority across all community hospitals expressed concerns about staffing levels. This related to the staffing of escalation wards and to staffing at night in particular. Recruitment of staff was an on ongoing concern. Bovey Tracey hospital inpatient beds were temporarily closed and patients and staff were transferred to Newton Abbott wards due to ongoing issues with retention and recruitment there. Staff felt concerned about staffing levels and skill mix on escalation wards. There was a high use of agency staff on these wards who did not have the right skills to manage stroke patients in particular. Staff of all seniority felt lessons from the previous year's escalation ward management had been discussed but not consistently applied.

We judged effectiveness within community hospitals as good. Staff followed national guidelines and recommendations to deliver effective care and treatment and ensured patients' pain was well managed.

Patients' care and rehabilitation goals were identified on admission to the hospital. Referrals to therapists and specialists were made in a timely way that would best support their reablement and recovery. A variety of quality and audit information was collected at each community hospital which was used to improve the quality of patient care. Length of stay for each community was shorter than the national average of 28 days.

Multidisciplinary team working supported effective planning and delivery of care for adults being cared for in the hospital and for their ongoing care following discharge. Staff engaged with patients' families and carers to ensure patients were discharged into the right setting with appropriate care and treatment in place.

We judged the care of community inpatients to be good. Patients and relatives across all eight hospitals provided positive feedback about patients' care and treatment. We saw staff treating patients with kindness, respect and dignity. Staff responded sensitively to patients' needs when patients experienced physical pain, discomfort or emotional distress. Patients and their relatives felt involved in their care and were supported emotionally. Patients we spoke with said staff took time to explain their care and treatment in a way they could easily understand. Relatives felt involved in the planning of patients care ready for when they returned home. Patients' call bells were answered quickly. Staff support and empowered patients to manage their own health, care and wellbeing to maximise their independence.

We judged the community inpatient services were responsive to patient's needs. The trust and staff from community hospitals worked with local commissioners of community services and partner organisations to ensure the division provided services that met local people's needs. Community hospital staff worked closely with community nursing and therapy teams, GP practices and social services to ensure patients access to ongoing care and treatment. Staff did their best to meet the needs of the patient and were sensitive to their personal, cultural,

Summary of findings

religious needs, or sexual preferences. Services were planned, delivered and coordinated to meet the needs of patients living in vulnerable circumstances, such as those patients living with dementia. Staff demonstrated a good level of awareness of how to best care for patients living with dementia, so that they were able to respond to their needs appropriately. People had timely access to initial assessment, diagnosis and treatment. However, some staff expressed concerns that some patients were transferred too late at night. Patients told us they felt they could ask questions or raise concerns if the felt they needed to, at any time during their stay. The complaints system was easy to use and posters and leaflets displayed around the community hospitals outlined the procedure. The trust RAG rated the number of complaints relating to community hospitals as green. The RAG rating system classified green as positive or above target and red as below target or negative, etc.

We judged the inpatients service to require improvement in its leadership. There was an organisational vision in place for the integrated care organisation overall. However, a strategy and vision for community inpatients had not been fully developed or communicated to staff. A number of staff felt the merger had gone well, whilst others felt disconnected from the rest of the organisation. This meant that staff did not always know or understand the organisational strategy and their role in achieving it.

Risk registers were in place across the community hospitals, which fed into the divisional risk register. Matrons and senior ward staff were not always able to articulate what their top three risks were but were clear about issues in relation to staffing. Lines of accountability including clear responsibility for cascading information upwards to the senior management and downwards to the clinicians and other staff on the front line were not always clear. However, staff were clear about who their local leaders were and found them to be open and approachable. It was identified that there was a lack of clarity between the Trust Executive and the community senior leadership in relation to the use of a community bed status report which incorporated a staffing tool. As such, this identified a gap in assurances regarding safety going back up to the board, in particular in relation to safe staffing and skill mix at night and on escalation wards. While the board recognised that staffing in the community needed to be reviewed, they had not fully understood the shortcomings of the tool used to align staffing levels to patients' care needs. Staff did not always feel actively engaged so that their views were reflected in the planning and delivery of services. The organisation and community hospitals engaged with the local community to seek feedback in order to shape service and kept the public informed about the changes within the organisation.

Summary of findings

Background to the service

Information about the service

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

There were 166 commissioned beds: 18 at Dawlish, 12 at Teignmouth, 18 at Totnes, 16 at Dartmouth, 20 at Brixham, 10 at Ashburton and 28 at Paignton. At Newton Abbot hospital, there were 15 beds on Teign ward, which was a specialist stroke ward, and 20 beds on Templar ward. Bed numbers increased at Newton Abbott for escalation purposes. There were 12 extra escalation beds opened out of a possible 30 during our inspection. Bovey Tracey Community hospital's nine inpatient beds were closed and moved temporarily to Newton Abbott.

Care and support were provided by nurses, health care assistants and allied health professionals such as occupational therapists and physiotherapists. Medical support was provided by GPs who were employed from local surgeries.

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 specialists ranging from community nurses, occupational therapists and physiotherapists.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection of NHS trusts.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

We undertook an announced inspection of Torbay and South Devon NHS Foundation Trust on 2-5 February 2016.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit we held focus groups with a range of staff who worked within the service. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider say

We received 36 comment cards from patients and relatives all of which were positive. Comments such as the nurses and ancillary staff go above and beyond the call of duty, were common. There were thank you cards and letters at all of the hospitals we visited thanking staff for the care and treatment of their relatives and loved ones.

Some of these comments included the following:

- "Staff recognise each patient's needs and you are called by your preferred name which is good."
- "Thank you more than words could say for looking after mum so well. We will always remember you."
- [when a patient made staff aware of a procedure to catheterise the patient had failed] "they fixed it in minutes."

Good practice

- Nursing, medical records and care plans across the eight community hospitals we visited were completed to a high standard. They were accurate, up to date with and good evidence of multidisciplinary team input. Our specialist advisors said these were some of the best care plans they had ever seen.
- Relatives spoke highly about the way in which staff involved them in the patients' care and treatment across all of the community hospitals. They felt involved in the planning of patients care, in their goals towards goals towards discharge and for when the patient returned home.
- Therapy staff involved family and carers on admission to the hospital. They would go out to the patients' home to meet with families in order to ensure the patient had access to the most appropriate services and equipment to enable their recovery. This enabled staff to fully understand the patients' home situation and whether the family or carer was best placed to support the patient with their ongoing care and reablement. They could support families with this process and assess the level of input the patient would need from other agencies.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure the systems and processes in place ensure information in relation to safety, particularly regarding staffing levels and skill mix, was shared and understood between ward and board level and acted upon.

Action the provider SHOULD take to improve

- Ensure daily checks of resuscitation equipment are carried out to ensure equipment is fit for use in an emergency situation.
- Ensure it dispenses controlled drugs directly from controlled drugs order books instead of faxed orders.
- Ensure substances that are hazardous to health (COSHH) are stored securely in locked rooms which are inaccessible to patients and visitors.
- Ensure an effective patient handover process is agreed between the acute trust and community hospitals, so that the complexity of patients being admitted from the acute hospital is reflective of their assessment of the patients' medical condition.

Torbay and South Devon NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safety in the community inpatients to require improvement.

- Staffing levels, skill mix and caseloads were not effectively planned and reviewed to ensure people received safe care and treatment at all times. Staff of varying seniority across all community hospitals expressed concerns about staffing levels. This related to the staffing of escalation wards and to staffing at night in particular. Recruitment of staff was an ongoing concern. Bovey Tracey hospital inpatient beds closed temporarily and patients and staff were transferred to Newton Abbott wards due to ongoing issues with retention and recruitment there.
- Staff felt concerned about staffing levels and skill mix on escalation wards. There was a high use of agency staff on these wards who did not have the right skills to manage stroke patients in particular. Staff of all seniority felt lessons from the previous year's escalation ward management had been discussed but not consistently applied. Staff felt these wards were not safe.
- Medicines were not consistently managed and stored in a way that would keep people safe from avoidable harm.

However

- We found there were good systems in place for reporting, investigating incidents and sharing learning from them. Staff made improvements to the management of pressure ulcer care and reduced the incidence of patient falls.
- The ward environments across all community hospitals were clean and tidy. There was brightly coloured paint, signage and pictures to help people with a form of dementia find their way to their beds, toilets and bathrooms.
- Patient records were completed to a high standard. They were detailed, up to date and showed evidence of multidisciplinary team input.

Requires improvement

Are services safe?

- There were reliable systems in place to prevent and protect people from a healthcare associated infection and staff followed appropriate infection control procedures.

Safety performance

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer data was displayed on the walls of the community hospitals we visited.This data provided a snapshot of avoidable patient harms occurring on one specific day each month and could be measured against other hospitals and wards in the NHS. Data collected looked at the prevalence of falls, catheter related urinary tract infections (C.UTI's) and pressure ulcers.
- Safety thermometer data analysed related to the period of November 2014 to November 2015. In Ashburton and Bovey Tracey hospital, no falls, C.UTIs or pressure ulcers occurred during this time.In Brixham, there was one pressure ulcer, two falls and three C.UTIs. In Dartmouth hospital, nine pressure ulcers occurred, mainly between November and May. Staff there reported two falls and one C.UTI. In Dawlish hospital, one fall occurred in December. At Newton Abbott hospital, staff reported two pressure ulcers, three falls and four C.UTIs at Teign ward. On Templar ward at Newton Abbott, four pressure ulcers and two falls occurred between December and April and three C.UTIs occurred between May and November 2015. At Teignmouth hospital, two pressure ulcers and three C.UTIs were reported between December and June. At Totnes hospital, staff reported five pressure ulcer and two C.UTIs.
- Incidents reported via the national incident reporting and learning system showed more than half of all incidents recorded between December 2014 and November 2015 were patient accidents. Of all incidents reported during this period, 83% occurred during inpatient treatment and assessment in community hospitals.

