Torbay and South Devon NHS Foundation Trust

Evidence appendix

Torbay and South Devon NHS Foundation Trust

Torbay Hospital

Lowes Bridge

Torquay

TQ2 7AA

Tel: 0300 456 8000

https://www.torbayandsouthdevon.nhs.uk

Date of inspection visit:

13, 14, 20 February and 6 to 8 March 2018

Date of publication:

xxxx> 2017

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Details of sites and locations registered with CQC

A list of the sites at the trust is below.

Name of acute hospital site	Address	Details of any specialist services provided at the site	Geographical area served
Torbay District General Hospital	Torbay and South Devon NHS Foundation Trust Torbay Hospital Lowes Bridge Torquay TQ2 7AA		Torbay
Brixham Community Hospital	Greenswood Road, Brixham, Devon, TQ5 9HW		Brixham
Ashburton and Buckfastleigh Health and Wellbeing Centre	9-15 Eastern Road Ashburton Newton Abbot Devon TQ13 7AP	•Community Therapy Team •District Nursing Team •Lower Limb Therapy Clinic •Musculoskeletal Physiotherapy •Podiatry •South West Counsellors	Ashburton

Dawlish Community Hospital	Dawlish Community Hospital Barton Terrace Dawlish Devon EX7 9DH	•Abdominal Aortic Aneurysm (AAA) Screening •Community Nursing •Depression and Anxiety Clinics •Diagnostic Physiological Measurement •District Nurse Service •Intermediate Care Services •Lower Limb Therapy	Dawlish
Newton Abbot Community Hospital	West Golds Road Jetty Marsh Newton Abbot Devon TQ12 2TS	•Children's and Adolescent Services •Colorectal •Cystic Fibrosis (RD&E) •Dermatology •Diabetic Medicine •Diagnostic Physiological Measurement •Ear, Nose and Throat •Endocrinology and Metabolic Medicine •Gastrointestinal and Liver Services •Genetics (RD&E) •Geriatric Medicine (Care of the Elderly) •Gynaecology	Newton Abbot
Teignmouth Community Hospital	Mill Lane Teignmouth Devon TQ14 9BQ	•Audiology •Children's and Adolescent Services •Day Surgery •Diagnostic Physiological Measurement •Ear, Nose and Throat •General Surgery •Gynaecology	Teignmouth
Totnes Community Hospital	Coronation Road Totnes Devon TQ9 5GH	•16 Bedded Inpatient Ward •Audiology •Children's and Adolescent Services •Community Therapy Team •Diagnostic Physiological Measurement •Ear, Nose and Throat •Gastrointestinal and Liver Services •General Surgery	Totnes

(Source: Routine Provider Information Request (RPIR) – Sites)

Background to the trust

Torbay and South Devon NHS Foundation Trust was established in October 2015 when the former South Devon Healthcare NHS Foundation Trust and Southern Devon Health and Care NHS Trust merged. The trust was the first integrated care organisation in England, bringing acute and community healthcare and social care together.

The trust provides a number of services across Torbay and South Devon. Most of these services are within the Teignbridge, Torbay and South Hams district areas. The trust's services cover a resident population of around 300,000 people, with around 100,000 visitors at any one time during the summer holiday season.

The hospital dates back to 1928. It was one of the first NHS Trusts established in 1991 and was authorised as one of the early NHS Foundation Trusts in 2007.

Facts and data about the trust

The trust has a total of 396 inpatient beds and an additional 154 day-case beds and 42 children's beds.

There are around 1,180 outpatient clinics and 60 community clinics held each week. The trust operates a high dependency and intensive care unit, runs 10 operating theatres, and has 34 medical and surgical inpatient wards.

The trust employs around 6,000 staff and has over 800 volunteers.

(Source: Routine Provider Information Request (RPIR) 2017)

Patient numbers

Every year the trust sees in the region of:

- 500,000 people in their homes and communities
- 78,000 emergency department attendances
- 2,100 births

(Source: Routine Provider Information Request (RPIR) 2017)

Financial position

For the financial year 2016/17, the trust's income was £401 million. At the end of the financial year the trust had a deficit of £11 million. The forecast for 2017/18 is for an income of £416 million and a surplus of £4.5 million. In 2018/19 the forecast is for £412 million income and a year-end surplus of £8.5 million.

(Source: Routine Provider Information Request (RPIR) 2017)

What people who use trust services say

Between November 2016 and October 2017 the trust's NHS Friends and Family Test results (percentage of patients who would recommend the hospital) was similar to the England average at around 96%.

In the 2017 CQC emergency department survey the trust scored about the same as other trusts in all but three questions asked. The trust performed worse than other trusts for information about medication side effects, privacy in the department, and privacy at reception.

In the 2017 CQC inpatient survey the trust scored about the same as other trusts in all but two questions asked. The trust performed better than other trusts for explanation of risks and benefits, and explanation of operation.

In the 2017 CQC maternity survey the trust scored about the same as other trusts in all questions asked.

In the 2017 CQC children and young people survey the trust scored about the same as other trusts in all but two questions asked. The trust performed better than other trusts for pain management and worse for children staying on a ward designed for children or adolescents.

Is this organisation well-led?

To write this well-led report and rate the organisation, we interviewed both executive and non-executive members of the board and a range of senior staff across the hospital, including clinical and non-clinical leaders. We met with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting papers and minutes, investigations, and feedback from patients and stakeholders. We were joined on the inspection by NHS Digital who looked at cyber security, and NHS Improvement who assisted us with assessing the trust's financial governance.

Leadership

At the time of our inspection, the Chief Executive was on a period of extended leave. The Deputy Chief Executive, whose full-time role was as Chief Operating Officer, was covering in her absence. The Chief Operating Officer role was being covered by a deputy. Although it was clear the board were greatly missing the Chief Executive, their resilience and continued function was exceptional. Many board members commented on how the interim arrangements had appeared 'seamless', which demonstrated the trust's succession plans were effective and appropriate.

The board were an experienced and well-respected team, both internally and externally. They performed well as a group and continued to move the trust forward, despite significant financial and performance pressures. The executive directors were appropriately skilled and experienced to fulfil their roles, as were the non-executive directors. There were good working relationships between the executives and non-executives, which enabled strong challenge to take place.

The Medical Director had two deputies who ensured visibility was maintained while the Medical Director was involved in the Devon Sustainability and Transformation Plan work.

The trust's finance team was experienced, knowledgeable and capable. The board had relevant financial expertise across the executive and non-executive directors. Executive directors demonstrated a sound understanding of the trust's financial position and areas of opportunity.

We found the board understood the quality of care provided across the integrated care organisation, and recognised challenges to this. All the directors we spoke with were able to talk about the challenges and the plans in place to address them.

We were mostly assured directors of the trust were fit and proper persons in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust had processes in place to ensure directors were assessed to be fit and proper prior to starting, and during employment, however there were some gaps in personnel files. The trust's recruitment and selection policy referenced the fit proper and persons requirements. We reviewed the personnel files of six executive directors, including the Chief Executive, and five non-executive directors, including the Chairman. Although at the time of checking not all the evidence was present in the files, we raised this with the trust and it subsequently provided most of the relevant evidence. However, there was no evidence of a Disclosure and Barring Service (DBS) check being completed for the Medical Director. A former Criminal Records Bureau (CRB) check had reportedly been completed in 1998, but the certificate number had not been recorded and this prior to the Medical Director's appointment. We also noted one non-executive director's file did not contain evidence of any qualifications being checked or of an occupational health referral being completed. Another non-executive director had a DBS certificate noted, but this was from previous employment and was dated 2009. Again, there was no evidence their qualifications had been checked.

Most staff felt their local managers were supportive, appreciative and visible. However, not all staff felt the executive team were visible in all areas, particularly in the community. Staff who did see the executive team in their areas told us they were approachable and supportive. The board were trying to address this and an executive director worked in the hospital over the weekend, with no specific duties other than to be visible across the trust, including community services.

Given the size of the trust, it was understandable that not all staff had seen the executive team in their clinical area. The executive team did take part in activities across the trust so they could meet staff and witness first-hand what it was like day-to-day in different areas of the trust. These included walk-rounds and 'back to the floor' shifts, where an executive director worked alongside operational staff for a shift. Additionally, a large number of staff events were held in the community to increase the executive team's visibility across the trust.

We were given examples of on-call executive directors attending the hospital to provide leadership and support in times of escalation. Staff recognised this, and commented on the positive impact it had, especially during the recent heavy snowfall. We were given one specific example of the Medical Director attending a ward to assist with a particularly complex situation with a patient needing a mental health assessment. The Medical Director attended promptly, assisted with getting the process moving and actively completed a joint assessment of the patient.

The trust had introduced a dispersed leadership model, supported by accountability frameworks, to give more ownership to service delivery units. However, this was still in relatively early form and structures and processes were still quite hierarchical in some areas. Some staff told us that since becoming an integrated care organisation the structures had not really changed. This meant those staff who worked across both the community and acute sites, for example some specialist nurses, had different line managers depending on whether they came from the former community trust or the acute trust. Staff told us this meant there were different expectations at times and this sometimes caused confusion. Some staff also gave examples of not being able to make decisions locally, for example filling vacancies within budget required sign off by executives.

Staff felt they were kept well-informed by leaders, including the board. They told us there were regular communications by email, newsletters, and bulletins. We were also shown recordings of senior manager meetings, which staff were able to access on the intranet.

Leadership development programmes were available, but staff were not always clear about what was accessible to them. We found there was limited information signposting staff to development opportunities, which was confirmed by two of the executive directors. The trust had already recognised this as a gap, and work was underway to improve information about leadership development. The trust was also due to start delivering a masters level leadership programme.

The trust's child and adolescent mental health service (CAMHS) and public health services were integrated with the organisation and felt well-engaged with, and supported by, the leadership across the trust. The service managers told us there had been active encouragement from senior leaders to work better together, rather than in silos.

Board Members

There were no British Minority Ethnic (BME) executive board members. Of the executive board members, 75% were female.

There were no BME non-executive board members. Of the non-executives, 50% were female.

Staff group	BME %	Female %

Executive directors	0.0%	75.0%
Non-executive directors	0.0%	50.0%
All board members	0.0%	62.5%

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

The percentage of the population served by the trust, according to the latest Devon census figures (2011), identifying with an ethnic group other than white was 1.9%.

Vision and strategy

The trust had a clear vision, which staff were aware of and felt connected to. The vision was based around delivering a truly integrated care system, with people at the centre being supported in their community wherever possible. The trust's vision was of "a community where we all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes. When we need care we have choice about how our needs are met – only having to tell our story once."

The trust had adopted the NHS values: respect and dignity, commitment to quality of care, compassion, improving lives, working together for people, and everyone counts.

A number of staff and managers told us they had been involved with developing the trust's strategy. They felt this had allowed more local ownership of the delivery of the strategy and had helped staff 'buy-in'.

Staff had a good knowledge of the trust's strategy and felt connected with the integrated care organisation. Staff believed in the vision of the care model as a system-wide approach to health and social care across the population served.

Although the trust had only been formed at the end of 2015, generally staff reported the integrated care organisation was starting to feel more joined together. They felt the trust's vision and strategy had helped to achieve this and continued to drive improvements in this area. However, a small number of staff were uncertain how the strategy would actually deliver the trust's ambitions.

The trust had an ambitious financial savings plan to deliver and this was reflected in its strategy. There were strong processes for the development and monitoring of cost improvement plans (CIP), which included working closely with local commissioners and the Devon Sustainability and Transformation Plan (STP) to develop joint plans where possible. Staff were generally aware of the significant savings that needed to be achieved, and managers told us they had been involved with the development of the cost savings plans. The trust had a 'call to action', which asked staff to identify possible savings. We were told by a number of directors that this had been hugely successful and the response from the operational teams had been exceptional, with almost £5 million of savings being identified through this scheme. The trust was on target to deliver savings of £40 million in 2017/18.

The trust was well-represented in the Devon STP and their strategy was aligned with the direction of travel within the STP. One key are being reviewed across the STP was having a shared bank staff group, which would provide greater flexibility and opportunities for recruitment and staffing.

Work was ongoing to refresh the trust's strategy to build on the first two years of progress. There were engagement programmes with staff and an engagement report was due to be presented to

the finance, performance and investment committed, through the Quality Assurance Committee and to the board.

The trust also had a number of other strategies, including for dementia care, end of life care, learning from mortality, learning disabilities and patient experience. All of these had clear actions and means of assessing progress.

Culture

Staff believed the trust had an open and honest culture. Staff spoke highly of the communications they received from the executive team and managers and felt they were kept well-informed. There were regular staff briefings and managers meetings, which were recorded and shared on the trust's intranet for all staff to access. Staff also told us they felt confident raising concerns and making suggestions, and believed action would be taken to improve things where possible.

Staff were encouraged to raise concerns. They told us they felt safe doing so and believed action would be taken. This was supported by a 'see something, say something' campaign, as well as the incident reporting system and Freedom to Speak-up Guardians. We were given an example where some staff working in the facilities team did not have breaks because they only worked six hours, which under the national Agenda for Change contract meant they were not entitled to a break. The affected staff worked with their union representative and the executive team to agree a solution, and they were subsequently permitted short breaks.

The trust had a number of Freedom to Speak-up Guardians who were given protected time to undertake the role. However, none of these were community-based staff. This was something the trust had already identified and a recommendation to undertake open recruitment to encourage community staff to join the network had been made by the Chief Executive. Staff said they knew how to contact them if they needed support in raising concerns. The trust had also introduced champions to promote the freedom to speak-up programme, but we found these arrangements were confusing and lacked structure, support and oversight. Although the Chief Executive was the direct report for the Freedom to Speak-up Guardians, there was no single lead guardian to provide day-to-day leadership to the group. As a result there did not appear to be a systemic approach to the programme and arrangements were not as strong as they could have been. The Freedom to Speak-up Guardians felt the trust had not significantly invested in development opportunities for the role. For example, none of the trust's guardians had attended a recent national speak-up conference and newer guardians had not completed any training for the role. Some guardians felt the role was not valued by all members of the board, and they spoke of varying responses depending on which director was hearing concerns being raised.

An independent audit of the duty of candour and freedom to speak-up had been undertaken on behalf of the trust and was published in January 2018. The audit concluded there was a "clear publicised process for raising concerns, a confidential database of concerns, and a network of Freedom to Speak-up Guardians."

The trust had also introduced equality and diversity guardians to act as points of contact and escalation for staff with equality and diversity concerns, for example discrimination.

Acceptable behaviour champions had been introduced to provide a 'listening ear' to any staff who felt they had experienced or seen unacceptable behaviour. The champions were then able to signpost staff to support systems.

Following staff feedback about the relentless pressure over the Christmas period, it was recognised a forum was needed for staff to speak openly about how they were feeling. The trust

had therefore implemented ‘connect and reflect’ sessions and dates for these had just been released at the time of our inspection.

The trust had encouraged an open and honest culture with patients and relevant persons. The duty of candour was embedded and well-evidenced. We looked at death reviews and incident investigations, which clearly demonstrated absolute honesty with the families and carers. There had been no attempt to disguise any mistakes and relevant apologies were made. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. An independent audit of duty of candour, published in January 2018, identified 80% of respondents were aware of the legal duty and 95% knew how to report incidents of harm. However, only 60% had received training in the duty of candour and 60% did not identify the correct level of harm that would require duty of candour to be followed. There were only 364 responses to the audit survey

The trust’s governors spoke of an open relationship with the board and gave examples where issues had been raised to the board and acted on. For example, the governors had concerns about Deprivation of Liberty Safeguards (DoLS) and raised these concerns with the Chief Nurse. As a result, a DoLS report was presented regularly to the governors to keep them informed of the trust’s position. Additionally, the governors were given dedicated time at public board meetings to raise concerns or ask questions of the board.

Overall, staff felt the trust was a good place to work. Staff spoke of a positive team atmosphere, which included the executive team. We saw examples of thank you messages from the board at times of high pressure, for example following significant snowfall which impacted on staff and patients being able to get to and from the hospital. Every member of staff we spoke with told us they were proud of the team effort during the snow, and felt everyone went ‘above and beyond’ to keep services running safely.

Staff working in the community felt there had been a lot of focus from the board to include them in the trust. They felt there was a good focus on community services, including social care, and improved partnership working had been encouraged as a result. However, some staff in the social care teams felt they were not valued as much as staff working in health care teams.

There were concerns about the culture in the research and development department, with claims of poor relationships and widespread bullying. We were told 16 members of staff had left department since August 2017. Although the board were aware of the issues and were taking measures to address them, we were concerned this wasn’t delivering the necessary results to improve the culture. We raised these concerns in our initial feedback to the trust, and in response the trust acknowledged the issues and outlined the actions that had been taken and the work that was ongoing. The work was being overseen by the Chief Nurse, Medical Director and Director of Workforce and Organisational Development.

Complaints process overview

Question	In days	Current performance
What is your internal target for responding to complaints?	The Trust aims to acknowledge all complaints within three working days.	10 complaints were not acknowledged within three working days within the reporting period.
What is your target for completing a complaint	The standard timeframe for responding to a complaint is 30 working days, unless the complaint	122 complaints were extended within the reporting period. This figure

	is being identified as having complex issues, in which case a timeframe is agreed with the complainants and the lead for the investigation**.**	incorporates all complaints with differing deadlines**.**
If you have a slightly longer target for complex complaints please indicate what that is here?	There is no specific alternative deadline for complex complaints. The Feedback and Engagement Team agree a deadline with the complainant and the lead within the Trust based on how complex the issues are and the amount of organisations involved.	N/A
Number of complaints resolved without formal process in the last 12 months?	1,768 records (includes Concerns, Comments and PALS enquiries).	01 January 2016 to 31 October 2017.

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)

Number of complaints made to the trust

The trust received 345 complaints between November 2016 and October 2017. The surgery core service received the most complaints.