Incident reporting, learning and improvement

- Staff understood their responsibilities to raise concerns, record incidents and report them internally and externally. Staff reported incidents using the trust's electronic incident recording system. All staff, excluding agency staff, received training in how to identify an incident or a near miss and in how to record it on the system. We found that qualified nursing staff in all locations we visited were confident about reporting and recording incidents. Some junior staff preferred to report incidents to their ward manager who would then record the event. The system required each ward manager or matron to record actions taken following every incident and the level of harm it caused.
- Staff gave examples of incidents they reported and their outcomes. They told us teams and the organisation as a whole learned from incidents. For example, following an incident relating to the discharge of a complex patient, the ward received a debrief and a teaching session was arranged for staff to improve their knowledge in relation to continuing healthcare assessments.
- Senior staff conducted root cause analysis (RCA) investigations into serious incidents. Following these investigations, staff received guidance and training. Discussions took place on how staff could escalate concerns in order to prevent similar incidents happening in the future.
- The number of RIDDOR incidents and near misses were both rated as green in the community in Dec 2015. RIDDOR incidents are injuries, diseases and dangerous occurrences that a hospital must report as part of the regulatory process. The traffic light colours represented green as positive or low risk and red as negative or high risk.
- Staff in community hospitals recorded all grades of pressure ulcers, grades one to four and reported them via the trust's electronic incident reporting system. Senior leaders told us a community health matron was appointed as a lead for pressure ulcer prevention. Work was done to reduce the incidence of pressure ulcers during 2015, which resulted in a reduction by 86% across community services overall. A tissue viability group met regularly to monitor pressure ulcer wound care and share best practice. Improved recording, pictorial aids and the introduction of the SSKIN bundle supported this. The SSKIN bundle involves 5 simple interventions that lead to effective care, prevention and management of pressure ulcers.
- The trust reported in its board meeting on 3 February 2015, staff investigated all falls incidents to examine any trends and shared learning with the wards. Community

hospitals reported a two month downward trend in falls per thousand bed days at the end of 2015. There had been an overall improvement of 4.2% on the 2014 to 2015 year end position.

- Learning reviews fed into service improvements. Matrons across the community hospitals had lead roles, which included different areas of safety. They informed us they would audit different areas related to safety and review investigations and route cause analyses in order to identify trends and share learning with ward staff. For example, changes to practice were made following a falls audit which identified lying and standing blood pressures were not always being taken.
- The hospitals had a falls prevention group and a tissue viability champions group who met regularly. They led on audit, learning and improvement across the community hospitals. For example, a problem was identified in the community hospitals with the alarmed falls prevention mats that would set off an alarm if a patient moved from a seat or bed. A device trainer visited a number of the community hospitals to rectify this and educate staff. We saw plans were in place to complete this training across all of the community hospital in early 2016. Staff also confirmed practice changed following this.
- Physiotherapists shared learning via a rehabilitation clinical interest group. Occupational therapists had a meeting in the last six months in which they shared learning across the community hospitals.

Duty of Candour

- Staff informed us they made patients aware when something went wrong. They apologised and explained what they would do as a result. This followed the trust's incident reporting policy, which included the duty of candour regulation. 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 saw evidence of an investigation into a pressure ulcer where the duty of candour process was used. The nurse spoke with the patient who did not feel they needed to be updated with the outcome of the investigation.

Safeguarding

- Safeguarding adults and children level 1 was part of the trust's mandatory training and available for staff to access via the trust's web TV channel or e-learning system. Staff across the community hospitals were compliant with mandatory safeguarding training with the average compliance across community hospitals at 92.7%. The trust's target was 90%. Bovey Tracey community hospital fell short of this target at 82%. One matron told us level two training might become mandatory. Level one training is for all staff including non-clinical staff and Level two training is specifically aimed at clinical staff. Minutes from the 3 February board meeting confirmed some additional training sessions for level two were being undertaken within the trust. We were not made aware of this training programme happening in the community hospitals.
- Staff across the hospitals competently described how to recognise and report safeguarding concerns. There was a divisional safeguarding team available for staff to ask for advice and support with and questions or concerns relating to safeguarding matters.
- Staff discussed safeguarding concerns at handovers and safety briefings to ensure staff were informed about the patients in their care.

Medicines

- Medicines were not consistently managed and stored in a way that would keep people safe from avoidable harm. At Totnes community hospital for example, we found staff did not always complete fridge temperature checks daily, as per the trust's policy. More than five dates were omitted since the beginning of 2016. One entry in February showed the temperature was outside of the safe temperature range of 2-8°C. A senior nurse was aware of the omissions of daily temperature checks in January. We saw they had taken action by emailing all staff and adding it to the agenda for the subsequent staff meeting. During the previous evening, two agency

nurses were the only nursing staff covering the same hospital and did not check fridge temperatures. Fridge temperature checks were not part of the ward induction check sheet.

- At Paignton hospital, medicine cupboards were over-stocked and nurses found it difficult to find the medicines they needed and therefore ordered more. There were open bottles of liquid medicine, which did not have a date of opening. Some medicines have a limited shelf life once opened, which meant this practice could not guarantee the medicine was effective. Staff took immediate action to dispose of these medicines once informed.
- Pharmacists visited the community hospitals weekly and reviewed medicine charts. Nursing staff reported pharmacists were helpful and could access advice 24 hours per day, seven days per week. A nurse was required to check medicine quantities and complete any ordering.
- At Paignton and Dawlish hospital, medicinal creams and some prescription only medicines were found on patients' bedside lockers and without patient identifiable labels. They were unsecured and unsupervised. This did not keep patients safe from avoidable harm.
- Staff often faxed controlled drugs orders to the acute hospital's pharmacy. This broke the audit trail as staff did not sign for receipt of the controlled drug in the original order book and the order number was not consistently written in the controlled drugs book. This action would hamper an investigation should a controlled drug go missing. We raised our concerns at the time. Following our inspection, a new process that was consistent with the Misuse of Drugs Regulations 2001 was initiated and due to be introduced by the 1 March 2016. Staff agreed a follow up audit to assess if staff were implementing the new protocol.
- The trust had a policy to support self-administration of medicines. However, staff did not routinely ask patients if they would like to self-administer medicines or assess self-administration competence during the rehabilitation process.
- We reviewed 16 medicines charts across Teignmouth, Paignton and Brixham community hospitals. These were found to be complete with few incidences of dose omissions.
- Allergies were well-documented and venous thromboembolism assessments and reassessments were completed. This meant it protected a high proportion of its patients from dangerous and potentially life threatening blood clots.
- During an operational matron's meeting, staff raised that patients were sometimes transferred from the acute hospital to community hospitals without their medicines. Matrons confirmed this happened on occasion but it had not been reported. The senior leadership team agreed to investigate this and take appropriate action.
- Controlled drugs were stored appropriately in locked cupboards across the community hospitals we visited. Keys were stored safely and only trained members of staff had access to them.
- There were daily pharmacy deliveries or a second delivery could be organised if needed.
- Medicine errors were monitored weekly through the random audit of charts. In the event of any errors, charts were photocopied and passed to the matron to discuss with the member of staff. Feedback was then shared across the community hospitals if necessary.
- In the surgery day unit at Teignmouth hospital, all medicines were adequately stored and records showed 100% compliance with weekly checks.

Environment and equipment

- The design, maintenance and use of facilities and premises kept people safe. The risk of fire was reviewed regularly in community hospitals. The trust fire audits were RAG rated as green in Dec 2015.
- There was a mix of both old and new buildings that served the patients using the community hospitals. The newer hospitals, such as Newton Abbott were spacious, light and provided a pleasant environment in which patients could be treated. Despite the age of some of the other hospitals, on the whole, the buildings were cleaned and maintained to a high standard. The theme of brightly coloured painted areas were mirrored

throughout the hospitals we visited. The purpose of this was to support patients living with dementia. However, this also contributed to a bright and pleasant environment for all patients and visitors.

- On the whole, staff reported they had adequate access to equipment. Staff at Newton Abbott hospital had an excellent gym facility in a large area with a range of equipment for rehabilitation purposes.
- The maintenance and use of equipment kept people safe across most of the community hospitals we visited however, we did find an exception to this. Each ward had a resuscitation trolley containing emergency equipment and medicine in the event that a patient suffered a cardiac arrest. Wards kept trolleys secured so that medicine did not go missing and could be ready to be use in an emergency. Hospital policy stated that these trolleys should be checked daily to ensure reliability and to allow for the replacement of essential equipment. At Newton Abbott hospital, we found a number of omissions in the daily checks of resuscitation equipment. At Ashburton hospital, we found a suction machine for which the safety testing certificate was out of date. Therefore, there was a lack of assurance that this equipment was fit for use.
- The hospitals kept an inventory of medical devices for traceability purposes. At Dawlish hospital for example, the record was managed by housekeeping and staff could write in a log if equipment was found to be faulty. Equipment was then fixed and the log updated.
- A wide range of therapy and mobility equipment was available across the different sites, which was found to be clean. In some hospitals, due to lack of storage space, we found equipment stored in patient bathrooms, where it may have been possible for patients to use or handle them, after they had been certified as clean. This also created a trip hazard within the bathroom areas.
- Chemicals and substances that are hazardous to health (COSHH) were used for cleaning and were on the whole stored securely in locked rooms which were inaccessible to patients and visitors. However, at Totnes hospital, we found bottles left out on worktops in the sluice and a door left open. A senior nurse agreed that this was not safe practice and took remedial action.
- The environment in the day theatre unit at Teignmouth hospital had been refurbished a number of times. Despite this being an old building, it provided patients with an extremely clean environment. A white board in the theatre had permanent wording, which served as a prompt to staff to carry out safe procedures.
- Gel pads were used on theatre trolleys for patients heels to prevent pressure sore occurring during more lengthy procedures.
- The theatre environment was of a suitable temperature and the ventilation and extraction system was checked at appropriate intervals.
- Some power cables from equipment were exposed on the floor in an area of the day surgery unit, which presented a potential trip hazard to staff. Staff were seen stepping over these on a number of occasions.
- In the theatre environment at Teignbridge, there was no spillage kit on site for staff to use in the event of a spillage occurring when taking a patient specimen for analysis purposes.

Quality of records

- Staff completed, stored and managed patients' individual care records in a manner that kept people safe and maintained patient confidentiality.
- Staff kept records securely stored in locked rooms. On ward rounds, notes were removed from locked trolleys, used and returned to the trolley.
- We reviewed a number of patients' nursing, medical records and care plans across the eight community hospitals we visited. We found them to be completed to a high standard. They were accurate, up to date and demonstrated good evidence of multidisciplinary team input.
- Staff in the day surgery unit at Teignmouth community hospital put procedures in place to protect patients from avoidable harm. Staff carried out monthly checks of five sets of World Health Organisation surgical safety checklists, which demonstrated 100% compliance with these checks. The WHO checklist ensured surgical errors and adverse event were minimised. We did not receive data in relation to records audits for community hospitals overall.

Cleanliness, infection control and hygiene

Requires improvement

Are services safe?

- There were reliable systems in place to prevent and protect people from a healthcare associated infection. Infection control procedures were monitored regularly. Cleaning audits were all RAG rated green for the community services from April to December 2015.
- Hand hygiene audits occurred on all wards and demonstrated high levels of compliance. For example, Dawlish achieved 99% for hand hygiene in January 2016..
- Senior nursing staff reviewed all infection outbreak incidents over the previous 12 months. Themes were identified and presented to community matrons during the December 2015 professional practice meeting.
- Ward staff used white boards to identify infection control risks and discussed specific patients as part of the handover and safety briefing. This ensured all staff on the wards were aware of the risks and highlighted any infection control precautions to be taken.
- Staff used green labels to identify when cleaning of the equipment and environment had occurred and who had carried out this process. We reviewed a number of pieces of equipment and found them to be clean.
- Each ward had hand-sanitising gel and/or sinks for hand washing located at the entrance to the ward. Within the wards, hand sanitising gel and hand washing facilities were available throughout. We saw staff used hand gel and washed hands in line with infection prevention and control guidelines.
- We saw, and patients confirmed, staff used personal protective equipment such as aprons and gloves when performing procedures and carrying out patient care.
- A number of areas within the community services directorate were part of the national PLACE audit. This is a patient led assessment of the care environment. All nine community hospitals scored above the England average for cleanliness scores, in excess of 98%. However, we found a high level of dust in a few areas at Ashburton hospital.
- A process for protecting patients from the risk of legionella was in place and well documented.

Mandatory training

- Mandatory training included training subjects such as: equality and diversity, fire, health and safety, infection prevention and control, information governance, moving and handling, safeguarding adults and safeguarding children.
- Community hospitals achieved the hospitals mandatory training target of 90% with 92% of staff overall having completed the training by October 2015 year to date. However, Bovey Tracey community hospital was below target at 78.9%%. This was attributed to sickness and staffing issues.

Assessing and responding to patient risk

- There were systems in place to assess and monitor patient risks. Staff carried out comprehensive risk assessments for patients and risks were well managed. Patients were assessed using recognised risk assessment tools. For example, staff assessed the risk of developing pressure damage using the Waterlow score, a nationally recognised assessment tool. Staff photographed wounds andpressure damage on admission to the hospital and during care, to monitor progress of healing.
- We reviewed over 20 patient records. All had completed risk assessments such as falls risk assessments, nutrition assessments and skin assessments. Staff monitored patients' conditions through the use of an early warning system that tracked changes in a patient's condition and those at risk of deterioration. Staff could speak with medical staff or contact medical care using the out of hours service, or dial 999 in an emergency. We heard of one example of how a member of staff monitored a patient's condition according to stroke guidelines. They carried out regular observations and called for an ambulance in response to the patients' deteriorating condition. The patient was transferred to the acute hospital at Torbay.
- Staff recorded allergy information on patient records and their prescription chart.
- At safety briefings, staff were made aware of any patients who required more close monitoring and supervision, for example if they were at increased risk of falling.

- Speech and language therapists carried out swallow assessments of stroke patients to assess their ability to swallow and risk of chocking. Food texture was adjusted accordingly and assistance given with eating if needed.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads were not effectively planned and reviewed to ensure people received safe care and treatment at all times. Staff of varying seniority across all community hospitals expressed concerns about staffing levels. Staff at one hospital informed us there had been a recent review of skill mix and a bid was submitted to increase the number of qualified nursing staff. Senior leadership within the division had not communicated the outcome of this review to staff, at the time of our inspection.
- A summary of a report on 3 February 2016 by the Chief Nurse looking at safe staffing was presented at the board meeting on the same date. It stated the trust recently undertook a piece of work to understand emergency department safe staffing in the acute hospital. It recommended further work should now be undertaken to determine how evidence based methods of assessing safe staffing could applied to community hospital settings.
- When looking at off duty and staffing levels across the hospitals, it appeared that on the whole, most shifts were filled, with a small number of exceptions. For example, in November 2015 the average fill rate for both day and night shifts for registered nurses did not fall below 80% or exceed 120% with the exception of one ward. This related to Teignmouth community hospital early shift, which achieved a 73% fill rate.
- However, staffing levels had not been assessed using current, relevant tools and guidance in which patient acuity was evaluated. Senior staff felt patient complexity had increased greatly since this was last reviewed some years ago. Senior leadership within the directorate confirmed staffing levels were set using historic information and the aspiration was to achieve a 1:8 nurse to patient ratio, which would be more in line with current guidelines. This guideline set by the nursing and midwifery council was a guide which could be used alongside an assessment of patient acuity and complexity in each hospital setting. However, they would not put plans in place to address this until the changes in the organisation were completed. A date for this was not conveyed. A matron reported they wanted staffing levels to be reviewed as they were currently set at one nurse and two healthcare assistants to every 12 patients.
- Senior leadership informed us there was a hospital daily bed status tool in place to support senior nursing staff to manage staffing levels, which took into account patient acuity. This was completed twice daily and was updated with information relating to community hospital bed occupancy. It also contained a level of information relating to patient complexity, such as the number of mental health patients or the number of patients at risk of falling for example. There was also a section to flag whether there were any ward staffing issues, which could be indicated by a yes or no response. However, matrons we spoke with were not confident this accurately reflected patient acuity and the complexity of patients on the wards, or that this was an effective way of assessing staffing levels based on patient acuity. They felt ward staff who were filling this in twice daily, viewed this as a bed status tool and that the understanding of this tool was low. It was acknowledged by senior leadership that this tool needed further refinement to more accurately reflect patient complexity.
- We were given some assurance that when senior nursing staff requested extra nursing staff due to sickness, staff shortages, or increased patient complexity, that this request was rarely refused.
- Patients on the Teign ward at Newton Abbott hospital expressed concerns about staffing levels at night. Unsatisfactory staffing levels at night appeared on the risk register for Totnes hospital on March 3 2015. To mitigate this, a comment dated February 2 2016 was added nearly a year later, which stated bank nurses were being requested to mitigate this.
- Some of the community hospitals, such as Ashburton and Dartmouth had difficulty in recruiting nursing staff and this left one registered nurse on shift during some late shifts and frequently on night shifts. Staff expressed concerns about the safety of this staffing level.
- Staff from Dawlish hospital raised concerns that regularly there was only one registered nurse on duty on the late and night shift. During the inspection, an incident occurred at Dawlish hospital. A patient arrived

at the minor injuries unit in the early evening, who was suffering from a suspected heart attack. There was only one registered nurse on the inpatient ward at Dawlish hospital. At the time the patient came in the lead minor injuries unit (MIU) nurse from Newton Abbott was visiting the MIU and a nurse consultant was at Dawlish hospital. This meant there was sufficient staff available to manage the patient on this occasion. However, normally only one registered nurse was rostered on duty on a late shift on the inpatient ward area and in MIU. This meant there was the potential for the ward nurse to have to leave the ward if there was an emergency in MIU. This would put patients at risk as the ward would be left without a registered nurse during this time.

- The trust reported changes to the service specification of the hospital left staff feeling unsettled. Some permanent nursing and healthcare and administrative staff left and there were difficulties in recruiting replacement staff. Shifts were filled using bank staff and discussions were due to take place in February with the Chief Operating Officer to decide if patients should be relocated to Newton Abbott.
- At Teignmouth hospital, a matron informed us she would be required to work clinically for the entire month following the inspection instead of carrying out her role as Matron. This was a result of continuing staff shortages. This meant the opportunity to carry out managerial tasks such as audits, staff appraisals and support would be reduced due to the lack of availability of the matron.
- In some hospitals, assistant practitioners who were not qualified nursing staff, were included in staffing numbers as registered nurses. This was also happening regularly at Dawlish community hospital. However, we were informed these staff were not left in charge of the ward at any time.
- The trust had a temporary staffing checklist and safety questionnaire which was used with agency staff. This included information such as fire exits, the location of resuscitation equipment and how to get medical support.
- Staff were able to request additional nursing staff when it had been identified that a patient required enhanced support. For example, on one ward a patient was receiving continual one to one care while they were waiting to be discharged to a care home. Another bariatric patient required five staff to turn them in order to maintain their health. Extra staff were requested via the trust's rostering system, however one matron told us this was often a fruitless exercise when trained staff were required. If no trained staff were available the assistant deputy director was informed. A decision to raise to 'level one' would be made, which required calling other community hospitals to see if they had spare staff available. If no staff were still available, the request was escalated by the assistant director to the trust's community executive who would make the decision to raise this to 'level two'. This then gave permission to request agency staff. One matron told us this was a very time consuming process, which could take up to a day to organise. We were informed by directorate leadership that requests for agency staff were expedited, however sourcing the required staff may take longer.
- Senior nursing staff reported concerns with medical cover at Brixham community hospital. However, we were informed there had been changes to medical cover at Brixham and Paignton hospitals due to retirement, but service continuity had been maintained.

Managing anticipated risks

- On 18 December 2015 Bovey Tracey community hospital inpatient beds were transferred to Templar ward at Newton Abbott hospital due to a combination of sickness absence and a shortage of registered nurses to ensure the safe care of patients. The trust, along with South Devon and Torbay clinical commissioning group agreed to the temporary closure. They stressed it was unrelated to plans for dealing with winter pressures. We reviewed an operational plan to meet the relocation requirement of inpatient beds. Potential risks were identified which looked at equipment, staffing, logistics and a number of other key considerations. The document reviewed contained a number of actions and deadlines but with comments about progress made only attributed to some actions. The plan did not include any specific ongoing action on how to monitor the impact on the change to the service, patients or staff. Staff felt that this was better planned this year.
- However, they expressed concerns that 'escalation point' before the hospital could close had to be reached and this happened suddenly, when there were not

enough staff to continue safe care at Bovey Tracey hospital. With a couple of days' notice, staff and patients were moved to Templar ward at Newton Abbott. Whilst this was well executed, a physiotherapist who ran therapy sessions at Bovey Tracey hospital was not involved in the consultation and had to find alternative accommodation at short notice for their clinics. Clinics were relocated to a nearby GP surgery to avoid lone working and therefore comply with the trust's lone working policy.