Core Service	**Number of complaints**	**Percentage of total**
Surgery	83	24%
Community Adults and Children	55	16%
Urgent and Emergency Care	51	15%
Outpatients	47	14%
Medicine	45	13%
Other	32	9%
Community Inpatients	12	3%
Children's Services	7	2%
Maternity	6	2%
Gynaecology	5	1%
Diagnostics	2	1%
Grand Total	**345**	**100%**

(Source: Routine Provider Information Request (RPIR) – Complaints)

The Chief Nurse regularly undertook a review of a random sample of complaint response letters to ensure they answered the complaint. Where it was felt the letter did not answer the complaint in full, it was returned to the team to complete further work. The Chief Nurse felt the majority of complaint letters reviewed were of good quality. We reviewed seven complaint files and found them all to be of a good standard. However, two of the response letters did not fully address the complainant's concerns.

The trust's handling of complaints had improved since our previous inspection, and information was more readily available to the public on the trust's website. However, the policy on the website

had not been updated with the current version. The trust's feedback, complaints and PALS (Patient Advice and Liaison Service) policy was detailed and comprehensive, although did not make any reference to duty of candour or cross-reference the incidents policy. Of particular note was the trust's positive attitude towards complaints, which was evident within the policy. It was clear that complaints were a useful form of feedback the trust valued as opportunities to learn from.

The two main themes from complaints were: attitude of staff, and staff competence & negligence.

Staff Diversity

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group. These were broadly representative of the local population.

Ethnic group	Medical and dental staff (%)	Nursing and midwifery staff (%)	Nursing and Health visiting staff (%)
White	77%	98%	92%
Mixed	3%	1%	0.40%
Asian	8%	0%	4%
Black	0.43%	0%	1%
Chinese	2%	0%	0%
Other	1%	0%	2%
Unknown / Not Stated	7%	1%	1%

(Source: Routine Provider Information Request (RPIR) – Diversity)

NHS Staff Survey 2017 – results better than average

The five key findings where the trust compared most favourably with similar trusts in the 2017 NHS Staff Survey were:

Key Finding	Trust Score	National Average
KF16. Percentage of staff working extra hours	67%	71%
KF17. Percentage of staff feeling unwell due to work-related stress in the last 12 months	36%	38%
KF3. Percentage of staff agreeing their role makes a difference to patients/service users	91%	90%
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	25%	27%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	23%	24%

NHS Staff Survey 2017 – results worse than average

The five key findings where the trust compared least favourably with similar trusts in the 2017 NHS Staff Survey were:

Key Finding	Trust Score	National Average
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	87%	91%
KF12. Quality of appraisals (Scale of 1 (low) to 5 (high))	3.00	3.11
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	44%	47%
KF2. Staff satisfaction with the quality of work and care they are able to deliver (Scale of 1 (low) to 5 (high))	3.83	3.90
KF32. Effective use of patient/service user feedback (Scale of 1 (low) to 5 (high))	3.62	3.69

(Source: NHS Staff Survey 2017)

The trust had only recently received the staff survey results so work had not yet started to fully understand the results and put action plans into place. Directors told us they were disappointed with the results and recognised there was work to do to engage with staff and make improvements over the next 12 months.

A significant number of staff told us they hadn't completed the staff survey because they didn't trust it was truly anonymous. Because the company running the survey were able to track staff who had and had not completed the survey, in order to target reminder emails, there were concerns staff could be identified.

Workforce race equality standard (WRES)

			Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	23%	26%	22%
		BME	25%	27%	28%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	22%	23%	22%
		BME	26%	29%	17%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	84%	88%	88%
		BME	73%	73%	85%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	7%	6%	5%
		BME	17%	15%	12%

(Source: NHS Staff Survey 2017)

WRES indicator	Data for current year	Data for previous year	Narrative	Action taken and planned
Relative likelihood of staff being appointed from shortlisting across all posts.	0.85 times more likely for white staff to be appointed than BME staff.	0.91 times more likely for white staff to be appointed than BME staff.	This is the second year of data for the ICO which was formed in 2015. Previously data was held in two separate accounts.	This year's figure is encouraging. However, recruitment training and practical skills for managers will continue to include unconscious bias elements to inform the recruitment process.
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	There were no BME staff involved in the disciplinary process this year	It was 1.2 times more likely for White Staff to enter formal disciplinary than BME staff.	Nationally, it is twice as likely for BME staff to enter formal disciplinary than White staff(Archibong et al 2010) No BME staff entered the disciplinary process this year.	This is encouraging data for this year. We utilise a centralised reporting system for disciplinaires and other employee relations data. This will ensure that all data can be analysed by demographic.
Relative likelihood of staff accessing non-mandatory training and CPD.	BME staff were 3% more likely to access Non-Mandatory training than white staff	BME staff were 8% more likely to access Non-Mandatory Training	BME staff continue to access training more than white staff.	Personal Development Policy (and training) emphasises personal development planning linked to the Talent Management Strategy and that staff have Personal Development Plans and opportunities for training and CPD. We have a new Learning Management System that ensures staff can now own their own records. We anticipate an

increase in uptake in the coming year.

(Source: Workforce Race Equality Standard report for July 2017)

In the trust's most recent workforce diversity annual report (2016) it was reported over 90% of the total workforce identified themselves as being 'white British', with 4.9% identifying themselves as black and minority ethnic (BME). This was representative of the local population. According to the 2011 Devon census, 1.9% of the local population did not identify themselves as white. The highest proportion of black and minority ethnic (BME) staff were working at bands five to seven (around 40%). However, in senior (non-medical) posts, BME representation was less than 1%, which was slightly lower than the local population representation.

Black and minority ethnic staff reported experiencing more incidents of harassment, bullying or abuse compared with their white colleagues. Fewer BME staff felt there were equal opportunities for career progression or promotion, and more BME staff reported they had experienced discrimination at work.

The results of the 2017 NHS Staff Survey showed there was a difference in the experience of BME staff in the trust when compared with their white colleagues. The most significant difference was those who reported experiencing discrimination at work, with 17% of BME staff reporting this was the case compared with only 7% of white staff. The percentage of BME reporting they had experienced discrimination was also slightly higher than the national average of 15%, and an increase from 12% the previous year. Another area of note was the percentage of BME staff who believed there were equal opportunities for career progression or promotion, with 73% of BME staff believing there were compared with 84% of white staff. This was again a worse position when compared with the previous year where 85% of BME staff had felt there were equal opportunities for progression or promotion.

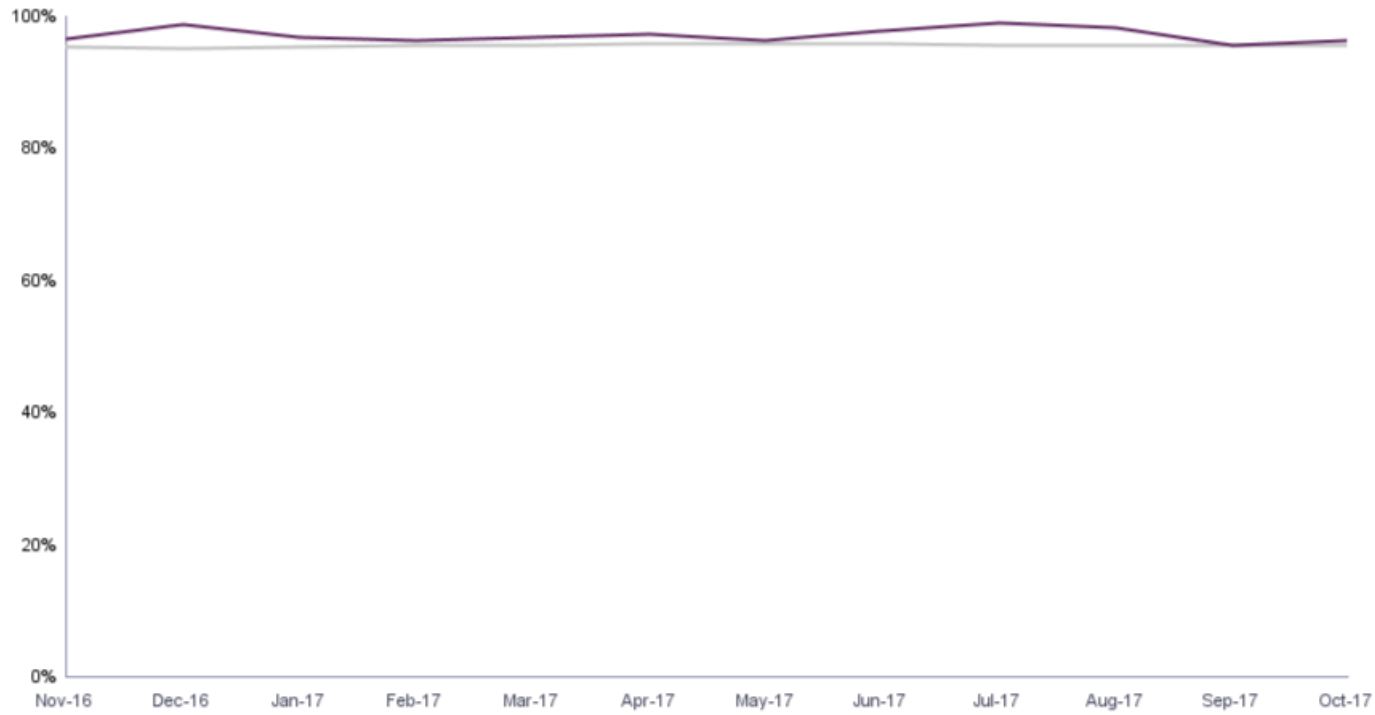
The percentage of BME staff reporting experiences of harassment, bullying or abuse from patients, relatives or the public had improved slightly from the previous year. However, the percentage of BME staff reporting experiences of harassment, bullying or abuse from staff had got worse.

The trust had a clear action plan, which had been updated in November 2017, that targeted areas where improvements could be made in accordance with the Workforce Race Equality Standard. These covered the areas above, for example improving talent management strategies to encourage and enable better career progression opportunities for non-medical staff, taking positive action to support under-represented groups to apply to work in the trust, and developing a leadership strategy that explicitly references managing and leading a diverse workforce.

Friends and Family test

The NHS Friends and Family Test asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

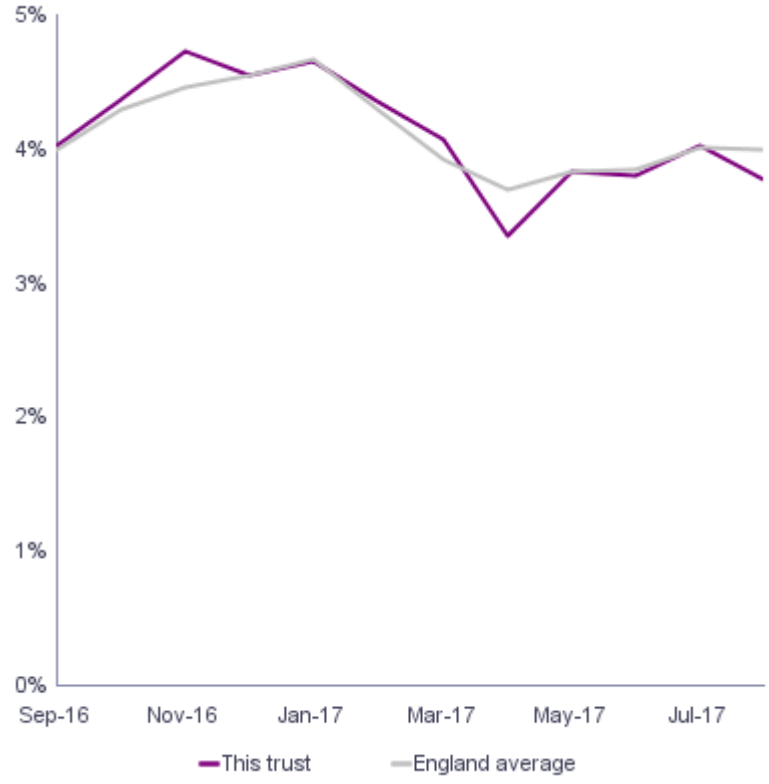
Between November 2016 and October 2017 the trust scored about the same as the England average for patients recommending the trust as a place to receive care.



(Source: Friends and Family Test)

Sickness absence rates

The trust's sickness absence levels from September to July 2017 generally followed the trend for the England average.



(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2017 General Medical Council Survey the trust performed as expected for all indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

The trust's governance structures were complicated, but generally effective. However, there were areas that could be strengthened and the trust was already reviewing these.

Through the dispersed leadership model, which was still in its early stages of development, the trust had strengthened governance arrangements within the service delivery units. These provided good links between quality improvement, finance and general governance. However, the trust's overall governance structures were overly-complicated. Staff and managers found it difficult to talk about how governance processes worked, and were unsure which committees and sub-committees were responsible for what. This was especially the case where the same items were discussed at different (sub) committees with a different viewpoint, with singular oversight being unclear. Executive directors told us the governance structures were still "evolving" and the trust recognised they were not where they would want them to be.

Service Delivery Unit boards met monthly to discuss quality and performance. Any exceptional matters were then escalated to the Quality Improvement Group (QIG). The trust's Quality Improvement Group was split into three parts: cross-organisational discussions (for example, staffing issues, social care performance, and incidents); service delivery unit clinical governance; and mortality. The Quality Improvement Group then reported the Quality Assurance Committee (QAC), a sub-committee of the board. The chair of the Quality Assurance Committee confirmed they saw the minutes from QIG and told us these were used to provide assurance, with escalation of issues being by exception. Minutes of the QAC meetings were sufficiently detailed, and actions were clearly captured and followed-up at following meetings.

We were not assured the Quality Assurance Committee (QAC) was sighted on all quality-related items. For example, the QAC had not been aware of quality issues in the fracture clinic until we raised significant concerns following our inspection of outpatients. We were told the concerns were related to the building and therefore would have been reported through the estates governance processes. However, the trust had identified quality issues and confirmed in their risk management processes these were a significant concern. We were therefore surprised the board sub-committee responsible for quality assurance was not aware of the issues. Additionally, we were told action plans following CQC inspections were discussed and monitored at the Quality Improvement Group, with only exceptional items escalated to the Quality Assurance Committee. This meant the board sub-committee responsible for quality assurance was not fully sighted on these important actions, and subsequently there was a risk the board was not fully briefed and able to monitor and challenge progress.

There was an opportunity for the trust to improve the reporting the board received regarding the care model. In particular, the information presented to the board regarding community care at home required further development. The information being reported did not clearly identify performance indicators and performance against these, and there was no real way of measuring success in a way that could be presented for others to understand. Similarly, the impact of removing a large number of beds from across the trust had not been assessed to ensure the action had not had any unexpected consequences (for example, the trust's readmissions rate was higher than expected but it was not possible to identify if the removal of beds had impacted on this). However, the trust did have comprehensive reporting metrics for the new care model as agreed in the integrated care organisation's business case. These were shared with GPs to ensure a coordinated overview of performance. A 'locality dashboard' included a range of measures by locality, including the numbers of admissions from care homes, and emergency department attendances. The trust recognised the need to build some of the information measures into the board performance report.

Finance and resourcing were given sufficient time at board meetings. Board meeting minutes confirmed there was good discussion about finance and resourcing, with appropriate challenge to ensure quality was also considered equally. However, although there had been initial quality impact assessments of the cost improvement plan, further quality impact assessments had not yet been undertaken centrally, which meant the trust was not assured the original assessments were correct and the savings had delivered what was expected. However, routine monitoring of the cost improvement plan had been devolved to local teams and we felt assured any risks arising, or areas going off track, were escalated through the governance structures.

The audit committee and finance committee were both chaired by appropriately qualified and experienced non-executive directors.

Reporting processes to the audit and finance committees were clear. The trust had reviewed and made improvements to its reporting systems during the year and was seeking feedback from staff and managers about how it could continue to improve these.

The trust could not be assured mortality and morbidity meetings were taking appropriate actions and ensuring these had been completed. Mortality and morbidity meetings did not appear to follow a standard agenda, and although actions were noted within minutes there were no action logs to record and monitor the actions. We found actions from previous meetings were not picked up at the next meetings and evidence of shared learning was not being recorded.

Although the trust's complaints policy clearly explained the governance processes for reporting and monitoring of complaints, there was no reference to any monthly reporting to any of the board committees. The Quality Improvement Group were expected to have a quarterly report presented. However, we were told this was no longer happening because there was a new monthly dashboard, and instead an annual report was presented to the board. A Learning From Complaints Group existed, but their terms of reference and the complaints flowchart were two years out of date. We were also told reporting from the Learning From Complaints Group to the Quality Improvement Group was not as regular as it could be. Complaints were included in the weekly complaints, litigation, incidents, coroner's cases and Central Alerting System alerts (CLICC) report that was sent to the executive directors.

There were clear governance processes supporting incident reporting, investigation and learning. A daily review of all incidents took place to confirm the level of harm reported against the details of the incident. Incidents were then investigated and reported through service delivery unit governance structures. A theme and trend analysis was completed lower level incidents and reported through the CLICC report. For more serious incidents, including moderate, major or catastrophic harm, a weekly 'huddle' took place with the Deputy Chief Nurse and Medical Director to review the incidents and agree the level of investigation required. Serious incidents were reported through the serious adverse events (SAE) group, which included an independent GP. Root cause analysis reports were quality assured and learning opportunities and actions were confirmed. A report was then produced for the Quality Assurance Committee before being presented to the board. The minutes of the SAE group were comprehensive and demonstrated good discussions took place to understand and ensure learning from serious incidents.

The trust was consulting with staff about a restructure of the operational delivery functions. The proposal was to move to two structures, rather than the existing four, from Autumn 2018.

Governors sitting as observers on the board sub-committees completed feedback templates, which were reported into the compliance committee to provide additional assurances and identify areas for development. We didn't review any examples of these, but directors confirmed they

received feedback from the governors about the effectiveness of meetings and how they chaired them.

The trust worked closely with partners delivering services relating to child and adolescent mental health. The trust only delivered these services in Torbay, with another provider delivering the services in South Devon. A partnership board had been established between the trust and the independent health provider to ensure services were being delivered in a joined up way and to maximise partnership working. They also worked closely with other organisations across the Devon Sustainability and Transformation Plan, with clear governance structures being in place to support this.

Board Assurance Framework and related risks

The trust's Board Assurance Framework detailed four strategic objectives:

- Safe, Quality Care and Best Experience
- Improved wellbeing through partnership
- Valuing our workforce
- Well led

A summary of key risks scoring 25 on the Board Assurance Framework are listed below.