- Senior therapy staff, nursing and healthcare staff raised concerns about the speed of opening escalation beds and the lack of competent staff to manage stroke patients, as agency staff were not adequately trained to manage these patients. They expressed concerns about lack of trained staff available to feed patients who required extra support to eat due to difficulties in swallowing following a stroke. Speech and language therapists provided additional advice and support to mitigate risks where possible, by identifying which patients were most at risk. Staff had to stagger mealtimes for these patients in order to make it safe and minimise risk to patients. Trained substantive staff were asked to work overtime, but this was on a goodwill basis. Some patients waited longer to be supported in this area of care as a result. There were also concerns that patients were waiting to be settled at night, as a result of having to stagger mealtimes.
- Senior management led a debrief in May 2015 to review the opening and management of the winter escalation ward at Newton Abbott during the winter of 2014/ 2015. Staff felt that many of the same concerns expressed during this meeting were repeated when the escalation wards opened suddenly in January 2016. Processes and plans that were agreed to enable the safe management of the escalation wards were not all implemented in line with this debrief. Staff of all seniority expressed concerns about the high levels of agency staff used on these wards who did not have the skills to manage stroke patient care. In the escalation de-brief on the 21st May 2015, it stated there should be a mix of organisational staff with bank and agency staff, and that some agency staff's skills were inadequate. Staff we spoke with felt the plan to ensure there was a good mix of hospital employed and agency staff across the two wards did not always happen. In addition, the debrief highlighted the need for consistent staffing. This would mean using the same bank or agency staff so that they could be more familiar with the patients, their needs and the skills needed to care for this type of patient. Senior nursing staff expressed concerns about the safety of staffing levels and skill mix across the wards as a result.

Major incident awareness and training (only include at service level if variation or specific concerns)

- Major incident and fire plans were kept on the wards.
- Dartmouth hospital was at risk of flooding twice during 2015. This appeared on the sites risk register and a plan was in place to transfer patient to an alternative hospital if required.
- Staff across the community hospitals were aware a generator was available in the event of a power cut.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We judged effectiveness within community hospitals as good.

- Staff followed national guidelines and recommendations to deliver effective care and treatment and ensured patients' pain was well managed.
- Patients' care and rehabilitation goals were identified on admission to the hospital. Referrals to therapists and specialists were made in a timely way that would best support their reablement and recovery. There were systems in place to ensure patients received adequate fluid and nutrition.
- A variety of quality and audit information was collected at each community hospital which was used to improve the quality of patient care. Length of stay for each community hospital was monitored. Although varied between hospitals, it was shorter than the national average of 28 days.
- Multidisciplinary team working supported effective planning and delivery of care for adults being cared for in the hospital and for their ongoing care following discharge. Staff engaged with patients' families and carers to ensure patients were discharged into the right setting with appropriate care and treatment in place.

Evidence based care and treatment

- We saw examples of staff following national guidance. Staff talked confidently about the guidelines they followed in delivering patient care, for example, guidelines for the management and prevention of pressure ulcers, the management of chronic obstructive pulmonary disease and stroke. We saw evidence from monthly matrons' meetings which demonstrated guidelines were reviewed and practice was updated.
- Staff assessed patients' needs and developed their care goals in line with evidence-based guidance and best practices. We saw patients had a care and rehabilitation plan devised to meet their needs. Therapy goals and milestones were identified, with review dates documented. Nurses and therapists explained how they sat with the patient to discuss and decide upon patients' goals and desired outcomes for treatment. We saw evidence of this documented in patients' records.
- Patients' rehabilitation goals were identified on admission to the hospital and referrals to therapists were made in a timely way that would support their reablement and recovery.
- Patients on the stroke rehabilitation ward at Newton Abbott hospital had clearly defined rehabilitation goals in place which involved different teams and were tailored to the patients' needs.
- Policies, care pathways and procedures were developed in line with national guidance and were available for staff on the hospital intranet site. We saw evidence that changes to national and local evidence-based guidelines were reviewed in meetings and changes to practice implemented as a result. For example, an external speaker came in to the professional practice meetings attended by community hospital matrons to discuss revised bowel and bladder care pathways.
- Staff we spoke with were mindful of not discriminating when making care and treatment choices. Staff talked consistently about treating the patient as an individual and would tailor their care and treatment to the patients' needs regardless of age, ethnicity, religion or disability etc.
- Staff had regard to the Mental Health Act Code of Practice. If staff were concerned about a patient's mental capacity, a mental capacity assessment would be carried out by nursing or therapy staff. Some more junior staff told us felt confident to flag any concerns about a patient's mental capacity with their superiors. We reviewed a number of mental assessments in patients' notes and found them to be completed correctly.

Pain relief

- The hospital wards received daily visits (Monday to Friday) by GPs, who were able to adjust prescriptions for

analgesia, as required. We observed doctors and other staff during ward rounds who spoke with patients about their perception of pain and their pain management requirements. Outside of these times, patients accessed pain relief through nursing and therapy staff. They asked where pain occurred and when.

- A recognised pain assessment tool was used and documented as part of the care pathway.
- Patients told us that their pain was adequately controlled. They told us that pain relief was offered and given immediately when it was requested.

Nutrition and hydration

- Staff followed NICE guidelines relating to screening for malnutrition. A malnutrition screening and assessment tool (MUST) was recently introduced at the trust and was completed for each patient within 24 hours of admission.
- Care plans were up to date and used by nursing and therapy staff to assess a patient's nutritional status meaning patients' intake and output was regularly assessed. We saw staff took appropriate action when a risk was identified, to ensure patients received sufficient nutrition and fluid to promote their recovery. Staff prescribed supplemental drinks to patients who needed them to support their nutrition and hydration needs.
- Staff and volunteers assisted patients at mealtimes and offered drinks to patients regularly. Patients had access to water at their bedside. There was a variety of hot drinks available to patients in the day rooms and seating areas to encourage hydration.
- Two health care assistants (HCA's) and nutrition champions at Dartmouth hospital established a lunch monitor system where a designated person recorded food and drink consumed by patients, onto their food and nutrition chart.This role was established following the merger as staff identified a misunderstanding of roles when catering and cleaning staff amalgamated. It was noted that patients with nutritional issues were not having their food and fluid charts completed. This system only happened at lunchtime as this was the only cooked meal of the day.
- Ward staff had access to advice from dieticians and speech and language therapists. Speech and language therapists provided advice and guidance for patients who had difficulties with eating and swallowing as a result of their medical condition. For example, patients could experience difficulties in swallowing following a stroke or during advanced stages of dementia. Dieticians and speech and language therapists visited patients at the hospitals regularly and were also available to give advice to staff by telephone.
- All hospitals we visited had protected meal times. This allowed patients to eat without being interrupted by non-urgent medical treatment and meant staff were available to offer assistance where required. In hospitals with open visiting, the matron told us some patients preferred their relatives to help them with their food and discussions had taken place with patients and carers to agree this.
- Patient-led assessments of the care environment (PLACE) assessments November 2014 to November 2015 showed the average score for food across the community hospitals was 94.8%. All scores were above the England average of 89% with the exception of Dartmouth, which scored88.3%. In general, patients we spoke with said the food was good and that all hospitals provided a variety of choices that were appetising.

Patient outcomes

- The Sentinel Stroke National Audit Programme (SSNAP) data for the stroke unit on Teign ward at Newton Abbott community hospital for the period July 2015 to September 2015 achieved a score of level A, and a B and 2 A's for the previous quarters from October 2014 to June 2015. The levels were achieved by comparing a variety of data received against a set of relevant questions about care provided post stroke. This was better than the England average.
- A variety of quality and audit information was collected at each community hospital which demonstrated local audits were ongoing. Staff monitored falls and displayed this information on the wards. The use of alarmed mats was implemented in order to reduce falls. These mats were designed to set off an alarm when patients stepped out of bed unaided and alerted staff to be vigilant of patients movements. At Dawlish hospital for example, falls audits reported in a staff meeting in January 2016 showed reductions in falls were seen during the previous two months. Senior leadership reported pressure ulcer care was regularly audited and

actions taken to improve the management of wound care, resulting in an 86% reduction in avoidable pressure ulcers. Staff had access to tissue viability experts based at the main acute hospital for advice and support.

- Matrons were aligned to specific areas of quality improvement, one of which included pressure ulcer care. Matrons provided feedback on quality of care at regular matrons' meetings and shared learning and recommendations to changes to practice to staff on the wards.
- Staff meetings were held at the community hospitals in which audit outcomes were discussed and learning shared to improve the quality of patient care. For example, staff audited patient care plans at Dawlish hospital. This process ensured care plans were completed effectively by staff and that that the quality of individualised care plans was monitored.
- Length of stay for each community hospital was monitored and varied from 12.5 days in Dawlish to 19 days at Ashburton (November 2015). This was shorter than the national average of 28 days. Senior leadership informed us that the average length of stay in the community hospitals was 14.5 days which had increased in recent years due to increasing patient complexity and the increasing difficulty in accessing packages of care in the community. The trust's target for length of stay for patients who had been transferred from the acute hospital was 14 days, 12 days for those who were admitted directly by their GP and 20 days for stroke patients.
- Information that improved patient outcomes was shared between the community hospitals meaning patients would benefit from improved practices. For example, a falls prevention meeting took place every two months in order to formulate actions to demonstrate a reduction in harm from falls across inpatient care at the trust. Data was audited, reviewed and actions taken as a result, such as the implementation of staff training.
- Senior staff and GP's oversaw robust mortality reviews for each patient death within the community hospital using a mortality review tool. The purpose of which was to understand and minimise avoidable deaths within the community, mortality trends, to ensure good end-of-life care.A monthly reporting system using the mortality review tool provided transparency and organisational learning in order to drive best practice.
- Therapists used recognised outcome monitoring scores such as the Berg Balance Scale, a widely used clinical test of a person's balance abilities and the modified Barthel Index to measure performance in activities of daily living. This allowed physiotherapists and occupational therapists to monitor the effectiveness of their treatments and to support patients in regaining independence. We saw that patients had regular therapy input where appropriate to enable their recovery and reablement.

Competent staff

- Staff were able to access mandatory as well as role specific training.Staff spoke highly of the trusts training, based at the district general hospital and online training was accessed via the internet at community sites.
- A range of staff at Newton Abbott hospital expressed their concerns about the staffing of escalation wards relating to the management of stroke patients. It was felt that staff did not always have the right skills to manage these patients effectively. Teign ward was a dedicated stroke ward where stroke patient were regularly being cared for in 15 allocated beds. This bed base doubled during escalation, as did Templar ward. Experienced staff were spread thinly across the wards to support agency and temporary staff. This also caused a lack of consistency. Agency staff were not specifically trained to manage the care of stroke patient. This included daily activities such as feeding patients with eating and swallowing difficulties or monitoring stroke specific observations. To help overcome this, speech and language therapists had provided additional support and guidance which senior staff reported helped staff to prioritise which patients needed more support to eat.
- New staff received a trust induction for one week and were supernumerary on the unit for the first two weeks. A recently employed staff member felt very satisfied with the induction and level of support they received.
- Training records showed between 89% and 100% of staff across the nine community hospitals participated in an annual appraisal in the year up to December 2015.