Ref	Strategic objective	Risk cause	Risk effects
1050	Safe, Quality Care Best Experience	Due to age and condition of plant etc possible major failure in Special Theatres (Acute).	Loss of Surgical Activity.
1083	Safe, Quality Care, Best Experience, Well Led	Lack of available capital funding to spend on backlog maintenance and contingency for Estates emergency expenditure.	A. Failure of key plant or building fabric resulting in impact on service delivery. B. Harm to individual staff, patients or member of the public from deteriorating infrastructure.
1231	Well Led	Financial position or national capital restrictions limit ability to access Loans or PDC.	Inability to fund necessary infrastructure developments.
1070	Safe, Quality Care Best Experience	Patient demand exceeding capacity within the ED department	Failure of the 95% standard, poor patient experience and possible adverse clinical 25 outcomes as patients not cared for in the correct environment.
1223	Well Led	Inability to meet total recurrent CIP savings target.	Results in a failure to achieve the business plan objectives for 2017/18.
1239	Well Led	Failure to achieve control total.	Failure to achieve Sustainability and Transformation (STF) and subsequent impact on financial performance plan. Damage to risk rating and reputation with the regulator.

1772	Well Led	Trust has given notice on Risk share agreement pending agreement of New Risk share for Q4 of 2017/18.	CCG and Council revert to challenging income under the national contract. Council mitigating actions cause reduced patient flow in ASC.

(Source: Trust Board Assurance Framework October 2017)

Management of risk, issues and performance

The Board Assurance Framework was discussed regularly at the audit committee and by the board. Executive and non-executive directors were able to talk about the key risks, why they were believed to be the highest risks, and the actions being taken to manage them. For example, the risk from a lack of money to invest in capital programmes (IT systems, estates work, equipment maintenance, etc.) was being managed through a prioritised action plan. The areas requiring investment were discussed at board level, risk-assessed and prioritised. These were kept under regular review and money was allocated in priority order when it was available. It was not clear who was responsible for managing risks on the corporate risk register. Recorded risks were allocated to directorates and did not have responsible directors identified on the corporate risk register we were provided. The trust subsequently advised this was recorded on the electronic system, but we did not see evidence of this.

The Board Assurance Framework and corporate risk register reflected the concerns and risks staff, managers and the board discussed with us. The highest risks (rated 25 on the corporate risk register) were all related to insufficient capital resources to fund high risk, high priority work, including:

- Possible failure of plant in special theatres due to age and condition.
- Backlog of maintenance and contingency for emergency estates expenditure.
- Limited ability to access loans and risk of national capital restrictions.

The trust's integrated performance report, which was presented to the finance committee and the board, included relevant financial information at service delivery unit level and included forecasting for the year. The board demonstrated a sound understanding of the financial position of the trust and recognised areas of financial challenge. Examples were given of positive debate that had taken place before decisions were made by the board. We observed three board meetings during the previous 12 months, one of which was during the inspection, and found this to be the case.

Risks associated with under-performance were well understood and strategies to improve performance were clear and regularly reviewed. For example, the trust was not achieving its referral to treatment targets and had a number of patients waiting more than 52 weeks for non-emergency treatments. The board had made a conscious decision to concentrate on urgent and emergency pathways first, recognising this would affect other non-emergency pathways. However, plans had been put in place to improve the non-emergency performance, including creating additional capacity. Patients who were waiting longer than planned for treatment were kept under review to ensure risks associated with delays were understood and any deterioration could be responded to sooner. However, there were a number of areas, for example stroke, where the trust was not meeting performance standards and was also no meeting their recovery trajectories.

The trust had strong audit processes that enabled good monitoring of quality, operational and financial processes. However, audit was not clearly linked into the trust's strategy. The trust had a three-year audit programme, which included national surveys and audits. During our inspection we were told the trust did not have an annual internal audit programme, but following the inspection

the trust advised there was an annual programme agreed and monitored by the audit committee. However, evidence of this was not provided. Most directorates had an audit lead who acted as a 'champion' for audit. In directorates where this wasn't the case the lead consultant took the lead on audit. Audit outcomes were presented at local team meetings, directorate audit meetings and at the trust's audit and effectiveness committee, chaired by the Chief Nurse and Medical Director. However, we were told sharing of learning was an area that needed strengthening. Audit activity was reported in the trust's annual quality account, and published on the trust's intranet. Examples included acute coronary syndrome, cancers, chronic obstructive pulmonary disease (COPD), diabetes, falls, procedural sedation, stroke, trauma and vital signs in children.

We explored the trust's approach to managing the risks associated with its lack of capital investment. Of particular note on the trust's risk register were the aging IT systems, the need to refurbish theatres and the investment required for the fracture clinic, amongst others. All the board members we spoke with were able to clearly outline the process by which risks were identified, assessed and prioritised. The process involved a formal risk assessment process being undertaken, which included the responsible executive director. The risk assessments were then scored and the board discussed each risk. This allowed constructive challenge between board members to ensure the risk ratings were consistently applied, and then the priority order for work was agreed. Money was allocated to the highest priority area first, then to the second, and so on, until there was no capital money left to allocate. The following financial year would then see the next priority area having money allocated, and so on. While we were assured the trust was managing the risks and allocating money as best as it was able within its financial plan, we did have significant concerns that capital investment was not sufficient to adequately manage all the risks and keep patients safe at all times.

We also explored how quality focus was maintained, even though finances were extremely tight. The trust's cost improvement plan had been quality impact assessed and local teams had been involved with signing off plans affecting them. We were given one example of a proposal to make changes to the provision of cleaning services. This was reviewed by the operational team and the director of infection prevention and control, who all raised safety concerns. As a result, the proposal was withdrawn and no changes were made.

We found examples where finances had impacted the trust's ability to provide high quality care. However, the trust was aware of the issues, had risk-assessed and prioritised them, and was allocating money to the highest priority areas. For example, we found the fracture clinic environment was extremely poor and did not provide an appropriate and safe service to all patients. The trust was already aware of the issue, and it was on the trust's risk register. A risk assessment had been carried out, and the work listed as a priority. However, other areas of the trust had been assessed as being at higher risk and money had therefore not been available to start work in the fracture clinic. Following our inspection, the trust completed a further risk assessment and re-prioritised the work, meaning money could be allocated for work to start in 2018/19. Higher priority areas for funding in the last two years had included building a new intensive care unit and changes in the emergency department to improve patient safety.

Some staff felt that although the trust's focus was on patient care, the financial savings programme had become of greater importance in the last year. For example, staff gave us an example of an administrative post not being filled when the staff member left because the post had been 'frozen' to save money. We were told the recruitment process was too slow and left gaps for too long, putting additional pressures on the remaining staff. A number of staff, managers, governors and directors raised concerns that the financial plan for 2018/19 would not be achievable without compromising quality. Significant savings in the region of £40 million were

being asked by NHS Improvement for 2018/19, following a similar level of savings in 2017/18, but the board felt this was not achievable without affecting patient care, especially given the lack of capital investment over previous years and the need for significant investment in areas such as IT and theatres.

The trust's escalation policy worked well and included all the relevant individuals and teams to ensure patient safety was maintained. We observed a control meeting during our inspection while the trust was experiencing a period of high demand. It was well-attended by senior managers, representatives from the acute and community services, and social care. Clear discussions took place to review pressures and identify key areas where focused attention could deliver improvements in patient flow, including discharge arrangements. Actions were assigned to individuals and regular reporting back to the group ensured focus was maintained.

The trust used an electronic incident reporting system. We were told by staff and senior managers, including executive directors, that the system generally worked well but improvements were needed. The Chief Nurse told us there was an improvement plan which was aimed at developing the system to better meet the needs of an integrated organisation, and to ensure staff had better access to the outcomes of any incidents they reported.

Some areas of the trust had challenges with recruitment and retention of staff, and it was not always clear how this was being addressed. For example, social care teams told us they were seeing increases in patient complexity but staff were leaving because of a lack of career progression and a pay system that did not reward them in similar terms to those doing similar work for a local authority. This had meant remaining staff felt under increased pressure, but they felt the risks were not being recognised and managed. The trust informed us they did have a plan to support recruitment and retention of these staff, including pay increases following the first year of practice after qualifying. Additionally, the trust told us three staff were being supported to complete a Master's degree to support their career progression, and further work was ongoing to formalise more continuous professional development opportunities. In other areas, for example difficulties recruiting oncology or cardiology specialists, the trust was managing the risks by working with a neighbouring trust to provide services together.

Finances Overview

The trust's financial picture was improving. In 2016/17, the trust reported a deficit of £11 million against a planned surplus of £2.3 million. In 2017/18, the trust's plan is for a £4.5 million surplus, which it is on-track to deliver. NHS Improvement considers the trust to be making good progress in moving towards a sustainable position.

	Historical data		Projections	
Financial metrics	**Previous Financial Year (2015/16)**	**Last Financial Year (2016/17)**	**This Financial Year (2017/18)**	**Next Financial Year (2018/19)**
Income	£325.1m	£401.3m	£416.2m	£412.1m
Surplus (deficit)	(£10.6m)	(£11.0m)	£4.6m	£8.4m
Full Costs	£336.0m	£412.3m	£412.0m	£404.0m
Budget (or budget deficit)	(£5.6m)	£2.3m	£4.6m	£8.4m

(Source: Routine Provider Information Request (RPIR) – Finances Overview)

Information management

The trust did not have a central information team looking at, and drawing together, all performance measures across the whole trust. Instead, different information teams were aligned to separate divisions and reported through different structures depending on their focus. For example, workforce-related information was reported through the Director of Workforce and Organisational Development structure, whereas quality was reported through the Chief Nurse structure. While ultimately the information was collated for the board, it was unclear how the impact of different performance measures on others were recognised and presented at operational level.

Information was available to provide a holistic understanding of quality and safety across the trust. Dashboards presented an array of information, including performance against key measures (for example, emergency department, cancer and referral to treatment performance), numbers of complaints, incidents, safer staffing, mortality, infection prevention and control, and bed occupancy. An overarching dashboard, presented to the board, included aggregated figures across the trust and was rated by colour: red, amber and green. We were told by directors that more analytical support was required to make best use of the information that was available. This would allow the trust to better present the information in easy to understand ways, and would also provide new information to provide a more thorough picture.

While performance indicators suggested the care model was working, there was a lack of evidence available to really evaluate and understand how this was working. We heard examples of the care model improving pathways – for example the in-reach team identifying patients who could be treated in the community to free up beds – but there were no real outcome measurement systems that clearly showed what aspects of the model were having an impact, and how the different processes worked together to deliver improvements.

We were told the trust's systems made some functions challenging to complete, for example audit. This was further complicated by the number of different computer systems in use that did not communicate with other, making it difficult to source information from a single location. However, despite the challenges, processes could be put in place to ensure these functions could still be carried out.

The trust had difficulties overseeing mandatory training compliance, but had already started improving the systems used to record attendance and completion. Some training was recorded in the electronic staff record system, while other training was recorded in a separate database. Collating the information and reporting centrally was challenging and did not provide the trust with assurance that staff were up-to-date with mandatory training. The trust had invested in an online training system that was designed to make access to training easier for staff, but also to improve central recording and oversight of training attendance and completion.

A number of the trust's IT systems were at significant risk due to their age and lack of capital investment to improve them, including the patient administration system. The week before our inspection of well-led, the trust experienced a significant IT failure that resulted in the loss of systems for a number of hours. While business continuity plans were put into action, the impact of losing these systems was substantial and continued after the systems had been brought back on line. The trust had applied for national funding to support the replacement of the patient administration system, but this had been unsuccessful. However, some investment in information technology had been made, for example electronic prescribing.

Engagement

The trust had actively engaged with the Devon Sustainability and Transformation Plan (STP). In particular, they had shared financial information and engaged with system-wide efficiency and productivity opportunities. Additionally, the trust's Medical Director was the lead Medical Director for the STP and committed two days a week to that role, although this was primarily undertaken from within the trust. The Medical Director was supported by two deputies who helped maintain visibility and staff engagement within the trust. The trust's Chief Executive had also been jointly leading the STP with another Chief Executive from a local NHS Trust.

The trust had a well-established and transparent relationship with its local commissioner, which extended to the development and monitoring of financial efficiencies on a regular basis.

The trust was in the process of engaging with carers across Torbay to help develop a new carers' strategy. Over 800 carers had already provided feedback and a public consultation was underway.

There was a strong group of governors who were well-engaged by the trust. The governors told us there was good two-way dialogue, they were included in board meetings and they met every other month with the trust's Chairman. Governors acted as observers on three board sub-committees: Finance, quality & assurance, and audit & assurance. The governors also regularly engaged with the public, including staffing a stand in the reception area and undertaking an annual membership survey.

A new staff engagement strategy was launched in January/February 2018 and we were told this had been well received by staff. As part of this work, the trust were working with an external company who were providing behavioural psychologists to engage with the workforce and really understand what was important to them to connect with the trust's strategy. The first stage was about gaining an insight from staff, communities and partners, and looking at the wider needs of the population. This work was planned to continue for 18 months.

The trust had a number of mechanisms to engage with staff, including 'Just ask', staff meetings and drop-in sessions, and executive 'back to the floor' days. Once a back to the floor shift had been completed, the director wrote up their experiences and shared these with the team and through blogs. Shifts were arranged based on a recognised need to connect with a particular team, or following requests from teams.

The trust had introduced a feedback tool so wards could receive real-time feedback from patients on their experiences. This piece of patient engagement work was based on a similar scheme introduced by Northumbria Healthcare NHS Foundation Trust. A 25-question survey was used to ask patients about their experiences while they were still in the ward. The data collected was put into a report and sent to the ward management team within 24 hours, allowing immediate actions to be taken where necessary. The process was being piloted in three community and five acute wards and the team of eight was led by one of the deputy medical directors and the deputy director of nursing.

Learning, continuous improvement and innovation

The trust had a staff recognition scheme, including the staff hero awards and blue shield awards. Staff hero awards could be nominated by any member of staff and were presented by a member of the executive team. The Blue Shield awards were a larger event and nominations were also accepted from members of the public. There were different award categories and a panel decided the winners. We were told by some staff that the trust-wide awards ceremony had been stopped due to financial pressures, and instead local presentations were taking place. However, following the inspection the trust confirmed this was not the case and the trust's award ceremony was planned to take place in July 2018. The trust advised the ceremony would include partners and

local stakeholders would also be invited, with the event being linked to the national NHS 70 year anniversary celebrations.

Workforce development was an important element of the trust's strategy to build a resilient workforce; however, progress to fully implement a development programme had been delayed by a consultation into new staffing structures. An end of year report was presented to the board in December 2017, which highlighted five overarching priorities for the following six months. These included:

- Developing an education and development strategy
- Implementing a new integrated education directorate structure
- Meeting cost saving plans
- Reviewing the education facilities
- Implementing annual education business plans

Following feedback being provided to the board about challenges in social care, a presentation was made at a board meeting to demonstrate the complexities and challenges. We were told by social care staff this had been powerful. They felt the board listened and responded well, and a number of changes were made as a result.

The trust had an active research team who were involved with, or supported, a number of research projects. In 2016/17 the trust had 2,167 patients involved with research trials, of which 1,481 were National Institute for Health Research (NIHR) adopted. To date in 2017/18, to the end of February, 2,203 patients had been involved with research trials and 1,796 were NIHR adopted. There were 250 current research projects underway. However, the trust's research strategy was out of date and focussed on the acute hospital services. We were told a refresh of the strategy was due to take place, but the team were waiting for new trust structures to be announced following consultation before this was done. This was to ensure the new strategy reflected the trust's working structures and was therefore able to include a greater variety of services. Conversations were taking place within the Devon Sustainability and Transformation Plan (STP) to explore research opportunities across the county, and discussions with directors were also taking place to better align research, improvement, education, innovation and strategy.

Quality improvement methodologies were used by the trust to develop services and encourage general improvements. The trust had a quality improvement lead and trained Institute for Healthcare Improvement staff. The quality improvement team worked alongside frontline teams to deliver projects jointly, ensuring local involvement and ownership. Examples of quality improvement projects included sepsis care rounding, GP streaming in the emergency department, and the introduction of a smartphone application called NHS Quicker. This app could be downloaded onto any smartphone and users were able to see current waiting times and numbers of patients at the trust's minor injuries units and emergency department. It also calculated journey times from the user's location and presented the estimated overall 'time to be seen' at each location.

A social care conference was held in October 2017 with representatives from the trust and the voluntary sector. Titled 'co-production and innovation in social care', the event built on links with local service providers and service users in order to strengthen service delivery in a more joined-up way. Work was ongoing to fully develop improved services following this co-production event.

A number of social care initiatives were already being worked on to enhance the service being provided. These included developing on-line videos for carers to access to help them fulfil their caring role, and accredited training programmes to help them return to employment if they wished.

The trust was using video-conferencing facilities to enable conversations to take place across the trust without requiring staff to travel. Staff found this extremely helpful and felt it encouraged improved relationships across the different functions of the integrated care organisation. Some care homes also had the technology available, which allowed staff to review patients and discuss care plans remotely, reducing travel time and improving efficiency.

We reviewed six serious incident investigations and found these were generally completed to a good standard. There was a clear focus on learning from incidents, but identification of good practice and sharing the learning from things that went well was not always clear. Learning was shared in a number of ways, including the monthly five-point safety brief, which was sent to all staff and available on the intranet, alert notices and falls prevention messages. Team meetings and safety huddles were also used to share learning.

Accreditations

NHS trusts often participate in a number of accreditation schemes where the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate they meet a certain standard of best practice. An accreditation usually carries an end or review date when the service will need to be re-assessed to continue to be accredited.

The table below shows which of the trust's services had been awarded accreditation.

Accreditation scheme name	Service accredited
Joint Advisory Group on Endoscopy (JAG)	Endoscopy achieved January 2016 - next assessment April 2018
Anaesthesia Clinical Services Accreditation (ACSA)	Anaesthesia Clinical Services from August 2017 to August 2019
Imaging Services Accreditation Scheme (ISAS)	Imaging Services from February 2016
CHKS Accreditation for radiotherapy and oncology services	Torbay Hospital Oncology Unit effective 23 September 2015 to 22 September 2018
Improving Quality in Physiological Services Accreditation Scheme (IQIPS)	Histopathology, Gynaecology and Non-Gynaecology Cytology 25 August 2017 - expires 16 August 2020

(Source: Routine Provider Information Request (RPIR) – Accreditations)

Learning from deaths

While the trust had started to implement new processes to support their learning from deaths, further work was required to strengthen and embed these.

The trust's policy did not cover all the required detail required by the national guidance, particularly in relation to learning disabilities and stillbirths. It was not clear how the policy was being put into practice, especially around determining the need for a review. While the policy intent was clear, the processes about making such a decision were not always as clear and we were not assured learning was taking place in all relevant cases. The trust's policy said all deaths required a review, but we were told by the medical director and patient safety manager this was not the case. We also found reference to 40 deaths being reviewed per month, but this was not being achieved and

we were told this was an aspirational target. In the month before our inspection there had been 80 deaths and during the month of our inspection there had been 98 deaths. However, only two deaths had been reviewed. In the year to date there had been 896 deaths, but the learning from mortality dashboard showed only 13 had been reviewed.

Processes within the trust's policy were not always clearly defined or effective in practice. For example, although the mortality surveillance group was an important step in the assurance process, there were no clear reporting structures underneath this. Additionally, not all specialties had defined death review processes in place. Although the trust's policy stated all learning disability and mental health-related deaths, infant and child deaths, and stillbirth/maternal deaths would be reviewed, it was not clear how this would be achieved. There was no clear method of collecting this information, or what the process was to ensure these were all reported to the mortality and morbidity meetings. We were told a spreadsheet was maintained and it was "hoped" this would be completed. We were also told incident reports, complaints and bereavement service involvement would act as 'safety nets', but ultimately there was no assurance everything was being recorded and reported.

The governance systems supporting learning from deaths were at times unclear. For example, there was a lack of action tracking across all the sub-mortality committees. This meant the trust could not be assured the actions required to improve were being implemented or monitored, and it could identify who was responsible for the actions.

A dashboard of deaths in the trust was presented to the board, but it was not easy to understand and did not enable the board to determine what the learning and outcomes were from deaths. The dashboard did not cover maternal or paediatric deaths, or still births. Although there had been five deaths of patients with learning disabilities, there had been no internal review of these deaths. Instead, deaths of patients with a learning disability were sent to the local clinical commissioning group for review, but these were not completed in a timely way and therefore opportunities to learn from these were delayed.

The trust was not able to demonstrate how learning from deaths was communicated to staff and shared across specialties. It was also unclear how findings were shared with patient's GPs. The trust's policy stated any "significant outcomes" would be notified to GPs, but it did not describe what a significant outcome would be or who should communicate with the GP.

There was no evidence of any staff training in relation to learning from deaths, including for those required to complete the reviews. This meant there was a risk staff would not understand the requirements of the policy or the processes that needed to be followed and learning opportunities would be missed.

The trust was able to demonstrate very open and honest communications with next of kin following a death, but evidence of learning being shared with next of kin was not always clear. We found exemplary examples of duty of candour being met in letters to next of kin and minutes of meetings with relatives. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Acute services

Maternity

Facts and data about this service

We completed an unannounced inspection of the maternity services at Torbay and South Devon NHS Foundation Trust as part of the new phase inspection methodology on the 13, 14 and 15 of February 2018.

Maternity care provided by Torbay and South Devon is managed centrally by the Women's Health Unit at Torbay Hospital. The trust provides a range of antenatal, intrapartum and postnatal maternity services which was available dependent upon assessment of individual risks, needs and personal choice. A small core team of midwives were based on the delivery suite at Torbay hospital and an integrated system was used for all other midwifery roles. This meant midwives were rostered to work in the acute or community setting dependent upon patient needs.

A consultant led service was provided at Torbay hospital for women whose preference was to deliver in the hospital or for women who were assessed as having increased risks. The hospital maternity services included antenatal clinics (midwife and consultant led) and a day assessment unit for women who required extra tests and/or surveillance without the need for admission. Other maternity services included: screening, ultrasound, fertility and early pregnancy clinics. The delivery suite has eight birthing rooms, one of which has a birthing pool. Close by is the Mary Delve suite reserved for use by bereaved parents. There is one obstetric operating theatre within the surgical services which is located next to the delivery suite. Other theatres could be utilised in the event of emergency. John McPherson ward has 20 beds and was available for women requiring admission for ante and postnatal care. The ward has seven individual en suite side rooms and three, four and six bedded bays with shared bathroom facilities. Next to John McPherson was the Special Care Baby Unit (not inspected as part of the maternity core service.

Women assessed as having low risks had the option to delivery in the Whitelake, 'freestanding' (no medical staff) midwife led birthing centre located at Newton Abbot Hospital. Whitelake has two delivery rooms, both en suite, one of which also has a birthing pool. There were five community midwifery teams:

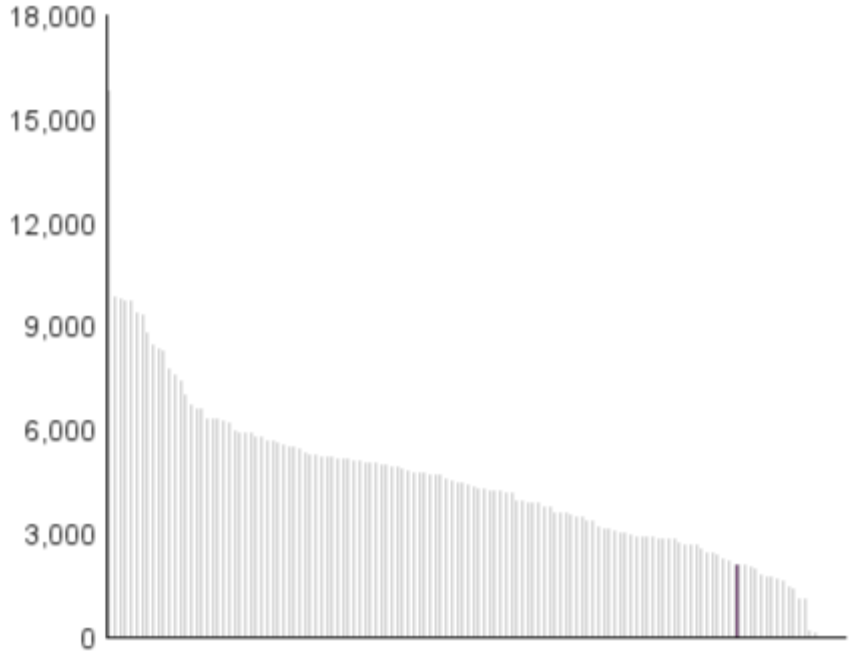
- Coastal - based in Paignton
- Riviera - based at Torbay maternity unit
- Templar - based at Teignmouth Children's Centre
- Torview - based at Newton Abbot Hospital
- Waterside - based at Brixham hospital

These teams provided ante and postnatal care and supported home births for those women assessed as having low risks.

From July 2016 to June 2017 there were 2,068 births and from July 2017 to the end of January 2018 there were 1343 births. All of these births had been supported by Torbay and South Devon NHS Foundation Trust maternity services.

A comparison of the number of births at the Torbay trust compared to other trusts is shown below.

Number of babies delivered at South Devon Healthcare NHS Foundation Trust – Comparison with other trusts in England.



A profile of all deliveries from July 2016 to June 2017 can be viewed below.

Table 1: Profile of all deliveries (July 2016 to June 2017)			
	Torbay and South Devon NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	2,048	99.0%	98.5%
Multiple	20	1.0%	1.5%
Mother's age			
Under 20	98	4.7%	3.2%
20-34	1,582	76.5%	75.0%
35-39	322	15.6%	17.8%
40+	66	3.2%	3.9%
Total number of deliveries			
Total	2,068		608,950

Source: Hospital Episode Statistics

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

Table 2: Gestation periods (July 2016 to June 2017)			
	Torbay and South Devon NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Gestation period			
Under 24 weeks	0	0.0%	0.2%
Pre term 24-36 weeks	123	6.0%	7.8%
Term 37-42 weeks	1,927	93.8%	91.8%
Post Term >42 weeks	*	*	0.2%

Total number of deliveries with a valid gestation period recorded		
Total	2,055	496,578

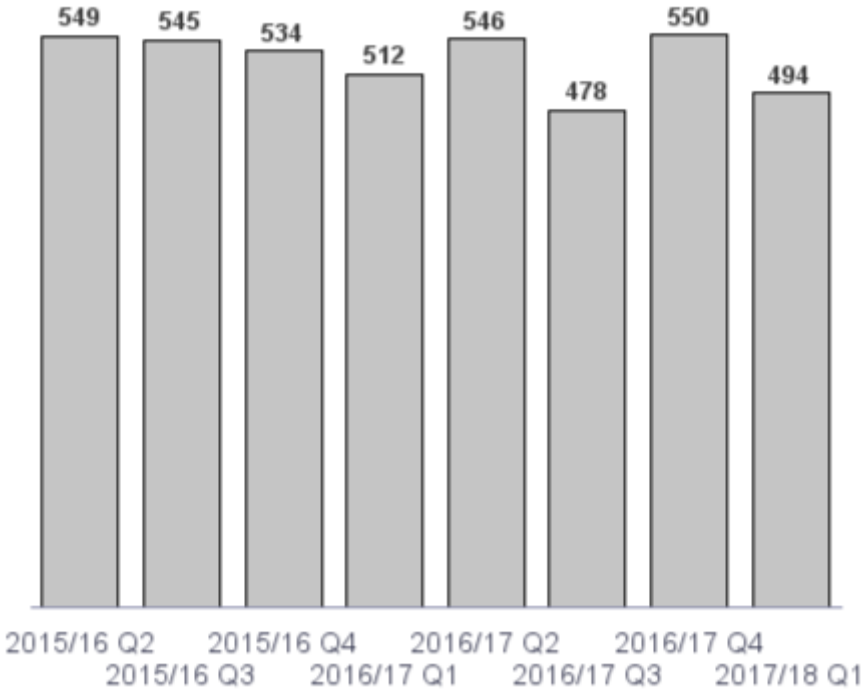
Source: Hospital Episode Statistics

Notes: For reasons of confidentiality, numbers below six and their associated proportions have been removed and replaced with '*'.

(Source: Hospital Episodes Statistics (HES) Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below.

Number of deliveries at South Devon Healthcare NHS Foundation Trust by quarter:



(Source: HES - Deliveries (July 2016 - June 2017)

During this inspection we spoke with 10 women to ask their opinion of the treatment and care they had received. We spoke to 49 staff including: consultant obstetrician, anaesthetists and a psychiatrist and obstetric and anaesthetic registrars, junior medical staff, midwives of all levels working in the hospital and community including senior and specialist midwives and student midwives, perinatal mental health staff including the service manager and occupational therapist, theatre staff including specialist practitioner and scrub nurses, reception and domestic staff. We reviewed 20 patient records and toured all areas of the maternity service at Torbay hospital and Whitelake birthing centre at Newton Abbot Hospital. We observed one maternity staff handover meeting, attended one multi-professional seminar and attended two meetings related to maternity risks and governance.

Is the service safe?

Mandatory training

The maternity service had completed a training needs analysis which stated that over 75% compliance with staff training was acceptable, with 100% compliance being an aspirational target. However, this did not fully meet the compliance levels set by the trust for midwives and medical staff. As well as the trusts mandatory training, all maternity staff had been required to complete annual updates on a range of obstetric specific training. This included: multidisciplinary emergency skills and drills (PROMPT), perinatal mental health, infant feeding, risk management and use of specialist equipment. The maternity service maintained a report, which was updated every month in order to monitor the percentage of staff compliant with mandatory training.

The trust set a target of 85% for completion of mandatory training apart from the information governance module which had a target of 95%. The target for the three resuscitation courses was included as part of the obstetrics mandatory training, which had a compliance target of 100%. A summary of compliance for mandatory courses from April 2017 to October 2017 for medical staff in maternity is below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Trust Target (%)	Met (Yes/No)
Conflict Resolution	15	21	71%	85%	No
Equality, Diversity and Human Rights	15	21	71%	85%	No
Moving and Handling	13	21	62%	85%	No
Health and Safety	13	21	62%	85%	No
Infection Control	13	21	62%	85%	No
Information Governance	11	21	52%	95%	No
Fire Safety	8	21	38%	85%	No
Resuscitation	15	21	71%	100%	No
Resuscitation - Paediatric Basic Life Support	5	12	42%	100%	No
Neonatal Basic Life Support	3	9	33%	100%	No

A summary of midwives compliance for mandatory courses from April 2017 to October 2017 is shown below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Trust Target (%)	Met (Yes/No)
Information Governance - 1 Year	69	76	91%	95%	No
Infection Control	66	76	87%	85%	Yes
Moving and Handling	65	75	87%	85%	Yes
Equality, Diversity and Human Rights - 3 Years	64	76	84%	85%	No
Conflict Resolution	62	76	82%	85%	No
Fire Safety - 1 Year	61	76	80%	85%	No
Health and Safety - 3 Years	60	76	79%	85%	No
Prevent WRAP - No Renewal	58	64	91%	100%	No
Resuscitation	64	75	85%	100%	No
Neonatal Basic Life Support	55	71	77%	100%	No

Staff were required to update mandatory training within each calendar year. From April to October 2017, the training target was met for two of the applicable mandatory training modules for which nursing staff were eligible. These were the infection control module and the moving and handling module. (Source: Trust Provider Information Request P14).

The target for obstetric mandatory training was 100% and staff did not meet this for any of the training. The following table shows the percentage of midwives, medical staff and maternity care assistants who were documented as compliant with obstetric mandatory training up to the 31 December 2017.

Training	Number of midwives (MW) eligible	Number of MW's who attended	% of MW's who attended	Number of medical staff eligible	Medical staff who attended	% of medical staff who attended	Number of maternity care assistant (MCA) eligible	Number of MCA's who attended	% of MCA's who attended
Health & Safety	120	107	89%	13	4	38.5%	34	28	94%
Adult/maternal resus	120	107	89%	13	5	38.5%	34	32	94%
Infant Feeding	120	107	89%	NA	NA	NA	34	32	94%
Manual Handling	120	107	89%	13	5	38.5%	34	32	94%
Mental health	120	107	89%	13	5	38.5%	34	32	94%
Obstetric Update Day	120	106	88%	14	9	64%	34	28	82%
CTG (method to monitor the fetal heart)	120	105	87.5%	14	9	64%	NA	NA	NA
Risk management	120	107	89%	14	9	64%	34	28	82%
Normal Birth	120	107	89%	14	9	64%	34	NA	NA
Neonatal resus	120	106	88%	14	9	64%	34	28	82%
PROMPT (PRactical Obstetric Multi-Professional Training)	120	107	89%	14	7	50%	34	25	73.5%
Shoulder dystocia	120	107	89%	14	7	50%	34	26	76.5%
Breech & cord prolapse	120	107	89%	14	7	50%	34	26	76.5%
Haemorrhage	120	107	89%	14	7	50%	34	26	76.5%
Eclampsia	120	107	89%	14	7	50%	34	26	76.5%
Sepsis	120	107	89%	14	7	50%	34	25	73.5%
Electronic CTG e-learning	120	69	57.5%	12	6	50%	NA	NA	NA
Antenatal & Neonatal e-learning	114	52	46%	NA	NA	NA	NA	NA	NA

When we reviewed the figures we found an error in the percentage of medical staff reported to be compliant with health and safety training. This had been reported as 38.5% but based on the numbers of medical staff confirmed as having attended; the figure should have been 30.7%. In addition, the maternity care assistants (MCA) had been documented as 94.1% compliant with

health and safety training. Based on the numbers of MCA documented as having attended; the figure should have been 82.3%.

The table also highlights that only 46% of midwives had completed the e-learning package within an annual timeframe. This was reported to be partly due to changes to the National Institute for Health and Care Excellence (NICE, February 2017) guidance on best practice to interpret cardiotocograph traces (fetal heart monitoring). The maternity services reported the use of the e-learning package was under review.

The trust provided records related to mandatory training which included the anaesthetists from the surgical department who regularly supported with obstetric care. Please see below.

	Medical Staff	Midwives	Maternity Care Assistants	Anaesthetist
CTG	65%	88%		
Risk management	65%	90%		
Mental health	39%	90%	94%	
Adult/maternal resus	39%	90%	94%	
Infant feeding		90%	94%	
Early recognition & post-op	39%	90%	94%	
Neonatal resus	65%	88%	82%	
Shoulder dystocia	50%	90%	77%	50%
Breech & cord prolapse	50%	90%	77%	50%
Haemorrhage	50%	90%	77%	50%
Eclampsia	50%	90%	77%	50%
Electronic CTG	50%	58%		
Screening e-learning		46%		

We were informed part of the reason medical staff had the poorest compliance with mandatory training was due to changes in roles, retirement and long term sickness. These reasons had made it more difficult for medical staff to attend training. We were informed that anaesthetists regularly attended the (monthly) PROMPT training. However, the compliance of the four lead anaesthetists for obstetric care up to December 2017 was reported as 50%. Records confirmed that all obstetric medical staff had been directly emailed to prioritise the need to complete mandatory training. All midwives and MCA's who had not attended mandatory training during 2017 had been booked to attend during 2018. It was also confirmed that the consultant lead anaesthetists for maternity and the clinical director for obstetrics had been kept up to date with the poor attendance rate of medical and staff.

A revised mandatory training schedule had been produced for 2018 for all maternity staff. This also incorporated additional training in response learning and action plans from reviews and audits. This revised training schedule aimed to improve and enhance systems, processes and practice in order to keep people safe, please see below. Senior staff told us mandatory training was being prioritised with all staff groups which we saw documented in meeting minutes.