Good

Are services effective?

- Staff told us they were encouraged and given opportunities to develop. They were supported by their managers to attend training days and to complete online training. Staff said the training they received was appropriate and relevant to their roles. One senior nurse told us about the dementia awareness course that all her staff were attending to support them in caring better for many of their patients living with dementia.
- Nursing matrons attended a leadership skills course. We were told that this course was now offered to staff nurses. Others had qualified as nurse prescribers and some staff received training to enhance the skills specific to their role.
- The hospitals set up link nurses for a range of specialisms such as tissue viability, dementia, falls, diabetes, nutrition, end-of-life care, and infection control. This meant staff were more extensively trained in specific areas of patient care and management and were available to support other staff with the effective care and management of patients at the hospitals.
- Training session with GPs and matrons took place quarterly and some quality standards for GPs had been developed.
- Nursing and healthcare support workers at some hospitals were offered the opportunity for clinical supervision on an ad hoc or on request basis. They did not speak about a formal process of clinical supervision but staff and line managers spoke of an open door policy in which they could request the opportunity to discuss concerns or issues at any time with their superiors. At other community hospitals, such as Dawlish, staff received clinical supervision every month or other month. However, this contrasted with information in a review presented in the
- < >taff at the community hospitals had access to a range of in-house, short courses as well as some that were provided by the University of Plymouth.
  Poor or variable staff performance was managed through the trust's internal performance management process. For example, a matron explained they would address poor behaviour verbally and write it formally in a letter, where expectations about standards of behaviour would be communicated. If they felt this was not listened to, they would start a formal process involving human resources. This followed trust's policy.
- In Dartmouth hospital the matron placed food hygiene on the risk register. It received a red RAG rating (Red, Amber, Green) using the trusts risk assessment tool. The entry on the risk register in February 2016 stated nursing staff did not receive food hygiene training yet are involved in food service and preparation for patients. There were no mitigating actions linked to this.

Multi-disciplinary working and coordinated care pathways

- All necessary staff, including those involved in different teams and services, were involved in assessing, planning and delivering people's care and treatment.We observed a number of different multidisciplinary team (MDT) meetings across the community hospitals. They were attended by a variety of different staff including doctors, medical students, ward sisters, therapists and social care. They were well organised, well led and each member of the team was listened to. All staff were clear about who was responsible for each patient and their ongoing care and treatment plans.
- The involvement of teams such as social workers enabled them to make timely referrals for services the patient would need following discharge. Joint visits with the patient, social workers and relevant therapists were also set up during the MDT meetings.
- Multidisciplinary team working supported effective planning and delivery of care for adults with long term conditions and complex care. Community nursing teams attended weekly MDT meetings which improved communication between teams. This meant nursing teams were already familiar with patients that were being discharged into their care in the community. Staff worked with other community teams within the community division to ensure the most appropriate support was organised for patients whilst an inpatient and for when they were fit to go home.
- Staff showed a real understanding of patients' needs and described their care requirements in detail during the meetings. Staff said they were proud about how teams had integrated following the merger and of the way that the groups of professionals worked together to deliver the best care for the patient.

Good

Are services effective?

- GPs from local surgeries provided medical cover on the wards and visiting consultants conducted ward rounds, which involved ward staff and the patient, where possible.

Referral, transfer, discharge and transition

- Staff told us patients were discharged at an appropriate time of day. We did not see any data relating to times of patients being discharged. A discharge coordinator on wards helped coordinate the discharge process. All relevant teams were informed and the patient only left the hospital when appropriate ongoing care was in place. The hospitals liaised effectively with patients' GPs and other services in a timely way in order to coordinate their ongoing care. We observed staff discussing how they had liaised with nursing and care homes during multidisciplinary meetings. We heard how an occupational therapist liaised with social workers in order to arrange a deep clean at a patients home so that the patient could be discharged in a timely way and into a clean and safe environment, so as to avoid readmission
- Therapy and outreach teams carried out assessments of patients in their homes as well as assessments of the patients' home environment. They used occupational therapy assessment kitchens in some of the community hospitals. The objective of these interventions was to reduce the risk of readmission following discharge from the hospital.
- Staff commenced planning for discharge on admission to the hospital. Therapy staff were proactive in seeking the patients' permission to discuss care with family and carers so as to understand the patients home situation and the level of support they would require following discharge. The patient was taken home by therapy staff for a number of home trials. The patient then remained at home if this was successful.Alternatively, staff arranged for a more suitable, interim placement for the patient, until they were ready to return home.
- During MDT meetings and board rounds, we observed staff discussed each patient, their diagnosis, estimated discharge date and the multidisciplinary team input needed to facilitate discharge. Alternatively, if needed, patients were given a date when discharge would be re-assessed. The package of care requirements were based on environmental assessments of the patient's home as well as their care needs. Patients told us they were kept informed about their discharge date and any changes to this.
- The most frequent reason for delayed discharge was the lack of availability of complex care packages in the community. Staff discussed discharge delays with the acute hospital and social services to ensure patients ready for discharge were prioritised.
- We saw staff completed discharge information effectively. It was accurately completed, dated and signed.

Access to information

- Patient records were paper based and generally arrived with the patient if they were transferred from the acute hospital. If records did not arrive, staff reported this as an incident. Staff had access to electronic pathology and test results but did not have access to social services assessments on their IT system.
- Staff across the community hospitals told us that they were phoned by Torbay hospital and given a verbal handover using the SBAR format, prior to the patient arriving at the community hospital. SBAR is a structured method for communicating critical information about the patient and their condition. However, staff across the community hospitals found the information relating to the complexity of the patient often differed from their assessment of the patient on admission. Staff expressed concerns that the patient's condition was sometimes more acute or complex. For example, one nurse said that they were told a patient to be transferred was living with dementia but not that they were under one to one supervision. One member of staff felt this related to approximately one quarter of all patients who came from the main hospital, based on their experience. However, we were not aware of any data being collected by the trust to quantify this information. Other staff said that patients being transferred from Torbay hospital were discharged into the discharge lounge there. This meant that the nurses who then carried out the handover of information about the patient did not know the patient well.

Good

Are services effective?

- Some of the community services staff were also based in the community hospitals or had regular access to them. Staff said that there was good communication and information sharing between the two teams in relation to patients' care.
- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. Ward staff, medical staff and allied health professionals wrote in the patients' records or medical notes. The medical notes included information about test results and care plans included information about care needs and risk assessments. Staff carried out documentation audits quarterly to ensure information was effectively documented.
- Therapists in the Dawlish hospital said they were unable to prescribe equipment for the Torbay area but could do so for patients who lived in South Devon. They would have to ring the community rehabilitation teams to ask them to prescribe as Torbay were on an IT system that therapists at Dawlish could not access.
- Patient records were transferred to the acute hospital at Torbay following the patient's discharge. They were retuned back to the community hospital upon request within 24 to 48 hours if needed.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff on the whole had a good level of awareness of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DOLS) and had received training for this. They articulated the process of how to complete a DOLS application and accessed the forms via the intranet. Staff were supported by their superiors or the safeguarding team if they had any questions. In Totnes hospital, a completed example form was available for staff to refer to.
- Staff we spoke with had received training for the Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff told us that Matrons were very supportive and knowledgeable about this subject and maintained awareness by flagging patients during ward safety briefings and handovers.
- If staff were concerned about a patient's mental capacity, they carried out a mental capacity assessment. We reviewed a number of mental capacity assessments and found only one of them to be partially completed.
- Staff were aware of issues relating to lawful and unlawful restraint and could contact the trusts safeguarding team for advice.
- Care records had risk assessments relating to the use of bed rails and alarm mats. Discussions around consent for the use of these were documented in the patients' records.
- We observed consent being sought for procedures and patients told us staff asked permission before carrying out care. Several patients said consent was sought at various stages throughout their care and treatment.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We judged the care of community inpatients to be good.

- Patients and relatives across all eight hospitals provided positive feedback about patients' care and treatment.
- We saw staff treating patients with kindness, respect and dignity. Staff responded sensitively to patients' needs when patients experienced physical pain, discomfort or emotional distress.
- Patients and their relatives felt involved in their care and were supported emotionally. Patients we spoke said staff took time to explain their care and treatment in a way they could easily understand. Relatives felt involved in the planning of patients care ready for when they returned home.
- Patients' call bells were answered quickly. Staff support and empowered patients to manage their own health, care and wellbeing to maximise their independence.

Compassionate care

- Patient-led assessments of the care environment (PLACE) for 2015 showed the average score for privacy, dignity and wellbeing across all nine community hospitals was 88.5% which was above the England average of 87%. Dartmouth community hospital scored 85.4%. In the February 3 Experience and Engagement annual report summary presented to the board, priorities to address areas of improvement as a result of the 2015 PLACE audits were outlined. These did not include any plans relating to privacy and dignity.
- Patients spoke positively of the way staff managed their privacy and dignity and maintained patient confidentiality. Staff spoke to patients discretely where necessary and in a kind and friendly manner. A patient was very complimentary about the sensitivity and care demonstrated by staff when for the first time, they had to be bathed and dressed by others.
- Staff took time to understand patients' needs and these were respected by staff. One patient commented, "Staff recognise each patient's needs and you are called by your preferred name which is good."
- Staff drew curtains around patients when personal care was taking place. We observed staff ask before entering drawn curtains and knocking on closed doors before entering. However, one patient we spoke with said that despite curtains being drawn, a volunteer had not sought permission before entering and a cleaner mopped underneath the drawn curtains.
- Staff showed a sensitive and supportive attitude towards patients, and patients and relatives confirmed this. Several patients told us that they felt treated as an individual.
- When patients experienced physical pain, discomfort or emotional distress, we observed staff responding sensitively to the patients' needs. For example, we saw a patient who was confused becoming increasingly anxious and calling out for a nurse. A doctor, therapist and healthcare assistant each took the time to comfort and reassure the patient until she was visibly calmer and more relaxed.
- Volunteers at the hospital played an important role in interacting and engaging with patients. We spoke with and observed a number of volunteers, who came into the hospital who talked with patients and helped them to eat and drink.
- We observed a variety of staff across the hospitals engaging with the patients. We heard them referring to them by name and talking about matters that were important to them, such as family members and personal interests. At Newton Abbott hospital for example, a healthcare assistant was singing along to music with a patient that was playing on the radio in a communal seating area. The patient looked happy, engaged and relaxed. At the same hospital, we overheard a healthcare assistant very patiently and kindly talking a patient through the menu choices and supporting them to make meal choices.
- We saw examples of cards and notes sent to staff to thank them for their care and kind treatment at the community hospitals. Families also wrote to thank staff. A card displayed at Dawlish hospital said, "Thank you more than words could say for looking after mum so well. We will always remember you."