Training	Frequency	Which maternity staff	How
Infection Control including hand washing	Annually	All Staff	On mandatory training day
Prevent/Health Wrap (identifying and preventing exploitation)	3yr	All Staff	Book
Transfusion	Annually	All staff	On mandatory training day

K2 – obstetric risk management	Annually	Registrars & consultants, Midwives	e-learning K2 package
388 eLearn Writing in Medical Case Notes	3 yearly	All obstetric staff, midwives, MCA's and consultants	e-learning
GROW (fetal growth assessment) training - measurement	Annually	All obstetric staff	At appraisals with Team Leaders
GROW training e-learning	Once only	All obstetric staff	Through perinatal institute
GROW training (full taught 2 hours)	Once only	All obstetric staff	Taught sessions – dates arranged

Safeguarding

Staff we spoke with regarding safeguarding demonstrated an understanding of what kind of issues might alert them to consider possible safeguarding issues, and what they could do to respond in a safe and supportive manner. We reviewed four patient safeguarding records. All had written evidence of interagency communication and clear plans of action. This included written evidence of multidisciplinary working in relation to safeguarding risk assessments. Staff were able to explain about Gillick and Fraser competencies (law relating to young people) and had experience of using this guidance in practice.

There was evidence of effective planning and coordination of care between the hospital and community. For example; we saw in care records how an outpatient midwife liaised and coordinated care with the perinatal mental health team, obstetrician and the anaesthetist for a planned caesarean section.

However, improvements were required with regards to the maternity staffing levels of compliance with mandatory safeguarding training. Staff attended one of five levels of mandatory safeguarding children and vulnerable adults training, dependent upon their role. All midwives were trained to level three and the midwifery care assistants to level two. We reviewed a training presentation which had been developed by the lead midwife for safeguarding for use during update training planned for during 2018. This had included examples of recently experienced safeguarding alerts and highlighted what relevant policy and processes should be followed. The head of midwifery confirmed this was to be used as part of the maternity mandatory training programme planned to take place during 2018. The resources were available for staff to access on the trusts intranet.

The tables below detail the midwives and obstetric medical staff compliance with safeguarding training from April 2017 to October 2017.

Medical staff

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Trust Target (%)	Met (Yes/No)
Safeguarding Adults Level 1	18	21	86%	90%	No
Safeguarding Adults Level 2	16	21	76%	90%	No
Safeguarding Children Level 1	16	21	76%	90%	No
Safeguarding Children Level 2	12	19	63%	90%	No
Safeguarding Children Level 3	3	18	17%	90%	No

Midwifery staff

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Trust Target (%)	Met (Yes/No)
Safeguarding Children Level 1	73	76	96%	90%	Yes
Safeguarding Adults Level 1	72	76	95%	90%	Yes

Safeguarding Children Level 2	70	75	93%	90%	Yes
Safeguarding Children Level 3	66	74	89%	90%	No
Safeguarding Adults Level 2	57	76	75%	90%	No

(Source: Trust Provider Information Request P18)

We were concerned that the lead midwife for safeguarding and one of the midwifery matrons who was the nominated individual for safeguarding for the trust had only completed safeguarding training to level three. Lead professionals have a pivotal role in providing safeguarding advice and expertise both within the maternity services and wider trust. National guidance recommends that named professionals in lead roles should be trained to at least level four (Intercollegiate Document: Safeguarding Children and Young people: roles and competences for health care staff, 2014).

Cleanliness, infection control and hygiene

There was a low (very small) risk of patients contracting a hospital acquired infection on the ante/postnatal (John McPherson) ward. From 1 January 2016 to 31 March 2017 there had been no incidents of Clostridium difficile (Cdiff) or of E.coli. There had been no incidents of methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-susceptible Staphylococcus aureus (MSSA).

Whilst all areas of the maternity environment appeared visibly clean some equipment such as birthing balls were seen to be stored directly on the floor which increased infection risks. In addition, we observed 'I am clean stickers' on some equipment which had not been dated. Other equipment such as blood pressure machines did not to have any 'I am clean stickers' on them. This meant it was difficult to confirm if or when equipment had been cleaned and if it was ready for patient use. In clinical areas, we observed there were daily checking lists to prompt staff to check cleaning schedules had been completed.

The processes used to ensure equipment was available for obstetric care in theatre could have presented an infection control risk. Staff told us that obstetric equipment was routinely taken from the delivery suite and wheeled into theatre within the surgical department as there were no theatre sets routinely available for obstetric cases. This meant non sterile equipment such as the ventouse machine and resuscitaire had been taken into a sterile environment. This could have, increased infection control risks.

There were inconsistent records to demonstrate hand hygiene audits had been completed. The trust supplied records confirming hand hygiene audits had been completed on John McPherson ward. From January 2017 to December 2017 the records documented 100% compliance for hand hygiene for seven months. For four months, no audit records were documented and one month recorded 80% compliance with hand hygiene. No hand hygiene audit summaries had been provided for other maternity clinical areas.

Antibacterial hand cleaner was available in most clinical areas. We saw staff dressed bare below the elbow in order to complete effective hand washing. We observed ample stocks of personal protective equipment (PPE) such as gloves and aprons and staff confirmed there were no shortages of supply. We saw maternity staff appropriately wore PPE and used antibacterial hand cleanser before entering and when leaving birth rooms.

Equipment and process were in place to transport clinical waste from home births to Torbay hospital in a manner which minimised infection risks. Midwives transported clinical waste in specially coded bags and containers. Equipment was re packed in the original packaging and transferred back to the sterile supplies unit.

Environment and equipment

The environment and equipment throughout the maternity services were generally fit and safe for purpose. Areas throughout the service were in need of review, updating and modernising. Flooring had been upgraded within the antenatal clinic and the flooring and decoration within the delivery suite was scheduled to be replaced. In order to improve the environment and equipment and to be able to better meet current and anticipated patients' needs, a combined maternity and gynaecology business case had been developed. The women and children's operations manager confirmed (February 2018) that the business case had been approved by the trust's senior business management team and finance committee. The trust's executives had also seen the business case and the plans had been placed on the trust's capital prioritisation schedule. The final steps being planned were to present and seek approval of the business case at board level.

Security systems were in place, understood and followed by staff to maintain the safety of women and infants. The delivery suite could only be accessed by a swipe card which was allocated to specific staff and the entrance was monitored by CCTV which was visible near the nurse's station. The Whitelake birthing centre was also secure and accessible only with key codes and the entrance area was monitored by CCTV which had been linked to the local hospitals security system. Staff and visitors could access John McPherson ante/postnatal ward but exiting was only possible by staff granting permission and deactivating the security system. Women kept their babies in cots next to their beds and staff demonstrated an understanding of the trusts abduction policy. Staff also gave examples of how they had accessed the trust's security personnel when women had been identified at risk of domestic abuse

We had some safety concerns as we observed that codes for locked areas had been written near entrances so that staff could access them promptly. We raised the potential risks to breaches of security this posed with senior staff at the time of the inspection. In the maternity day assessment unit we observed sharps and liquids on a treatment trolley positioned near the waiting room. In the three patient rooms, only one of the call bells was functional and none had working emergency buttons. In delivery rooms, curtains did not fully cover the windows which had the potential to impact on the privacy and dignity of women using the rooms. These issues and the potential safety impacts were raised with senior staff at the time of our inspection. The trust responded promptly and confirmed these issues had been attended to.

Checks of some equipment had not been consistently documented as completed and some obstetric equipment ready for use was dated past the expiry date. Resuscitaires were scheduled for daily checks. This equipment was used when babies required additional support or monitoring. We looked at the records for checking the resuscitaires on the delivery suite (numbered 1, 2, 5, and 6), and at the Whitelake birthing centre. For some months there were gaps of two, three of four dates within one month. This indicated checks had either not been completed or had not been documented as completed. Other months showed gaps in records of 14, 18 and 22 days over a one month period. On a treatment trolley on John McPherson ward we saw equipment with expiry dates for February, March and October 2017 and one item (catheter) with an expiry date of June 2011. On the day assessment unit, the emergency delivery pack included equipment past the expiry dates. This included: sterile gloves, cord clamps and mouthpiece for use with nitrous oxide entonox (gas). These findings were raised with staff at the time of our inspection to ensure out of date equipment was replaced.

The central delivery suite, ante and postnatal wards and the obstetric theatres all had adult and baby emergency resuscitation equipment. These were accessible and appropriately stocked. There were also emergency grab bags available such as for use in the event of unexpected

haemorrhage. Records showed that this equipment had been regularly checked in accordance with trust policy.

A spacious and private environment was available for parents who had experienced loss. The Mary Delve suite had a separate entrance from the delivery suite and en suite, kitchenette and lounge facilities that could accommodate extended family. Furnishings and attention to detail had been used to increase comfort and minimise the appearance of a clinical setting.

Obstetric surgery was organised and managed by the surgical department located next to the delivery suite. One theatre in particular was used by the obstetricians and if a second theatre was required, this was organised by the theatre coordinator. The special care baby unit was adjacent to the ante/postnatal ward.

All midwives were supplied with lone working equipment which could be covertly activated providing a GPS signal of where the midwife was and enabling others to hear and record conversations. All the midwives we spoke with about lone working were familiar with the trusts policy. When women chose to give birth at home risk assessments were completed which included all aspects of the home environment and immediate family. Appropriate actions were then put in place and plans were logged on the trust intranet to ensure all necessary staff had access to this information.

Assessing and responding to patient risk

The delivery suite was consultant led and able to support women with high risk pregnancies and/or complex health. Appropriate experienced and skilled staff were available to respond to acute, severe and unpredictable obstetric emergencies. Anaesthetic and obstetric medical staff were available 24 hours a day, seven days per week. Midwives and junior medical staff confirmed consultants were responsive to phone calls and came into the delivery suite out of hours whenever required.

All pregnant women had comprehensive risk assessments that started at their first appointment. This included screening for pre-eclampsia, gestational diabetes, venous thromboembolism, and other medical conditions. Other risk factors were assessed and discussed with women including: previous obstetric history, family medical history, social issues, and screening for domestic abuse and mental health issues. All women requesting a home birth had their home situation assessed prior to delivery. Risk assessments and action plans were reviewed with every subsequent contact with a doctor or midwife. We saw evidence of advanced plans to mitigate individual risks written in care plans. For example; women who had been identified as likely to have a pre term births were planned for. This included written discussion and action plans between consultant obstetrician, midwife, neonatal clinical staff and microbiologist.

The maternity service did not have a high dependency area and decisions were made based on each individual's assessment of needs, which was kept under review. The consultants were responsible for deciding if a woman with complex health could remain on the delivery suite or if they should be transferred to critical care. The trust had a critical care outreach team who were available to support the maternity staff. We observed during our inspection the outreach team were contacted and they provided additional advice and support. From April 2017 to January 2018 no women had been transferred from the maternity services to critical care. Senior staff confirmed the critical outreach team would be contributing to the obstetric mandatory training programme planned to take place during 2018.

Midwives and medical staff worked collaboratively in order to assess and respond to changeable patient risks. A staff escalation process was followed when required in response to the complexity

of care needs or numbers of women attending the delivery suite. This meant staff were redirected to work on the delivery suite or any other area where patient risks had been assessed as being the highest. As the delivery suite and ante/post-natal ward was consultant led, the medical staff had ultimate responsibility for obstetric risk assessments. There were three or more staff handover meetings every day to ensure patient information was understood by all staff coming on shift. We were told the handovers were not multidisciplinary due to the different shift patterns of the doctors and midwives. A senior midwife attended the medical handovers in order to share and update on clinical care information. A handover diary was also used by the midwifery shift coordinators (lead midwifery staff). The diary was used to record any significant information about staffing, safety issues or what patients were expected that day and why.

There was evidence of good understanding of the management of sepsis (a life threatening condition in response to infection). From January 2017 to June 2017 a review of 12 sets of notes where a diagnosis of sepsis was suspected had been audited. Records showed action plans from the audit had been made and disseminated to staff. These had been based on national guidance and best practice (MBRRACE 2014). The trusts medical director had written to the obstetric multidisciplinary team in acknowledgement of the good sepsis management provided.

Women from the maternity service who attended theatre had all their care and safety needs provided within the surgical department. Specialist obstetric medical staff attended all emergency and planned surgical procedures. Midwives attended to monitor each new born in theatre but all other staff were provided from the surgical department. We saw a range of pre-operative and perioperative checks and care plan documents were used to record all treatment before and during surgical procedures. This included documentation to record safe practice guidance was followed before patient surgery commenced. The trust confirmed audits for the completion of the World Health Organisation (WHO) surgical safety checklist had been completed. This prompted actions for safe clinical practice before anaesthesia, before incisions, and before the patient left the operating room. The trust said they did not audit compliance with the checklist.

Post operatively, women who had a general anaesthetic or had any medical complications were cared for in the main surgical recovery area. Women who had had surgery under regional anaesthesia (epidural) had an initial recovery in theatre and were then transferred back to delivery suite where midwives continued with recovery support. An anaesthetist would attend if the midwife had any concerns. Midwives attended mandatory training for care of deteriorating woman to support with post-operative recovery. Records stated that 90% of midwives were in date with this training. However, it was not clear if this training or the trusts policy; ‘Recovery on Delivery Suite, Version 4’ fully met the national recommendations’ for safe anaesthetic care and recovery (Association of Anaesthetists of Great Britain & Ireland 2013, Guidelines for Obstetric Anaesthetic Services). These guidelines state that any staff responsible for supporting patients with obstetric anaesthetic recovery must be trained and competent to the same level as other surgical recovery staff. In addition, the clinical area in which this is done (the delivery suite) must be to the same standards as used within general (surgical) recovery.

There was inconsistency in records to demonstrate all policy and documentation had been completed regarding women’s risks of deterioration. The trusts policy (Early Recognition of Severely Ill Pregnant Women) stated that all high risk women admitted to the maternity services (not in labour) or those women stating they feel unwell after delivery should have had a maternal early obstetric warning score completed (MEOWS). This checklist scored observations which could be used by clinicians to support the identification of deterioration and thereby prompt timely and less invasive interventions. We reviewed a MEOWS audit dated November 2017 which reviewed 25 charts. Whilst some observations had been completed to a high level of compliance,

this was not consistent and the overall scores had only been calculated for 48% of the MEOWS. Whilst escalation may have been identified and appropriately responded to, this was not documented in 47% of the MEOWS audited. In addition, the use of MEOWS post-surgery was integral to compliance with recovery on the delivery suite and important when providing care to women assessed as having any other high (level two) medical care needs. An improvement action plan had been documented; however, there was no apparent evidence to confirm how these actions had been followed up.

Processes were followed to accurately record and share information when any women phoned the delivery suite for advice. Staff had been using SBAR (Situation, Background, Assessment, and Recommendation) records. The use of SBAR helped staff to share important risk information and record what actions to take in response in a standardised manner. The use of SBAR was reported to be embedded practice by midwifery staff.

Staff monitored and reviewed the reasons for transfer of women from the Whitelake midwife led centre at Newton Abbot to Torbay hospital. Processes were in place and followed to safely transfer women by ambulance. Staff confirmed emergency transfer by ambulance took seven minutes. The number of transfers and reasons for transfer is shown in the table below:

Figures from 1 April 2016 to 31 December 2017 Numbers of home births and number of births at Whitelake centre. Number of transfers from home and numbers of transfers from the Whitelake centre.		
	Whitelake	Home
No of women	135	230
No of births	97	171
No of Intrapartum transfers	38 (28%)	59 (26%)
No of Postnatal transfers	18 (18%)	0

Mandatory emergency obstetric skills and drills training (PROMPT- PRactical Obstetric Multi-Professional Training) was available to all maternity staff. This training was valued by staff who told us training sessions were often based on previous situations which had been experienced within the service. Staff felt these training sessions also covered potential situations that could be experienced in both the hospital and community settings. However, not all staff had practiced emergency skills related to evacuation of a woman from a birth pool. A video was used for this training which staff felt could have been improved. Records dated 31 December 2017 stated 89% of midwives, 73.5% of maternity care assistants and 50% of medical staff were in date with the PROMPT training. Senior staff had been informed of the training gaps and action plans had been put in place to address this. Staff had access to resources to support the assessment and response of safe patient care. We reviewed staff training presentations which included: the management of sick patients and fetal monitoring. The head of midwifery confirmed that these presentations were part of the maternity mandatory training programme planned for 2018.

Midwifery and nurse staffing

Staffing levels and skill mix had been planned and reviewed. The trust had sufficient midwives and maternity support workers (MCAs) in post to meet service demands. During October 2017 an evidence based assessment of staffing levels had been completed. The Birthrate Plus Midwifery Workforce Planning (Royal College of Midwives, RCM) system assessed midwifery staffing levels based on reviews of maternity activity in the hospital and community over a four month period.

This enabled recommended levels of midwives and MCAs in order to be able to deliver safe care. The review confirmed that Torbay maternity service had the right number of staff in both clinical and non-clinical roles. Women in established labour received one to one care from a midwife which complied with national guidance (National Institute for Health and Care Excellence (NICE), (NG4) 2015). Records provided by the trust dated February 2018 showed the service was funded to have 86.1 whole time equivalent (WTE) midwives and 20.9 WTE maternity support workers. Nationally, most midwife to birth ratios range between 1:26 and 1:34 (Royal College of Midwives). From 1 January 2017 to 31 December 2017 the midwife to birth ratio at Torbay was confirmed as between 1:25 and 1:36. Please see the table below. The head of midwifery confirmed these figures excluded senior and specialist midwives who did not normally provide clinical care.

2017	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Midwife to birth ratio	1:36	1:26	1:29	1:26	1:30	1:26	1:28	1:29	1:35	1:30	1:28	1:25

An experienced midwife was available for each shift on the labour ward and student midwives on placement were not included in the staffing numbers. This complied with national recommendations on staffing (Royal College of Obstetricians and Gynaecologists, 2007.) We observed staffing numbers for each 24 hour period were displayed for any visitors to view on John McPherson ante/postnatal ward. Senior staff confirmed any staffing gaps were filled by part time or bank shift staff. There was an established, integrated system of working which enabled midwives and MCAs to work seamlessly between the acute and community settings, wherever service demands were the highest.

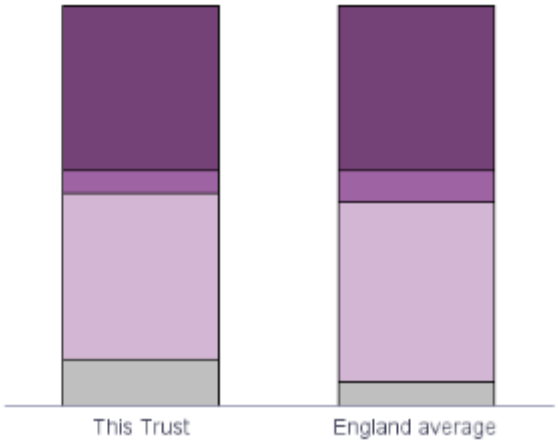
The trust set a target of 10% to 14% for turnover rate. Between November 2016 and October 2017, the trust reported an annual turnover rate of 6.4% for midwives. An internal staffing review identified that on average there were two WTE midwives on maternity leave at any one time. In response the trust had approved the recruitment of two additional midwives above establishment to be able to provide consistent cover for leave. As a staff group, midwives had the worst sickness rate within the trust. From November 2016 to October 2017 the trust reported a sickness rate of 5.9% in maternity for midwifery staff which was worse than overall trust target of 3.8% for sickness. (Source: Routine Provider Information Request (RPIR) – P19 Sickness) We spoke with senior staff about these figures. We were told, as a staff group, there were a lot of midwives approaching the end of their careers and as such they were also in the age range which placed them at higher risk of long term health issues.

Medical staffing

Obstetric medical staffing skill mix was planned and reviewed. There was sufficient medical staff who worked to provide clinical care and support 24 hours per day, seven days per week. Medical staff confirmed there were seven whole time equivalent (WTE) consultants. One consultant was leaving the service but a replacement consultant had been appointed. Consultants worked Monday to Friday from 8.30am to 5pm and on Saturday mornings and were on a rota during out of hours. This meant there was sufficient consultant presence available to comply with national guidance based on the number of births per year (Royal College of Obstetricians and Gynaecologists, 2007). The consultant rota was emailed to all obstetric medical staff and senior midwives to ensure they knew who was on call and how to get in contact. Consultants were reported to be very supportive by all staff we spoke with. Staff said the consultants were always responsive when called and were happy to return to the hospital if required. The obstetric service was funded for eight WTE obstetric registrars and seven were in post. Staff told us the shortfall was filled by using locum registrars and this was usually the same locums who had therefore

become familiar with the maternity services systems and processes. There was six obstetric senior house office (SHO) level staff. The SHO staff worked night shifts also supporting the gynaecology and general surgery services. Systems were in place that in the event of an obstetric emergency. If the obstetric SHO was involved with another specialty case and was needed in maternity theatre, back up medical staff would relieve the SHO so they could attend the maternity case. Anaesthetic staff were provided from the surgical department and were accessible 24 hours a day, seven days per week. Staff confirmed they had good relationships with anaesthetists who were prompt and responsive to any obstetric requests.

Staffing skill mix reported during September 2017 for the 17 WTE obstetric medical staff. (Source: NHS Digital Workforce Statistics).



	This Trust	England average
Consultant	41%	41%
Middle career^	6%	8%
Registrar group~	41%	45%
Junior*	12%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

From November 2016 to October 2017 the trust reported a sickness rate of 1.1% in maternity for medical staff. This is better than overall trust target of 3.8% for sickness. *(Source: Routine* Provider Information Request (RPIR) P19 Sickness)

Records

The way patient records had been used and organised enabled clinicians to easily access relevant information to review care. Maternity records were a combination of hand held, written and computer based. Pregnant women had hand held records (a file of all the information related to their pregnancy) which was started and provided at their initial booking of ante-natal care. These were maintained by maternity staff through to completion of post-natal care. We saw individual risk assessments had been completed and regularly reviewed. Risks were documented as having been discussed with patients. We observed records were stored securely in locked trolleys and rooms that could only be accessed by staff.

Staff told us it could be difficult keeping computer based records updated in some areas of the community. This was due to poor internet access. In response staff worked from local children's centres, the Whitelake birthing centre or had to return to the hospital to complete records in full

There were no record keeping audits but senior staff told us records had been reviewed as part of other ongoing audits and through the course of investigating serious incidents. We saw records reviews had been completed as part of audit evaluations. Staff confirmed where required feedback was provided to staff. We looked at 20 random sets of records and found they were legible,

factual, signed, and dated which met professional standards (Nursing and Midwifery Council, General Medical Council).

Medicines

In the maternity theatres and other clinical areas throughout the maternity service, we observed medicines; including controlled drugs, stored appropriately in locked cupboards and tamper proof resuscitation trolleys. Midwives and nurses told us they had adequate stocks of medicines and no issues with the pharmacy services.

Specialist medicines advice and support was available for women with mental health needs. The perinatal service facilitated clinics for women who were required to take high dose medicines as medical treatments or who had substance misuse issues. A specialist mental health pharmacist attended these clinics and was able to advise on safe medicines plans for women during pregnancy and labour. The specialist pharmacist also gave advice regarding medicines and breastfeeding.

There were no systems in place to monitor how long specific medicines could be kept safely outside of fridges. Some midwives working in the community kept their own records to show when they took medicines out of fridges for use with home births. These records were used to also prompt medicine disposal. There was inconsistency among staff as to how long it was considered safe to keep specific medicines (syntometrine) out of fridges. Some midwives reported this was six weeks and others three months. The recommended safe time was two months and this was also with the requirement to keep medicines out of light. (https://www.medicines.org.uk/emc/product/865).

Systems had not been fully followed by staff to ensure all medicines available for use were within their expiry dates. We observed medicine in the drug cupboard on John McPherson ward with an expiry date of January 2018 and at Whitelake medicine was dated expired March 2017. Also it was not clear what processes were in place and audited to ensure how medicines carried by midwives working in the community were reviewed for expiry dates.

We were concerned with a lack of evidence for auditing the safe keeping of medicines and prescriptions within the antenatal clinic. We observed the medicines fridge had gaps in recording when temperature checks had been completed. Whilst we saw prescriptions (FP10) sheets stored securely within the controlled drug cupboard the most current prescription number was not consecutive with the last recorded number (during 2014). There was no apparent audit of the FP10s which meant there was potential for theft or misuse of the prescription charts. In addition, whilst midwives working in the community used padded bags to transport nitrous oxide (gas used for pain relief) there was no facility for the nitrous oxide to be secured within vehicles.

Midwives were not able to consistently demonstrate an understanding of what medicines they were permitted to give as part of their registration and what medicines they were permitted to give due to Patient Specific or Patient Group Direction. Registered midwives may supply and administer, on their own initiative, any medicines that are specified in medicines legislation under midwives exemptions, provided it is in the course of their professional practice. If a medicine is not included in the midwives exemptions then a prescription, or a Patient Specific or Patient Group Direction would be required (Nursing and Midwifery Council, 2011). These are written instructions for midwives to supply or administer medicines to a patient or group of patients in specific circumstances without the need for a doctor's prescription. Senior staff confirmed the policy and list of medicines included in the trust's obstetric Patient Group Direction had been completed and distributed to midwives during 2013.

Incidents

The maternity and gynaecology services maintained a joint incident database. Each entry provided a summary of incidents and immediate actions taken to minimise risks to patients. This included the number of near misses which were events which may have caused patient harm if issues had not been averted by staff. Improvement actions were identified and recorded following the completion of investigations. Please see the chart below for a summary of the number and type of incidents reported between October 2017 and January 2018.

Month and year	Number of incidents reported	Most frequently reported incident type
October 2017	30	3rd Degree tears
November 2017	44	Blood loss
December 2017	33	Incorrect labelling on blood tests
January 2018	41	Intrauterine growth restriction not detected

A multidisciplinary meeting took place each week to review progress on outstanding actions and where and how information would be shared more widely. Staff spoke positively about incident reporting, stating they understood their responsibilities, gave examples of what type of incidents to report and what processes to follow. Staff we spoke with confirmed they were encouraged to report incidents and received feedback for incidents they had reported if they were found to have caused moderate or above harm or impact. This was completed on a one to one basis and through service wide emails, newsletters and meetings.

From November 2016 to October 2017, the trust reported no incidents which were classified as never events for maternity. (Source: Strategic Executive Information System (STEIS)). Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From November 2016 to October 2017, in accordance with the reporting criteria set by NHS England Serious Incident Framework 2015, the trust reported nine serious incidents for maternity. Of these, 78% were related to the baby and 22% to the mother. Root cause analysis investigations had been completed for all serious incidents in order to review in more depth for possible safety improvements.

The maternity service contributed to the national quality improvement programme ‘Each Baby Counts’ (2015) Royal College of Obstetricians and Gynaecologists (RCOG). The programme aims to halve the number of babies who die or are left severely disabled as a result of preventable incidents occurring during term labour. This is done by collating investigation information classified as serious completed by every maternity service and collating and analysing this at a national level. This enables the identification of overarching common themes and key actions that can be taken to improve the quality of clinical care. The most recent RCOG report for Torbay maternity services was dated October 2017. This concerned all serious incidents reportable during 2015 for which there were none for Torbay. The trust followed national best practice guidance which incorporated recommendations within the RCOG programme. Torbay maternity service used the Saving Babies’ Lives’ (NHS England, 2016) care bundle which is based on the best current available evidence to reduce stillbirths.

Safety thermometer

The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care and involves a monthly snapshot audit. Patients staying on John McPherson ante/postnatal ward had a very low risk of experiencing an avoidable harm such as resulting from a fall or contracting an infection. The trust provided records which recorded 100% harm free care from January 2017 to December 2017. However, this information was not on display for staff and visitors to see.

Is the service effective?

Evidence-based care and treatment

Most policies were in date and referenced national best practice. These included a range of National Institute for Heath and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologist; Safer Childbirth (RCOG, 2007) and NHS England (Better Births, 2017). Women received care in line with NICE quality standards 22 (for routine antenatal care), 32 (for caesarean section) and 37 (for postnatal care). We observed some of the resuscitation guidelines were not the most up to date but these were replaced with the most current version (Resuscitation Council 2015) during our inspection. We also observed one of the guidelines on the delivery suite for cord prolapse did not contain any protocols or references.

Records showed women's care was reviewed during all contacts. Women identified with any risks had these managed in line with national guidance and specialist clinics were provided by medical and midwifery staff. For example; we observed women attending for glucose tolerance testing for gestational diabetes which complied with NICE guidelines (NG3, 2015). Ongoing monitoring of fetal movements was integral to care plans and customised fetal growth charts had been documented as used to identify possible growth restriction. Both of these followed national guidance (MBRRACE, 2015, NICE CG62 and RCOG Green-top Guideline No 57). Other evidence of compliance with best practice standards included: blood pressure routinely monitored during and after pregnancy, assessments for venous thromboembolism and assessments for ante and post-natal mental health issues (NICE QS35, QS3, and CG192). We saw appropriate actions had been documented in the 20 care records we reviewed.

Policies were accessible to staff through the trusts intranet. Staff also confirmed they were emailed policy updates and where applicable these were included as part of mandatory training updates.

There was evidence of learning and improving practice as a result of audits. The maternity service had focused on responding to the audit actions resulting from a still births review (completed during 2017). Senior staff explained they had been using a sampling method to be able to evaluate and demonstrate learning and improvements in an ongoing way. Audit sampling is a method that can be used regularly to provide factual evidence and a reasonable basis to draw conclusions about a population from which the sample is selected. For example: monthly audits had been completed of compliance with guidance and policy on fetal monitoring, fetal growth, maternal pulse, and for supporting with maternal smoking cessation. Sampling audits had been completed each month and the results had been used to compare and contrast the effect of action plans, and evidence safety and quality improvements. We saw in other records (governance, senior midwives meetings and newsletters) that updates, progress and revised action plans related to these audits had been shared with the whole maternity team and more widely within the trust. The stillbirth review during 2017 and other audit information had identified the maternity services had not been able to adequately meet antenatal scanning requirements for pregnant women who smoked. This related to a lack of capacity to provide repeat scans to monitor fetal growth. This had since been addressed and the trust had supported two additional staff to be trained to scan during pregnancy.

There was an annual audit plan in place which both midwives and medical staff contributed to. There was a lead midwife for audits and the consultants routinely undertook audit work. There was also an expectation that all junior medical staff should be involved with auditing whilst on placement with the maternity service. A multidisciplinary staff meeting was held every month to review details of current audits, and how evaluations were being used to improve clinical practice and reduce safety risks. For example, we reviewed audit information which had identified a trend in the numbers of babies who had low APGAR scores recorded. APGAR is a simple test done at one and five minutes after birth. The test is used to help determine how well the baby has tolerated the birthing process and if additional support might be required. The audit reviewed a range of possible influences and indicators such as type of birth, whether labour was induced, known risk factors and maternal health. Although no clear issues or predictors were identified, the audit provided assurance on current clinical practice which had been linked to national best practice (The National Institute for Health and Care Excellence (NICE) Clinical guideline CG190, updated February 2017). In the meeting minutes we reviewed for November 2017, we saw documentation of reviews of audits and action plans.

Nutrition and hydration

Processes were in place and staff had the competencies to support women and babies with nutrition and hydration. The maternity services had accreditation with the UNICEF (United Nations Children's Fund) UK Baby Friendly Initiative. This is a global programme based on best practice standards for feeding infants. An external assessment had been completed which included interviewing mothers about the care they had received and reviewing policies, guidance and internal audits. The maternity services had been awarded a high level three (out of four) Baby Friendly Initiative award. We reviewed an audit dated June 2017 which had included mothers experience and views on how they had been supported with infant bottle feeding. This established that accreditation standards had been met.

There was lead midwife for infant feeding who provided specialist advice and support to patients and staff with all aspects of baby feeding. The maternity care assistants (MCAs) were also knowledgeable regarding infant feeding. The MCAs told us they explained to parents a full range of information related to nutrition and feeding. If women chose to breast feed, staff offered support in order with expressing milk, positioning and attachments. Each newborn had weight loss and gain monitored by staff throughout the postnatal period and any relevant nutritional information was documented in records. Staff provided education on all care related to bottle feeding and could teach how to feed using a syringe or by cup. Staff used knitted resources shaped like breasts as teaching aides which had been made by volunteers. There was a dedicated baby feed fridge which we saw was clean and regularly checked. Breast pumps were available for use by women if required.

Women staying in the hospital had access to hot meals which catered for all dietary requirements at all times. Women were complimentary about the hospital food and told us they had been offered plenty of hot and cold drinks. We observed water jugs were frequently refreshed. Between set meal times, snacks and drinks were available to purchase 24 hours a day. On the ante/postnatal ward there was a kitchenette area where women and their partners could access hot and cold drinks and snacks.

Pain relief

A range of medicines and other resources for the relief of pain and discomfort were available on the delivery suite and at the Whitelake birth centre. All the patients we spoke with told us they

regularly had their pain assessed by staff and had been given medicines promptly. We looked at patient care records and saw pain and comfort needs had been assessed.

Women were offered a choice of pain relief which could be provided on demand in the delivery unit. Epidurals and other pain relieving medicines were available for women in labour 24 hours a day, seven days a week. Staff confirmed anaesthetists responded promptly and usually within half an hour to requests for support with pain relief which. Each room on the delivery suite and the birth centre had an electronic delivery bed which could be adjusted to support different positions and ease pain. Nitrous oxide gas and oxygen were piped into delivery rooms and midwives had mobile supplies for women to use with home births.

There was a small range of other additional equipment or resources available to support and assist with pain relief and promote a natural birth. Birthing pools, birth balls and a TENS (transcutaneous electrical nerve stimulation) machine was available. We were told patients were able to bring in and use their own equipment.

Patient outcomes

Torbay NHS trust provided effective and responsive maternity services for pregnant women. A range of antenatal, intrapartum and postnatal care was provided from the hospital and within the local community. From July 2016 to June 2017 there had been 2,068 births and from July 2017 to the end of January 2018 there had been 1343 births.

The trust took part and contributed to the national audit programme MBRRACE. This is the national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry in Maternal Deaths (CEMD). The 2017 MBRRACE report focussed on relevant information during 2015. Torbay maternity services did not have any stillbirths or neonatal deaths during 2015. Records documented that all maternity staff had been provided access to the MBRRACE report.

From January 2017 to February 2017 the trust reported a cluster of five stillbirths. Stillbirth is defined as a baby delivered at or after 24 weeks gestation showing no signs of life, regardless of when the death occurred. In England the number of stillbirths during 2016 was 4.3 per 1,000 total births, a reduction on the rate for 2015 at 4.4. The stillbirth rate for Torbay between 2010 and 2015 was between 4.7 and 1.2 per 1,000 births. The small number of stillbirths in Torbay shows how the numbers can fluctuate. Following an internal review of each of the five still births, an external review was commissioned by the trust. This involved a review of all aspects of antenatal care provided for the five women and for one of the five; analysis of care during labour. The aim of the review was to learn from events and to take any necessary actions to support the prevention of future stillbirths. At the time of our inspection, the maternity services had continued to audit and evaluate an action and improvement plan. This had, and continued to involve for additional support and reassurance, representatives from the local clinical commissioning group (CCG) and NHS England.

The maternity services maintained a dashboard with clinical outcomes (RAG) rated as red, amber or green. This related to birth figures and complications experienced by women during delivery. The parameters for rating outcomes were based on locally (Torbay) set targets which were seen to be higher than some of those set by other similar services within the south west region. We reviewed the dashboard dated from 1 April 2017 to 31 January 2018 and observed the following:

- The average rate of elective and emergency caesarean sections was 26% which was the same percentage as the national average

- The rates of third degree perineal tears were below (better than) the recommended rate. At Torbay, the average rate of perineal tears was 3%. The Royal College of Obstetricians and Gynaecologists (RCOG) guidance stated tears should occur in fewer than 5% of deliveries.
- Postpartum haemorrhage of between 500mls and 1000mls is common (RCOG, Green-top guidance no 52, 2011). Postpartum haemorrhage rate at Torbay of above 1500mls was 2% and 0.2% for haemorrhage of more than 2500mls. This was within the recommended rate of between 1% and 5% of all births (RCOG).