Good

Are services caring?

- When call bells sounded, they were answered quickly. Staff who were busy reassured patients and showed concern about responding quickly. They returned to them as soon as they could or asked for help from others if it was more urgent.
- When we were speaking with one patient, they advised us that they wanted to be made more comfortable in their bed and we saw staff assist the patient with their wishes promptly.

Understanding and involvement of patients and those close to them

- Patients we spoke with across all community hospitals said staff took time to explain their care and treatment in a way they could easily understand.
- We talked to a number of relatives who all spoke highly about the way in which staff involved them in the patients' care. They felt involved in the planning of patients care ready for when they returned home. For example, we saw notes relating to the involvement of a patient's daughter in the patients care and treatment in the hospital and at home. There were contingency plans in place that involved other agencies, in case the patient's condition on discharge meant their daughter was not the most appropriate person to care for them.
- People who used the services and those close to them were routinely involved in planning and making decisions about their care and treatment. Patients told us that they and their families were involved in the planning of nursing care and were aware of their goals towards discharge.
- Therapy staff explained how they gained consent from the patient to involve their family and carers on admission to the hospital. They would go out to the patients' home to meet with families in order to ensure the patient had access to the most appropriate services and equipment to enable their recovery. This enabled staff to fully understand the patients' home situation and whether the family or carer was best placed to support the patient with their ongoing care and reablement. They could support families with this process and assess the level of input the patient would need from other agencies.
- One patient we spoke with felt staff had not listened to them effectively about their health concerns. We informed a senior member of staff who acted upon this information and spoke with the patient immediately to understand their concerns. Another patient had raised concerns with staff about a catheter trainee staff had just fitted under supervision. Staff acted promptly, it was removed and correctly re-inserted. The patient said staff "fixed it in minutes."

Emotional support

- Staff were seen comforting patients and relatives in a supportive manner. The relative of one patient in particular told us how staff had demonstrated care and concern after he had travelled a long distance to visit his wife in hospital. They said they were really well looked after by staff.
- Chaplaincy services could be arranged if required. Patients at the community hospitals had access to their own local Clergymen who visited the wards on a weekly basis. At Newton Abbott hospital, there was a beautifully constructed multi-faith room, which provided a calm environment for peaceful thought or prayer.We were told that communion could be arranged as patients required. Staff also described being able to access support for those of other religious denominations.
- Volunteers offered a befriending service which helped to support patients emotional needs in particular for those without family or relatives.
- Staff arranged for the patients' hairdressers to come in if needed, which made them feel better. Staff who were capable assisted patients with their hair, makeup and applied nail varnish which demonstrated care for their emotional wellbeing.
- We saw staff of all grades and roles assisting and supporting patients and empowering them to manage their own health, care and wellbeing to maximise their independence. Therapists walked with patients to help them gain confidence and gave them support with aid such as walking frames. We saw staff providing kind words of encouragement to patients when assisting them to walk down corridors and checked how they were feeling whilst doing so.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

- We judged the community inpatient services were responsive to patient's needs. The trust and staff from community hospitals worked with local commissioners of community services and partner organisations to ensure the division provided services that met local people's needs. Community hospital staff worked closely with community nursing and therapy teams, GP practices and social services to ensure patients access to ongoing care and treatment.
- Staff received training in equality and diversity. They told us they always did their best to meet the needs of the patient and were sensitive to their personal, cultural, religious needs, or sexual preferences.
- Services were planned, delivered and coordinated to meet the needs of patients living in vulnerable circumstances, such as those patients living with dementia. Staff demonstrated a good level of awareness of how to best care for patients living with dementia, so that they were able to respond to their needs appropriately. All of the community hospitals had dementia friendly environments, with signage, pictures and brightly coloured paint to differentiate between different areas.
- People had timely access to initial assessment, diagnosis and treatment.
- Patients told us they felt they could ask questions or raise concerns if the felt they needed to, at any time during their stay. The complaints system was easy to use and posters and leaflets displayed around the community hospitals outlined the procedure. The trust RAG rated the number of complaints relating to community hospitals as green.
- However, there was no therapy input at weekends, which sometimes resulted in a break in the continuity of treatment. Staff also expressed concerns that some patients were transferred too late at night.
- The trust worked with local commissioners and organisations such as Healthwatch, to ensure the division provided services that met the needs of the local population.
- There was a clear admission policy for community hospitals. At times of extreme capacity pressures and in agreement with commissioners and the acute hospital, patients were sometimes admitted outside of the standard admissions criteria to ease patient flow.
- Staff told us that as part of the admission criteria, they verified where the patient resided so they were admitted to the community hospital closest to their own home and community.
- For the previous two winters, an escalation ward was opened at Newton Abbott hospital to manage winter pressures, usually from January for several months. This resulted in additional beds being made available to accommodate patients from the locality. During escalation the trust reported it would organise short term support arrangements for relatives to visit. Patients would be prioritised to move to a more local hospital when possible.
- Staff worked closely with other social workers, councils, GP practices and community based nursing and therapy staff to support the ongoing care of patients with long-term conditions and complex needs.
- Therapists from community hospitals worked with community based therapists to coordinate ongoing rehabilitation for patients, which included supporting patients to gain access to ongoing therapy. For example, patients were encouraged to attend chair-based outpatients classes, post falls groups and were prescribed equipment for patients to use in their homes.
- Community hospital nurses worked closely with community based nurses to ensure the most appropriate packages of care were in place for when the patient returned home, or to a different care setting.
- All of the community hospitals we visited told us the most common cause of delayed discharge was due to

Detailed findings

Planning and delivering services which meet people's needs

patients having to wait for a suitable package of care in the community. These delays were outside of the hospital's control but did affect the patients' length of stay in hospital.

- Facilities and premises overall were appropriate for the services that were planned and delivered. Space at the newer hospitals such as Newton Abbott and Dawlish hospital was more readily available. In older hospitals, there was little space for therapists to work other than at the patients' bedside. However, at Newton Abbott hospital for example, there were excellent gym and rehabilitation equipment facilities available. Staff throughout the community hospitals said they always looked for ways to improve how they ran their services and did their best to deliver good care in the facilities provided.
- All hospitals had step free access and disabled parking. However, it was noted at Ashburton and Buckfastleigh hospital, the ground from the car park sloped which may have proved difficult terrain for patients with mobility issues.
- We were not made aware of any specific plans to specifically accommodate the needs of bariatric patients, other than accessing bariatric patient designed equipment. A bariatric patient told us their wheelchair was too wide to support him to gain access to their en-suite bathroom and they felt therapists could have better supported them with their rehabilitation.
- Staff were aware of which patients were living with dementia as it was flagged during handovers and safety briefings and information was stored on the electronic white boards and white boards. This meant staff were informed about the patients care needs and could care more appropriately for these patients.

Equality and diversity

- Staff received training in equality and diversity as part of the mandatory training programme.
- Staff told us they had access to interpreter services if required. Many staff admitted they could not remember an instance where it had been required, due to the demographic of the area. However, ward clerk at Newton Abbott explained a patient recently admitted spoke little English. Whilst awaiting translation support, staff used the internet to translate the menu so they could help the patient in choosing their preferred food and did their best to communicate with the patient.
- Staff could access 24-hour support to provide sign language services.
- Leaflets were available in all of the hospitals community and could be printed in large print or other languages as required.
- In general, staff said they would always try to meet the needs of the patient and in doing so be sensitive to their personal, cultural, religious needs, or sexual preferences. For example, a member of staff explained how they acted sensitively when caring for a transvestite patient. Based on the patient's wishes, they were cared for in a side room where they felt more comfortable.
- We were told by ward staff food could be provided to cater for patients' specific dietary, cultural and religious needs.

Meeting the needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to meet the needs of those patients living with dementia, so that they were able to respond to their needs appropriately.
- Staff demonstrated a good level of awareness of how to best care for patients living with dementia. All of the community hospital wards had 'dementia champions' who worked across a variety of disciplines. They had extra training and attended link meetings to ensure they were up to date with best practice recommendations. They were available to give staff guidance and support to meet the needs of people in vulnerable circumstances such as patients living with dementia or learning disabilities.
- Community hospitals participated in a national dementia care audit once per year which staff report resulted in lots of changes to dementia care, such as changes to the colour schemes. The theme of brightly painted and different coloured walls helped patients identify their own beds and was replicated throughout the hospitals we visited.

Good

Are services responsive to people's needs?

- All of the community hospitals had dementia friendly environments. Some areas had signage and pictures indicating bathrooms and toilets on doors. Staff had visited another community hospital locally to see how they had developed their dementia friendly ward in order to gain further ideas.
- Sandwiches, toast and finger food snacks were available at all times in line with the dementia friendly initiative.
- Patients living with learning disabilities were not highlighted on admission to the hospital. However, staff accessed support from the learning disability team at Torbay hospital or through South Devon local authority. We heard of two recent examples where patients living with learning disabilities were enabled to have their carers with them 24 hours a day. This practice enabled patients who were living in vulnerable circumstances to access care when they needed.
- Volunteers and staff engaged with patients in activities such as reminiscence therapy. For example, at Dawlish hospital volunteers came in every first and third Wednesday of the month. This form of therapy used guided communication, music and familiar objects from the present and past. These activities aimed at stimulating the senses and memories to achieve positive outcomes.
- At Ashburton hospital, we heard how a representative from a charity attended a multidisciplinary team meeting to help with patients who were being discharged. Representatives from the charity had driven relatives to visit patients in the hospital and were increasingly involved in helping patients at mealtimes. These patients required extra support with daily tasks and services to support them to return home following care and treatment.
- We reviewed shift handover sheets. They were very detailed and used symbols to identify patients at risk, either because they had a form of dementia, or due to poor mobility.