Processes were in place to monitor all unplanned admissions to the hospital. Senior staff told us all unplanned transfers were scrutinised for potential service improvements. The majority of transfers were due to unpredictable issues such as failure to progress during the second stage of labour and requests for an epidural. The percentage of planned community or home births resulting in transfer to the delivery suite was as follows:

From 1 April 2016 to 31 December 2017	Number of births and number and reason for transfers from Whitelake Birth Centre	Number of home births and number and reason for transfer
No of women	135	230
No of births	97	171
No of Intrapartum transfers	38 (28%)	59 (26%)
No of Postnatal transfers	18 (18%)	0

Systems were in place and being followed to monitor other patient outcomes and review for potential service improvements. The maternity service collated information related to the number of babies born at term who required transfer to the special care baby unit (SCBU). Avoiding Term Admissions to Neonatal Care (ATAIN) is a programme led by NHS improvement and follows the NHS priority for reducing avoidable harm which results in babies being admitted to neonatal units. We reviewed the audit dated April to September 2017. Torbay maternity services had a SCBU admission rate of 8% against a southwest target 5%. An action plan had been completed and this included links to the maternity business plan. It had been estimated that nearly 3% of SCBU admissions could have been prevented if the service had transitional care provision, and the provision of this had been included as part of the business plan. Other actions had been put in place to support a reduction in term admissions to SCBU and further audit planned. We saw meetings minutes dated 9 January 2018 which documented an ATAIN presentation had been presented and discussed at the trust's monthly quality improvement group. We attended the trusts quality improvement programme on 13 February 2018. During this meeting, senior midwifery staff presented a summary and update of actions and learning from the still birth review.

The maternity services monitored the uptake of breastfeeding. Women had been encouraged to breastfeed following best practice guidance but target rates for the trust had not been achieved. Records dated 1 April 2017 to 31 January 2018 recorded the average percentage of women breastfeeding from birth was 73%. This was the same rate as the national average in England (Figures for 2015/16 published 2017, Royal College of Paediatricians and Child Health). but below the Torbay target of 77%. The average percentage of women breastfeeding at discharge was 67% against a local target of 70%.

In the 2016 National Neonatal Audit of Torbay Hospital performance was as follows:

- Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

There were 6 babies born at <29 weeks included in this audit for Torbay Hospital. 83% of these had their temperature measured within an hour of birth. This was below the national average, where 94% of eligible babies had their temperature measured within an hour of birth.

- Are all mothers who deliver babies from 24 to 34 weeks gestation given any dose of antenatal steroids?

There were 47 eligible mothers identified for this audit measure for Torbay Hospital. 96% of these mothers were given a complete or incomplete course of antenatal steroids; this was above the national average of 86%.

- What proportion of babies < 33 weeks gestation at birth was receiving any of their own mother's milk at discharge to home from a neonatal unit?

Only babies who had a final neonatal discharge to 'home' at the end of their first episode of neonatal care are included in this analysis. Babies who were transferred between neonatal units at any point were excluded. There were 8 babies born at < 33 weeks who met the criteria for Torbay Hospital. 63% of these babies were receiving mother's milk exclusively; this was above the national average, of 59%

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

From July 2016 to June 2017 the total number of caesarean sections was similar to the expected rate. The rate for elective sections and rate for emergency sections were also similar to the expected rates.

Caesarean section rates

Type of caesarean	England	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	RAG
Elective caesareans	12.1%	239	11.6%	101.4 (z=0.1)	Similar to expected
Emergency caesareans	15.4%	321	15.5%	102.0 (z=0.2)	Similar to expected
Total caesareans	27.5%	560	27.1%	101.1(z=0.2)	Similar to expected

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Source: Hospital Episode Statistics July 2016 to June 2017

In relation to other types of delivery from July 2016 to June 2017 the table below shows the deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method

Delivery method	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Total caesarean sections[1]	560	27.1%	27.5%

Instrumental deliveries[2]	235	11.4%	12.5%
Non-interventional deliveries[3]	1,265	61.2%	59.7%
Other/unrecorded method of delivery	8	0.4%	0.3%
Total deliveries	2,068	100%	100% n=(608,950)

[1]Includes elective and emergency caesareans
[2]Includes forceps and ventouse (vacuum) deliveries
[3]Inlcudes breech and normal (non assisted) deliveries

Competent staff

All maternity staff had the skills and competencies to work in all areas of clinical practice. The midwives worked as part of an established, integrated system which supported the maintenance and development of clinical skills. Apart from a small number of core staff, the majority of midwives were rostered to work where it was anticipated patient needs would be highest. This meant that midwives developed the necessary skills and maintained their competencies to work in all areas of maternity care within the trust and community settings. However, midwives did report inconsistently regarding the provision and sign off of postnatal care. We reviewed the trusts policy regarding postnatal care which had been based on Staff provided different time scales and discharge processes that they routinely provided. The community matron told us she was aware of potential inconsistencies in care provision by staff and that this needed to be reviewed.

We spoke with junior medical and midwifery staff who all told us they felt well supported and had access to senior staff for advice. Junior staff told us they felt their induction to the maternity service had been comprehensive and they had been supported to feel both confident and competent with new systems and process before working increasingly independently.

Junior medical staff felt supported with their continuing professional development by all staff working in the maternity services. Trainee medical staff told us they had protected time every week to attend training and had been encouraged to attend governance and other meetings. There were a number of midwives and consultants who had specialist roles. These included midwives with lead roles in: governance, auditing, staff education, infant feeding, public health, safeguarding and antenatal screening. The consultants provided specialist antenatal clinics on: fetal medicine, general high risk pregnancies, diabetes, perinatal mental health, and drug and alcohol related issues. A further obstetric anaesthetic antenatal clinic was being planned.

Junior medical staff had been supported to have an education supervisor meeting with consultants. These were planned at four monthly intervals and were used to review experience and progress against evidenced competency. An annual review of overall obstetric competency was held annually to ensure junior medical staff had the correct competencies to progress to the next level of training. Junior medical staff told us they received a lot of ‘on the spot’ teaching by the consultants which they valued.

Not all midwives had been supported to have an annual appraisal. From November 2016 to October 2017, 86% of staff within maternity at the trust had received an appraisal. Please see the table below for more detail. There was no information provided about obstetric medical staff appraisals within the maternity service.

Staffing group	Number of staff appraised – November 2016 to October 2017	Sum of Individuals required - November 2016 - October 2017	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Qualified nursing midwifery staff (Qualified nurses)	58	67	87%	90%	No
Support to doctors and nursing staff	15	18	83%	90%	No

(Source: Routine Provider Information Request (RPIR) - P43 Appraisals)

Midwives may have lacked some specialist training to be able to fully support women with very complex and/or high risk medical health needs. We were told on occasions women attending the delivery suite also had level two care needs. This high dependency level of treatment and care is linked to the need for single organ support such as with renal or heart failure. The obstetric team had established and positive team working practices and were supported when required by the trusts critical care team. However, there was no evidence that midwives had gained specialist competencies to support all women with high risk health care.

We reviewed various staff training presentations that linked national policy and guidance with clinical practice. For example: audit of babies with low APGAR (initial assessment of colour and breathing) with best practice, (Royal College of Obstetricians and Gynaecologists, 2015). This had included case reviews of clinical practice. The actions taken in response included inviting medical paediatric staff to join obstetric training. We reviewed a number of other staff training presentations which were accessible on the hospital's intranet. This included: non-invasive pre-natal testing, pregnancy loss, human factors training and assessing for lack of fetal development. Staff confirmed these would be presented as part of the maternity mandatory training planned for during 2018. We saw records which showed learning from audits and other reviews had been emailed directly to maternity staff

External and internal staff had been supported to develop their skills and competencies. Staff told us they regularly offered placements to paramedics. With permission from women, paramedics observed births and were also invited to attend the emergency skills and drills staff training. Staff told us they had received very positive feedback from paramedics who had previously completed placements. Midwives had been trained to treat babies born with tongue tie (tissue under the tongue which is restrictive). Additional staff training was being facilitated during 2018 in response to staff requests to learn how to provide treatment for this condition. One midwife had attended a two day breast feeding conference during November 2017. This midwife had taken notes of each speaker's presentation. Records we reviewed (November, 2017) stated meetings had been organised to share good practice updates.

Multidisciplinary working

There was evidence of established effective and positive multidisciplinary working within the maternity service. Midwives, midwifery healthcare assistants, doctors and sonographers all reported constructive multidisciplinary working. Staff said relationships were supportive and communication was open and honest. Midwives told us they felt valued and respected by medical staff who they reported to be approachable and willing to offer advice when required. When staff spoke about multidisciplinary working they described this as "excellent", "brilliant" and "at an enviable standard". One person told us: "there is genuinely good rapport between staff. There are

very healthy relationships; midwives do positively challenge medical staff if they have any query, which is good".

The maternity services worked effectively with other departments and services. For example, if a woman attended the emergency department maternity staff worked collaboratively to ensure both the medical and obstetric treatment and care was effectively managed. We observed this in practice during our inspection. Staff told us they had good working relationship with staff from the neonatal services and the surgical department staff we spoke with also confirmed positive and effective multidisciplinary working with maternity staff. Some of the records we reviewed showed clear and detailed communication with other external services. These included; GPs, perinatal mental health services, ambulance service and with local authorities through safeguarding procedures. Information was recorded as shared appropriately with other professionals and services for the benefit of patient care.

There were no combined medical and midwifery handovers. Staff said this was because doctors and midwives started shifts at different times. This meant the midwifery coordinator on shift was required to attend the medical handovers and then update other staff as required. Staff told us they had tried ways to work around this and combine handovers, but this had not been successful.

Seven-day services

The maternity services provided care and support at all times for women in labour and for obstetric emergencies. The central delivery suite and John McPherson ante postnatal ward was staffed with medical and midwifery staff 24 hours a day, seven days a week. Midwives were on call to assist with home births as all times. The Whitelake birthing centre was staffed by maternity support workers from 8am to 8pm seven days per week. The centre was accessible for women in labour 24 hours a day, seven days per week and was supported by midwives working on call. Midwives had offices on site and ran ante and post-natal clinics from the centre.

The day assessment unit was open during weekdays from approximately 8am to 6pm. During weekends and out of hours when the day assessment unit was closed senior midwives on the delivery suite triaged all calls and based on the information provided, made plans of action. If women required additional monitoring out of hours they had a home visit from an on call midwife working in the community, or were admitted to the delivery suite or John McPherson ward. Systems were in place and followed when required to access pharmacy, ultrasound and surgical services out of hours. Antenatal and postnatal checks and clinics were provided from Torbay hospital, Whitelake birthing centre or at the home address of pregnant women or those who had recently delivered.

Health promotion

Health promotion was a routine part of all maternity care provided to women from their initial booking in appointment through to discharge. All staff worked collaboratively with women to assess all aspects of general health and to provide support and advice to promote healthy lifestyles. Each woman's care records included an assessment of mental and physical health. Throughout pregnancy, scans and blood tests were used to assess for both random and inherited health conditions. Midwives working in the community discussed health screening tests with women that could be completed during the antenatal period. Midwifery care assistants received training on antenatal screening education and took blood for screening tests. Specialist health and pregnancy outpatient clinics were available and offered to women. For example on: diabetes, perinatal mental health, smoking cessation, and drug and alcohol related issues. These clinics were managed by consultants and midwives who had specialist interests, skills and experience.

There was a lead midwife for public health. This person attended multidisciplinary meetings with other services including for child and adolescent mental health and adult mental health. The lead midwife for public health facilitated a staff support group for mothers with complex heath and care needs.

One of the recommendations from the still births review completed during 2017 was to promote smoking cessation with women who smoked during pregnancy. This was in line with national policy and guidance (National Institute for Health and Care Excellence (NICE) 2010, 2017). In response the maternity service had put in place range of health promotion actions. These included: a revision of the maternity related smoking policy and associated referral forms, the purchase of additional CO2 monitors, updated information leaflets provided to women during antenatal appointments, a recorded message which could be activated outside the entrance to the maternity service, this advised all visitors of the no smoking policy applicable anywhere on the trust site, and midwifery staff had been emailed and provided with links to be able to access national training modules to support smoking cessation during and pregnancy.

Other health promotion activities and information was evidenced. Meeting minutes (dated November 2017) recorded that a maternal flu and whooping cough vaccination programme was being offered to pregnant women. In addition, from October 2018 the antenatal service would be able to offer mothers non- invasive NHS testing for three congenital syndromes. Maternity staff had been provided with health promotion updates through meetings and newsletters. We looked at a smoking cessation public newsletter dated autumn 2017. This summarised care to be provided in the hospital and community and stated the rate of women in Torbay smoking at the time of delivery was 16%. This was higher (worse) that the national average in England of 11%, and national target of 6%.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed the correct processes to gain consent. The patients we spoke with confirmed that staff had asked for permission before proceeding with any care or treatment. We observed during our inspection, staff explained what they would like to do and why before proceeding with any care. The maternity hand held records for antenatal, perinatal, and postnatal care all contained written information on consent. This included how information would be used, sharing with agencies if safeguarding alerts were to be made, and data protection information. Staff had been required to sign to confirm all of these issues had been discussed with women. The consent sections had been signed in the care records we reviewed. Also within these records we observed clear documented discussions regarding consent before carrying out any examination or procedure.

Specific care plans were used for miscarriage and still birth. These linked with consent documents for post mortem and funeral types. We saw these consent forms included information for parents who changed their minds regarding anything previously agreed to. The post mortem consent form included detailed guidance for staff to follow to ensure parents were provided with full information in order to make informed decisions.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards training was included as part of the trusts mandatory safeguarding training. Staff told us if they believed a woman had a learning disability they could access specialist support. This included referral to a specialist support service and use of picture and sign communication book. However, we saw this communication book did not contain anything specifically related to maternity treatment and care. Staff told us if they had any concerns about any aspect of a woman's capacity to provide informed consent, they would

consult other colleagues and ask the lead midwife for safeguarding midwife or the perinatal nurse to ask for advice.

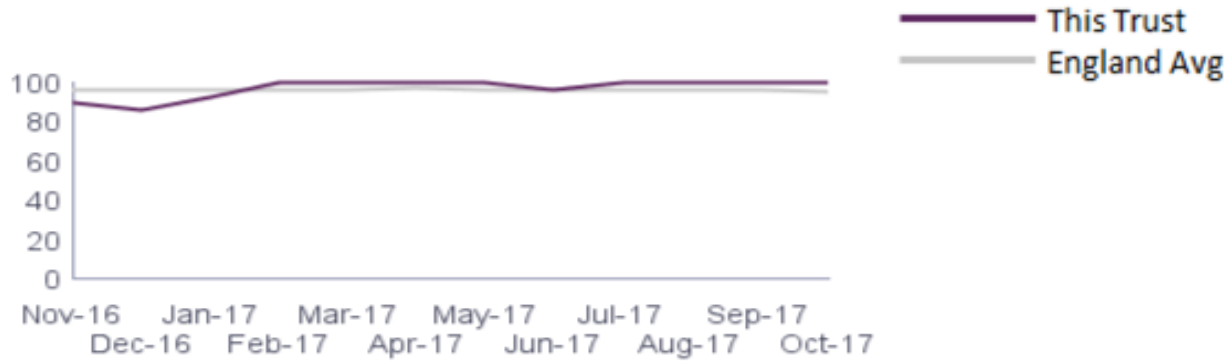
Is the service caring?

Compassionate care

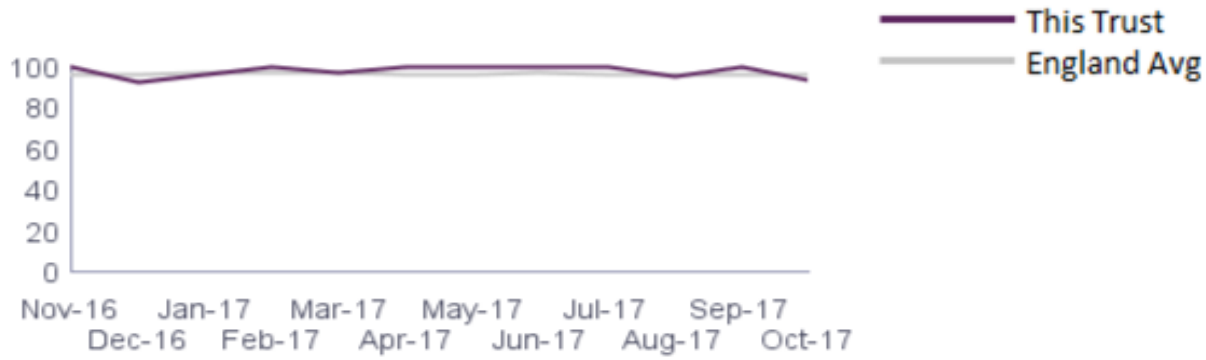
The maternity service provided compassionate support and care to women and those people close to them. We spoke with 10 women who spoke positively about their experiences and the compassion and understanding staff had demonstrated. For example: “the staff have been fantastic, I just cannot fault how understanding and kind they have been”, “I was really quite scared but the staff were extremely kind and gave me and my husband lots of reassurance” and “everyone, all the staff have been great; helpful, polite and caring”.

The maternity service asked women to complete a questionnaire (Friends and Family test) on their experiences of using the service.

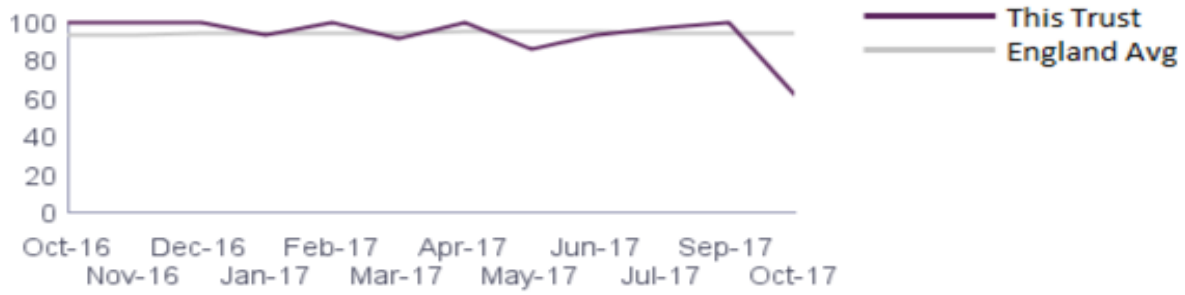
From November 2016 to October 2017 the trust’s antenatal Friends and Family Test performance (% that would recommend the service) was generally similar to the England average.