Access to the right care at the right time

- People had timely access to initial assessment, diagnosis and treatment. The community hospitals had access to medical care form doctors during Monday to Friday between 8-5pm. GPs provided medical cover for the wards, who were either directly employed by the trust or through a service level agreement. Each community hospital had a lead GP.
- GPs conducted daily ward rounds and patients with the most urgent needs were seen quickly. They were prescribed medicine or referred for tests as needed.
- The service prioritised care to those who needed it more urgently if necessary. Local out of hours services provided medical cover outside of these time. If a patient suddenly deteriorated, staff would call an ambulance in order to transfer the patient to the acute hospital.
- Newton Abbott hospital had access to a stroke consultant who visited patients on the stroke ward, which provided additional specialist care to patients.
- Out of hours support staff reported out of hours medical support was responsive to their calls. An on call GP service has provided telephone advice and came to the hospitals to assess and treat patients as required.
- Therapy staff supported patients from Monday to Friday. There was no therapy input at weekends, which sometimes resulted in a break in the continuity of treatment and progress. During the trusts 'perfect week' initiative in October 2015, seven day therapy cover was suggested by some staff but this had not yet been put in place.
- Patients told us that they were happy to be on a ward close to home and to their relatives.
- Pharmacy services were provided Monday through to Friday and included pharmacy technician support. A pharmacy technician we spoke with told us generally, medicines were available on discharge and in a format suitable for the patient. We were told, however, of instances when patients had been discharged without their medicines, as it had not been delivered to the hospital in time. Staff had previously had to send medicines to the patient's home by taxi service.
- During the month of November 2015 the trust reported bed occupancy rate as high and on average across the community hospitals was 92.7%.
- The day surgery unit at Torbay ran on time and kept people informed about any disruption. They reported

patients rarely had to wait long for a procedure. If a procedure was cancelled, the sister in charge would contact the patients to inform them. Patients were able to call for advice at any time and staff recorded this in the patients notes for audit purposes or in case of any follow up appointments.

- Admission criteria and pathways were in place but on occasions, due to inaccurate handover information from the acute hospital, patients were readmitted back to the acute hospital. Staff also expressed concerns that some patients were transferred too late at night. This was not good for the patient and put staff under pressure during late and night shifts when there were less staff. This sometimes included patients who were confused or living with dementia, which was contrary to the trust's transfer policy. Some staff said they recorded this using the incident reporting system but we were not clear as to whether all staff would do so.

Learning from complaints and concerns

- Most patients we spoke with said they would raise a concern or complaint by speaking with staff on the ward first of all. Some patients were aware of how to make a complaint through the patient advise and liaison service (PALS) as staff had offered them a PALS leaflet or they had received this along with other information whilst in hospital.
- Patients told us that they could ask questions or raise concerns with any member of staff at any time during their stay.
- Patient feedback was encouraged on discharge from all community inpatient wards.
- The complaints system was easy to use and posters and leaflets displayed around the community hospitals outlined the procedure. This involved talking with staff, writing in, sending an email, calling the quality and experience team, speaking with SEAP (an independent complaints advocacy team). If not satisfied, patients could then contact the independent health ombudsmen.
- Staff we spoke with were unaware of any ongoing patient Advice and Liaison Service enquiries. However, staff demonstrated a willingness to learn from a complaint and to listen to patients' concerns and queries. Staff felt that concerns at ward level were their responsibility and most problems were solved by listening and talking to patients or relatives about their concerns.
- Some staff were aware that learning from complaints was shared with ward staff. Staff at Dartmouth hospital shared the learning from a complaint relating to communication between a patient and a GP. A review took place to look at patient's medical notes and a ward's staff communication book. This resulted in improvements in communication between nurses and GPs.
- It was reported in the board meeting on 3 February 2016, the trust received limited feedback from people who had used the complaints process. This is an area that was being considered by acute and community teams who were unifying processes following the merger. Improvements were made following an internal audit to ensure learning identified was recorded onto the trust's electronic incident recording system. The system ensured actions were followed up in a timely manner.
- Staff at the day surgery unit at Teignmouth community hospital recorded the temperature of all patients pre and post-operatively. Staff audited this process for compliance having implemented this system in response to the complaint from a patient who had complained about a drop in temperature during a procedure.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We judged the inpatients service to require improvement in its leadership.

- A strategy and vision for community inpatients had not been fully developed or communicated to staff. A number of staff felt the merger had gone well, whilst others felt disconnected from the rest of the organisation. This meant that staff did not always know or understand the strategy and their role in achieving it. Staff did not always feel actively engaged so that their views were reflected in the planning and delivery of services.
- Lines of accountability including clear responsibility for cascading information upwards to the senior management and downwards to the clinicians and other staff on the front line were not always clear.
- It was identified that there was a lack of clarity between the Trust Executive and the community senior leadership in relation to the use of a community bed status report which incorporated a staffing tool. As such, this identified a gap in assurances regarding safety going back up to the board, in particular in relation to safe staffing and skill mix at night and on escalation wards. While the board recognised that staffing in the community needed to be reviewed, they had not fully understood the shortcomings of the tool used to align staffing levels to patients' care needs.
- However, there was an organisational vision in place for the integrated care organisation overall.
- The organisation and community hospitals engaged with the local community to seek feedback in order to shape service and kept the public informed about the changes within the organisation
- Risk registers were in place across the community hospitals, which fed into the divisional risk register. Matrons and senior ward staff were not always able to articulate what the risks were on the hospitals' risk registers but were clear about issues relating to staffing.
- Staff were clear about who their local leaders were and found them to be open and approachable.

Detailed findings

Service vision and strategy

- On 1 October 2015, the services that were provided within the former Torbay and South Devon Health and Care Trust were incorporated into the new organisation Torbay and South Devon NHS Foundation Trust. A senior leadership team was established across the single organisation with the appointment of a triumvirate leadership team. It was recognised this was a new organisation which was in transition. Whilst work was ongoing in relation to the strategy for community services, senior leadership described community services, as being in need of further re-organisation, or "re-wiring".
- The strategy and vision for community inpatients had not been fully developed or communicated to staff. According to the 3 February board report, the final Clinical Commissioning Group (CCG) proposals on the future configuration of community hospitals was to be made in early 2016 and would be subject to public consultation.
- Staff were not able to identify a link to the overall organisation strategy. Staff were not aware of the strategy at the time of the inspection or of a clear vision and strategy for community services. However, they felt there had been a good level of communication about the merger that had recently occurred.
- Staff we spoke with were not always forthcoming when asked about the vision and values of the organisation. Staff were aware acutely aware of staff shortages that were ongoing and of the difficulties the trust continued to experience in recruiting permanent staff.
- There was an organisational vision in place for the integrated care organisation overall. Whilst some staff were aware of this vision, they did not feel fully integrated into the new organisation. A number of staff felt the merger had gone well, whilst others felt disconnected from the rest of the organisation. This meant that staff did not always know or understand the strategy and their role in achieving it.

Requires improvement

Are services well-led?

- There was a good level of awareness of the values of the organisation, which were based on the values described in the NHS Constitution: respect and dignity, commitment to quality of care, compassion, improving lives, working together for people and everyone counts. Staff demonstrated theses values in their approach to patient care in particular.
- The temporary transfer of inpatient beds at Bovey Tracey hospital, which saw patients moved to Newton Abbott hospital, caused staff to feel concerned. Staff expressed ongoing concerns about the future of this hospital and the implications this would have for their roles.

Governance, risk management and quality measurement

- The assistant director for Community services confirmed governance arrangements were new following the merger. They were established in line with the new Integrated Care Organisation governance reporting structure.
- A lead GP from each community hospital was funded for one session per month to meet with their matron to discuss quality, governance issues and safety.However, a matron form one community hospital informed us that GPs did not attend governance meetings at the community hospitals. A GP from another hospital said they met with the deputy matron every six weeks.
- There were quarterly meetings with the GP and matron to review learning and share best practice, to offer peer support, peer review and to monitor quality, safety and performance.
- During monthly operational meetings, matrons and senior leadership reviewed areas of quality and performance, operational and human resources issues.
- Monthly matron's professional practice meetings looked at some areas of quality, for example falls or pressure ulcer care.
- Bi-monthly band 7 deputy matron's meeting reviewed some operational issues and minutes from meetings we reviewed were brief.
- Team meetings took place monthly with standing agenda items such as falls, pressure ulcers, learning from incidents and training opportunities.
- Risk registers were in place across the community hospitals, which fed into the divisional risk register. There was some level of alignment between the recorded risks on the risk register and what people said was on their worry list. However, matrons and senior ward staff were not always able to articulate what their main risks were, although all expressed concerns relating to staffing and recruitment.
- The governance framework was not always understood by consultants who were involved in delivering care at community hospitals.
- Lines of accountability including clear responsibility for cascading information upwards to the senior management and downwards to the clinicians and other staff on the front line were not always clear. However, staff were clear about the roles of senior nurses and matrons on the wards and across the community hospitals.
- Staff expressed that they had been through an unsettling period as two of the 11 community hospitals had moved into another organisation. Transformation within community hospitals was in progress and there were concerns amongst staff that more hospitals would be closed or would become rehabilitation units. There was a plan in place for Teignmouth hospital to become a rehabilitation unit by July 2016. The risk of instability caused to staff was recorded on the risk register for Teignmouth. Mitigating actions were in place but completed actions were not recorded against the review date of 30 November 2015.
- Each hospital reported its staffing levels and bed status twice daily. It was identified this was not an accurate process for assessing staffing levels and patient acuity. Implications for this affected staffing levels across all community hospitals, as well as on the escalation ward at Newton Abbott.
- The board and senior leadership for community services could not be assured that staffing levels were safe, as there was not an effective tool in place that could accurately measure patient complexity. Senior leadership informed us there was a tool in place which enabled them to RAG (red, amber, green) rate the overall daily bed status by collecting data at a ward level twice daily from each community hospital. It relied on staff inputting data about patient complexity, bed occupancy

and staffing, in order to give a RAG rating. Having triggered amber or red, matrons could then phone to request further staffing. However, it was identified that there was a lack of clarity between the Trust Executive and the community senior leadership in relation to the use of a community bed status report which incorporated this staffing tool. Not all senior leadership within the trust had a clear understanding of it. Following the inspection, the trust clarified the Chief Nurse, Chief Operating Officer and other members of the Executive Team were not aware of the tool. After consideration, the response from the trust was that the tool referred to a community data set collected and collated by the community operations team to track community hospital bed use. As a result, they identified there was a lack of clarity on how these reports and the information linked into the operational business process, and the quality and risk process. They further identified a need to clarify how the community hospital bed state report linked into the acute trust's bed management. This identified a gap in assurances regarding safety going back up to the board, in particular in relation to safe staffing and skill mix. While the board recognised in its February 2016 report that staffing in the community needed to be reviewed, it was clear they had not fully understood the shortcomings of the tool used to align staffing levels to patients' care needs.

- Staffing levels were based on historical data and senior leadership had identified this need to be reviewed. This did not appear on the risk register across community hospitals. Staff continued to express concerns and felt that staffing levels in some hospitals, in particular at night, were not safe.
- The staffing of escalation wards was a key concern to senior nursing staff, and staff of various roles on the wards at Newton Abbott. Staff felt concerns expressed in the escalation ward de-brief, in May 2015 were being repeated. These included increased workload due to lack of availability of bank and agency staff and in particular their skills to manage the care of patients on the stroke ward. In addition the lack of continuity of agency staff created a lack of clinical continuity. This was captured on the risk register for Newton Abbott. Actions to mitigate this were around ensuring temporary and permanent staff were spread evenly across the wards. However, staff of all seniority at Newton Abbott remained concerned about the safety of the ward in relation to these issues. The triumvirate of senior leaders within community services raised concerns about retention and recruitment of staffing but not the staffing of escalation wards.
- The trust reported an increase in the number of bariatric patients admitted in recent years. This appeared on the risk register for Dartmouth and Brixham hospitals. The risk registers stated there was insufficient Bariatric equipment available within community hospital stock. Arranging transport and tracking of bariatric equipment, and additional staff needed to be available to support safe practice and care was a concern. However, mitigating actions were not established.
- A GP lead and matron in each community hospital ensured there was a review of all deaths occurring in their community hospital using the mortality review tool. The overarching purpose of the tool was to understand and minimise avoidable deaths, ensure good end of life care, and to understand mortality rates, ratios and trends. Senior medical and nursing staff analysed data to promote learning and drive improvements and best practice. A GP in each hospital reviewed all deaths and the matron or senior nurse supported each review. The Medical Director and Director of Nursing and Professional Practice were responsible for reviewing and evaluating mortality rates across the hospital. The Quality, Safety and Clinical Risk Committee reported monthly and this was reviewed at board level via the Medical Director's report.

Leadership of this service

- There was a triumvirate management structure in community services under the Assistant Director of Community Services had leadership responsibility for the nine community hospitals. All of the nine community hospitals were led by a matron. One matron was responsible for three of the nine hospitals. Matrons roles were threefold, providing clinical leadership, site management and a portfolio of lead roles linked to safety and quality.
- Line managers were on the whole described as good, open and friendly. Staff felt they could speak with their line managers when they needed to.
- Some senior nursing staff felt that senior leadership within the community services were under pressure

from the acute hospital due to bed management pressures, which was a driver for decisions made within the community hospitals. They felt this meant their concerns were not always understood or acted upon.

- Staff were visited by senior leadership in the community hospitals on occasions. A number of visits were undertaken by members of the executive team during November and December 2015.
- Staff informed us the trust's Chair had visited some of the community hospitals on Christmas day to speak with staff and patients.

Culture within this service

- There was a culture which centred on the needs and experience of patients using the hospitals and this was reflected in staff's behaviour and through the trusts values.
- Feedback from staff was that they felt well supported by their immediate colleagues and that it was a good place to work.
- Some staff felt integration following the merger had gone well. Others felt in agreement that the acute trust "didn't get community hospitals". There was a feeling of pressure from the acute hospitals to discharge patients into community hospitals and that the community were expected to absorb the additional workload.
- Some felt there had been too many changes which staff found unsettling. There was a feeling of uncertainty about the future of some of the community hospitals in particular.
- A culture of being listened to and the promotion of staff safety and wellbeing was not consistently reflected. Some staff felt listened to when they made suggestions and presented ideas. However, others felt their concerns about staffing and skill mix were not being listened to.
- Sickness in November 2015 was at an average of 4.12% versus a trust target of 4.15%. The highest rates of sickness were at Ashburton hospital,which was RAG rated as red. Ashburton, Brixham, Paignton, Bovey Tracey, Newton Abbott and Teignmouth sickness rates were RAG rated as red for 2015 overall. The two main reasons for sickness were musculoskeletal and those issues classed under 'other' as stress.
- The trust had a 'see something say something' campaign which was developed in response to the findings from the NHS Staff Survey 2014 and the Freedom to Speak Up Report. It was described as a local initiative designed to encourage and support all staff in raising genuine concerns at the earliest opportunity. Feedback from staff we spoke with about this said they would feel happy to raise a concern or challenge behaviour they did not feel was appropriate towards patients of colleagues.
- There was a 'You said, we did' initiative which was designed to communicate actions that had been taken as a result of staff feedback. It was identified staff were not always completing patients' MUST scores in their risk assessments. This is a malnutrition screening tool used to identify patients at risk of malnutrition. Alarmed falls mats were not always working which meant they did not always sound to warn staff a patient had moved from their chair or bed and was at risk of falling. As a result, all staff were reminded about the three steps needed to complete a MUST score and an audit was put in place to monitor this. Staff also implemented a falls alarm mat testing document that was checked on each shift.
- 'Hello my name is' was a trust wide initiative to encourage staff to introduce themselves to patients, visitors and colleagues. We saw all staff were welcoming, open and friendly towards patients, relatives and colleagues and saw some of these principles being applied.
- Staff were encouraged to seek feedback from patients and carers by encouraging them to complete the national friends and family test feedback questionnaire.

Public engagement

- The organisation and community hospitals engaged with the local community to seek feedback in order to shape service and to keep the public informed about the changes within the organisation.
- The trust's board summary report for 1 December 2014 to 30 November 2015 reported how it used its understanding of how people`s experience influenced its service provision and it used this information to improve the services it provided through the Executive led Experience and Engagement (E&E) committee which met bi-monthly during 2014 to 2015. There was evidence the community service division, maintained partnerships with patients, service users and stakeholders in the community to develop services.

Requires improvement

Are services well-led?

- A series of local engagement events took place in January organised by the clinical commissioning group. Directors met with local stakeholders to discuss the proposals for local services. A variety of attendees were involved including: local councils, GPs, voluntary groups, the League of Friends, patient participation groups, and the wider health and social care community. The trust reported the feedback would continue to inform the CCG's proposals for public consultation on the future configuration of Community Hospitals.
- The public had been consulted prior to the closure of Bovey Tracey hospital, following lessons learnt after the closure of the hospital during the winter of 2014/15.
- A local meeting took place in the Dawlish area where a GP led a consultation meeting with the public to discuss the changes to the merger and the new model of care.
- An open day was held one year after the early supported discharge scheme commenced for stroke patients from the Teign stroke ward at Newton Abbott hospital. Everyone who had used the service was invited to attend and one patient baked a cake to present to staff, expressing their gratitude for the support they received with their recovery.
- < > community hospitals had a good relationship with league of friends who supported the hospital to raise funds to improve facilities at the hospital.
  There were action plans in place to address public feedback regarding some of the key areas of complaints which were noise at night, information about discharge and greater menu variety
- An ex-patient who was local to the trust and had spoken internationally about their experience of living with a form of dementia, addressed staff and patients in order to help shape dementia care. Their work, alongside other organisations, and the NHS in Torbay, helped raise awareness and knowledge of staff at the trust and in the community hospitals. It had influenced some of the recent changes in creating more dementia friendly environments.

Staff engagement

- Staff received a weekly bulletin from the trust as well as updates via the intranet. Staff felt there was a good level of communication prior to the merger and descried the 'rumours board' as brave. The rumours board was set up in a variety of locations for staff to pose questions about rumours they had heard about changes within the organisation around the time of the merger.
- A meeting with the Newton Abbott team occurred in October 2015 in order to plan the closure of Bovey Tracey Hospital and the movement of patients and staff to Newton Abbot Hospital. This was attended by the Assistant Director for Community Services who explained to staff what was happening.
- However, staff did not always feel actively engaged so that their views were reflected in the planning and delivery of services.Many staff expressed their concerns about the opening of escalation wards and felt that despite a debrief led by senior management following the January 2015 winter escalation programme, mistakes were being repeated.
- Staff reported the merger was unsettling but senior staff and the trust kept them well informed throughout. Some staff felt continuing updates in relation to this would be beneficial Staff were encouraged to complete the 2015 NHS Staff Survey which opened in October 2015 and closed in early December. NHS England benchmark reports were due in February 2016.
- Some staff felt they did not want to complete a staff survey, as they did not feel it was anonymous as it requested staff complete their discipline and place of work on the form.
- The organisation ran a scheme of WOW awards which recognised the hard work and commitment of staff by publicly thanking them in their place of work. The award was then shared on internal and external websites. Senior leadership presented a member of staff with a WOW award for going the extra mile to support colleagues on their ward. They wrote a series of protocols and step-by-step guides to support others who may be new to the ward or covering absences. The Chairman and a line manager presented the surprise award to the ward clerk.
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Innovation, improvement and sustainability

- Skin graft procedures had commenced at Teignmouth hospital following issues being raised at a

multidisciplinary team meeting at Torbay hospital. Relocation of the procedure to the day surgery unit released 260 slots at Torbay hospital and showed good organisational working.

- Following patient feedback, information for patients about their care when discharged had improved. All patients now received a discharge summary, or relatives and carers of deceased patients received end of life summary.
- Staff frequently discussed their concerns about the future and sustainability of community hospitals. There were plans in place to change the service provision at Dawlish and Teignmouth hospitals and for Teignmouth to become a therapy led rehabilitation unit. An overall long term strategy for sustainability of community hospital had not been communicated at the time of the inspection. However, senior leadership discussed the longer term ethos of moving care into the community and away from acute hospital under the principle "the best bed is your own bed".
- The challenges of recruitment and retention were ongoing despite a variety of methods being employed to address this.
- The matron of Totnes hospital was negotiating with the hospital at Plymouth's renal unit to set up a satellite dialysis service in some underutilised space at the hospital. This would be staffed solely by the renal team but could generate revenue.
- Recruitment issues were ongoing and senior leadership informed us about a number of initiatives established to drive recruitment of staff. These included a 'you tube' video, overseas recruitment and recruitment stands at Royal College of Nursing meetings. Healthcare apprentices for the community hospitals were due to start in February 2016. The aim was for them to complete their care certificate and bolster the current establishment to enable substantive staff to special complex patients where required, which would reduce the need for temporary staffing.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems or processes must be established and operated effectively to ensure the provider assesses and monitors their service. The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service. The system must include scrutiny and overall responsibility at board level or equivalent. 17 (2) (f) Evaluate and improve their practice in respect of the processing of the information referred to in 17 (2) (b) Assessing, monitoring and mitigating 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. The systems and processes in place did not ensure information in relation to safety, particularly regarding staffing levels and skill mix, was shared and understood between ward and board level. The audit and governance system in place was not effective, as concerns identified in the management and staffing of escalation wards in early 2015 had not been consistently addressed.