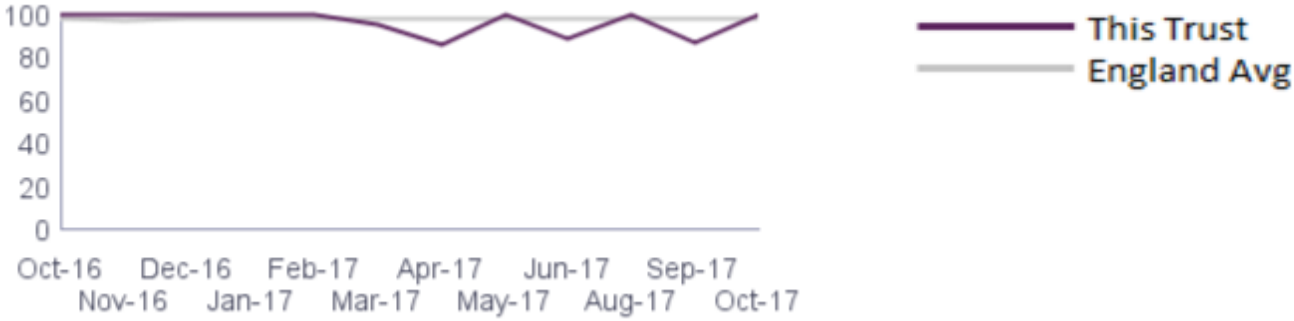


From November 2016 to October 2017 the trust’s care during birth Friends and Family Test performance (% that would recommend the service) was similar to the England average.



From October 2016 to October 2017 the trust’s postnatal ward Friends and Family Test (% that would recommend the service) was similar to the England average but was worse during October 2017





From October 2016 to October 2017 postnatal care in the community Friends and Family Test (% that would recommend the service) was similar to the England average.

The trust performed better than most other trusts on the Care Quality Commission maternity survey 2017. Nationally, 130 NHS trusts were involved in the survey, with responses coming directly from thousands of women who gave birth during January and February 2017. Torbay maternity service was rated by 118 women who had given birth either at home, at Whitelake midwifery led unit or at Torbay Hospital. Women gave very positive feedback about their experiences and placed Torbay maternity services in the top 20 per cent of hospitals in the country in 31 of the questions asked.

Summary CQC maternity survey 2017 for Torbay maternity services:

Area	Question	RAG	Score
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?		9.0
	During your labour, were you able to move around and choose the position that made you most comfortable?		8.4
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?		9.6
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?		9.3
Staff during labour and birth	Did the staff treating and examining you introduce themselves?		9.3
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?		8.3
	If you raised a concern during labour and birth, did you feel that it was taken seriously?		8.3
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?		9.5
	If you needed attention during labour and birth, did a member of staff help within a reasonable amount of time?		8.7

	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	9.0
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.6
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.0
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	7.5
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.0
	If attention was needed after the birth, did a member of staff help within a reasonable amount of time?	8.2
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	9.2
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.8
	If your partner or someone else close to you was involved in your care, were they able to stay with you as much as they wanted?	8.1
	Discharge from hospital being delayed	6.0

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

Emotional support

We received positive feedback from women about their experiences of treatment and care. One woman explained that she had previously had a miscarriage and staff had been sensitive and supportive throughout. This person told us how staff had supported her during her current pregnancy whilst being sensitive to the experience of previous miscarriage. Of the five women noted within the stillbirth review during 2017, four of these women had subsequently become pregnant. All four of these women had chosen to have their maternity care at Torbay again rather than attend an alternative maternity service.

We observed emotional support being provided to women. We heard midwives, doctors, maternity support workers and administrative staff supporting women and concerned relatives on the telephone and in clinical areas. People were spoken to kindly and with respect and concerns were seen to be responded to in reassuring and positive ways. When speaking on the telephone, women were encouraged to call back at any time, however minor they perceived concerns to be

The maternity service recorded the numbers of formal compliments received from women and shared this with individual staff if they were named or more widely with staff. From October 2017 to December 2017 there had been 14 letters of praise. Throughout all areas of the maternity service we observed numerous cards to staff from women and those people close to them thanking staff for the care and support they had received.

Understanding and involvement of patients and those close to them

Women told us they felt fully involved in all aspects of their maternity care and had been allocated a named midwife whom they knew how to contact for any advice. Women told us staff were friendly and helpful and the care and support provided had enabled them to feel calm and reassured, even when things didn't go as planned. We were told for example; " giving birth here was a really good experience and I would recommend this place to anyone* and "all the midwives are fantastic, they made sure I understood everything and then double checked if and I had any issues".

In response to feedback from women who had previously used the service, partners were permitted to stay overnight on John McPherson ward. This enabled partners to be increasingly involved with all aspects of care.

Torbay maternity service had a Facebook page which linked to the trusts information and maternity service contact details. The Facebook page was regularly monitored by maternity staff and was used to share information and ask for opinions on potential service developments. For example; we saw women had been asked to state who they would prefer to receive contraception information. We accessed the Facebook page on 28 February 2018 and saw numerous examples of experiences, the majority of which were overwhelmingly positive. For example: “The team cannot do enough. The midwives in delivery suite were astounding, the calm registrar, the anaesthetist who showed such compassion, the nurse in recovery who made me feel safe at a scary time, we are forever grateful for the care you took. The whole of John McPherson ward clearly who made us feel so fabulously looked after” and “my midwife through this pregnancy has been amazing; supportive, informative, cheerful and she generally helped to make my experience a positive one at every step. She stayed for the birth even though her shift had just ended and she helped me a great deal through the hard bit. I'll never forget and will always be grateful to the midwives for their support and knowledge”.

Is the service responsive?

Service delivery to meet the needs of local people

Torbay maternity services had been commissioned by the local Clinical Commissioning Group (CCG) to provide a full range of antenatal, postpartum and postnatal care. All pregnant women had been allocated a named midwife for the duration of their pregnancy. This complied with National Institute for Health and Care Excellence (NICE) guidance. Dependent upon risks assessed a range of midwifery or consultant led maternity care was available for women to choose from. The service was patient led which meant all the maternity staff worked to provide wherever possible, care that was directed and led by women. A combined maternity and gynaecology business case had be produced which aimed to reflect how the service could best effectively be able to respond to anticipated longer term service needs. At the time of our inspection, these initial proposals were in the process of being submitted to the board for review

The midwives who worked in the community covered a wide geographical area. This incorporated: Dartmouth, Brixham, Paignton, Totnes, Torquay, Newton Abbot, Buckfastleigh, Ashburton, Teignmouth, Dawlish and Bovey Tracey to the borders of Chagford. The maternity services consulted women on their views of the service through the trusts Facebook page and by encouraging participation in surveys. Following feedback, male partners of women admitted to the ante/postnatal ward were permitted to stay overnight. Whilst some restrictions were in place in order to protect the privacy and dignity of women, partners had been provided with recliner chairs and had access to food and drink.

Meeting people’s individual needs

The maternity service was responsive to individual needs. Women had the option (dependent upon assessment of risks) to have consultant led or midwifery led care within Torbay hospital, at the Whitelake ‘freestanding’ (no medical staff) midwife led birthing centre located at Newton Abbot hospital, or at home. Women were supported to develop birth plans, which we saw documented in records. We saw numerous thank you cards and other feedback from women who had been delighted with how individual choices and requests had been supported. Staff provided examples of supporting women to give birth in the place of their choice even when risks had been identified.

On occasions this included places or methods of childbirth that would have been considered to increase risks. For example: birthing in remote areas with limited or no access to running water or freebirths (refusing medical assistance from a doctor or midwife). Midwives explained that they worked hard with women and their partners to ensure all potential risks were fully understood. These had to be written clearly in care plans which were shared with senior midwifery staff and obstetric medical staff.

In the Mary Delve bereavement suite, facilities were provided to enable family to stay for extended periods. This included comfortable seating, sofa bed and kitchenette area. Information booklets and keepsake boxes were available for families which contained suggestions and resources to collect mementoes. Midwives we spoke with explained that they all felt experienced and well supported by other staff to effectively care and support women with miscarriage. We were told two midwives took responsibility for ensuring bereavement care plans and care bundles of information were kept updated. This information was used to support families and to keep staff up to date. We saw information was arranged and available to support care following loss related to different scenarios and gestations. There were care bundles of information for bereaved parents. This included specific stickers (supplied by a bereavement charity) that could be used on records related to bereavement and loss. Staff told us the use of these stickers prompted further actions to be taken to stop external baby and childcare services from inappropriately contacting parents.

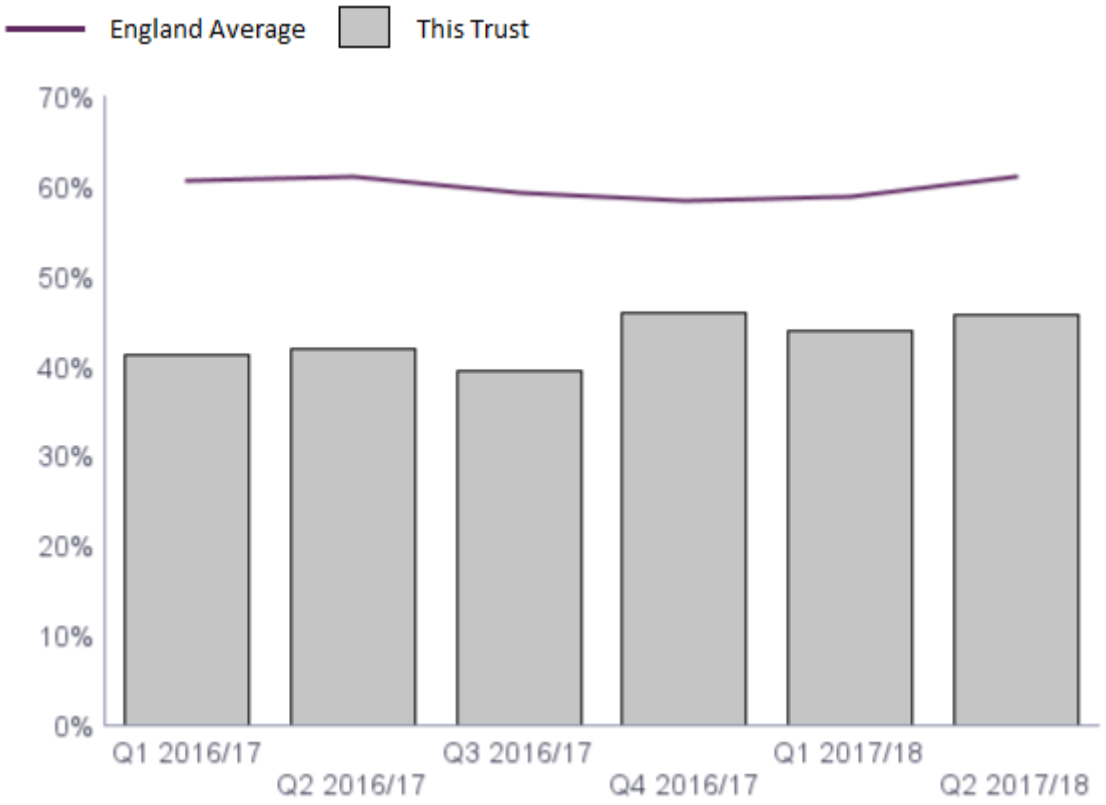
Staff demonstrated familiarity with the trusts interpreting service and during our inspection we saw this being used to support women whose first language was not English. Computer tablets were available and accessible for women and could translate maternity information in more than 30 languages. The trusts website provided videos and a range of other information on the maternity service. The website and maternity Facebook page all had facilities to convert to numerous different languages.

The maternity services made reasonable adjustments to support and accommodate women with mental health issues and or learning disabilities. For example; staff explained how they had supported women to visit the unit repeatedly in order to support and promote familiarisation with the environment, staff and common processes. This had been done to reduce high anxieties. We observed discussions in care plans and documented in other records between maternity staff and the local perinatal mental health service. We were told of a 12 week programme that had been organised to provide additional support to women with mild to moderate mental health issues. The course had been organised by a perinatal occupational therapist and funded by charitable monies. This included employing two women with previous personal experience as support workers for the group.

Access and flow

Systems were in place to support access and flow around the maternity services. The midwifery shift coordinator and lead consultant for each shift worked together to prioritise and manage the flow of women attending the delivery suite and ante/postnatal ward (John McPherson). The day assessment unit and a range of antenatal and postnatal services were available during week days. Out of hours, all calls or unexpected attendances were reviewed by clinical staff on the delivery suite. If women required ongoing monitoring, treatment or care out of hours they were admitted to the John McPherson ward or the delivery suite. There was access to surgical theatres at all times. If required, medical staff could access scanning equipment out of hours or refer patients to the trusts diagnostics department. The Whitelake birth centre was staffed from 8am to 8pm and midwives and maternity care assistants were on call to cover all times out of hours.

From April 2016 to June 2017 the bed occupancy levels for maternity were generally lower than the England average. Torbay had 40-45% occupancy compared to an England average of around 60%. The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

Learning from complaints and concerns

Staff told they encouraged women to provide feedback and for the majority of the time issues were dealt with at the time they had occurred. Women told us they understood how to make complaints. We observed when staff spoke with women they checked if there was anything they needed or wanted to know. From 1 January 2017 to 31 December 2017 there had been 10 written complaints about the maternity service at Torbay hospital. The types of complaint received included issues concerning: care (7), treatment/delay in treatment (4), communication (3), breach of confidentiality (1), and attitude (1). A range of actions were documented as being taken in response and these were monitored and reviewed as part of the weekly maternity risk review meeting. Staff told us when they received a complaint this was reviewed to see if issues were isolated incidents or whether wider clinical or service improvements could be made. For example; a range of actions had been documented as completed or ongoing as a result of the still births reviews (2017). Staff of all grades demonstrated an understanding of these actions. Complaints took an average of 40 days to investigate and close which complied with the trusts complaints policy. (Source: Provider Information Request P55).

Is the service well-led?

Leadership

Improvements were required to some aspects of midwifery the leadership in the maternity service. We spoke to a total of 49 staff which included: obstetric medical and midwifery staff of all levels, maternity care assistant's and reception staff. Junior medical staff all felt well supported and able

to access senior staff at any time. Many of the midwifery staff we spoke with about leadership and support described a feeling of disconnection between senior midwives (in specialist roles and above) and others. This had led to midwives reporting they did not fully understand the scope of roles of others and did not always feel fully supported. How the escalation process was followed was given as an example. This was used when either the complexity of issues or the numbers of women attending the delivery suite or other areas increased and staff were redeployed. A senior midwife was identified and scheduled in these processes to have a lead role as the escalation midwife at all times. However, not all of the senior midwives would undertake a clinical role and often did not work beyond 5pm. While other midwives, including the delivery suite coordinator and medical staff worked collaboratively and clinically during periods of escalation, the lack of hands on support by some senior staff was viewed as negative midwifery leadership.

There was acknowledgement at a senior level of these issues and that some midwives had not always been as visible, accessible or as responsive as they possibly could have been. In response senior staff had started to look for ways to improve elements of midwifery leadership. This had included a senior midwife study day and commissioning a staff culture and safety survey (South West Patient Safety Collaborative) to investigate all issues and concerns in more depth. Staff we spoke with about the survey confirmed they had been encouraged to contribute to it. At the time of our inspection the results were still pending.

Vision and strategy

All the staff we spoke with stated their goal was to provide high quality, person centred care. Staff had been and continued to be consulted about possible long term plans for the maternity service provision. Possible long term options had been included in the combined maternity and gynaecology business development plan which had articulated the strategy and vision for the maternity services during the next 10 years. The head of midwifery and senior midwifery manager were well supported by the executive team and other senior trust staff. This included: the chief nurse and medical director, the women and children's operational manager and general manager and the trusts deputy director of quality assurance.

There were no clear succession plans in place for maternity posts. This meant if any specialist or senior roles became unexpectedly vacant, there might not have been staff readily available with the skills and experience to step in and maintain the continuity of the service. Senior staff told us they were aware of which midwifery staff were approaching retirement. Senior staff contributed to the sustainability and transformation programme lead by regional commissioners. We reviewed meeting minutes which documented that Torbay and three other maternity services were being asked to create common standards and protocols which could be established across all areas.

Culture

There was evidence of a positive working culture but this appeared inconsistent across the whole maternity service. The midwives worked seamlessly between the acute and community. All of the staff we spoke with told us they were proud of the work they provided. Many staff told us they loved working for Torbay trust and for the maternity service specifically. When taking about direct clinical care, staff spoke very positively about team working practices. Medical and midwifery staff of all grades told us they felt respected and supported and able to speak up and contribute regarding clinical care. However, many staff we spoke with told us they felt senior midwifery staff, including those in specialist roles were less visible and appeared reluctant to engage with issues outside their specific roles. This reported lack of prominence and full team working left some staff feeling uncared for, particularly when the service was busy. Senior staff told us they had become

aware of these views and had put in place actions to start addressing them (see 'Leadership' section above).

Governance

Governance processes were in place including audit trails to track progress on any required actions. We looked at a range of maternity departmental meeting minutes and information. These included; senior midwives meeting minutes, perinatal minutes and clinical governance meeting minutes. These meeting minutes documented a range of performance information related to clinical practice, policy, staff training and audits. Maternity specific governance meetings linked into the trusts clinical and divisional governance meetings. These meetings provided the processes to link governance information from maternity ward to board and vice versa.

There was some inconsistency in how some governance information had been reviewed and disseminated. There had been a clear and focused response to the stillbirths review since this had been completed during 2017. Governance and assurance meetings had been held with the involvement of the local clinical commissioning group and from NHS Improvement. There were clear audit trails to evidence how information had been monitored and shared within the whole midwifery team and escalated up to the trust board. However, other governance information was not as effectively managed and disseminated. For example; the maternity service collated a range of governance information on a local maternity specific performance dashboard. This included number and type of births, health promotion information and emergency transfers of mother and/or baby. This information was also shared and updated to a southwest clinical network dashboard. This compared the governance and performance information of 14 maternity trusts in the south west region. Governance and performance information could then be reviewed locally for trends and potential service improvements. We reviewed the local dashboard and saw that it had been RAG (red, amber, green) rated against targets that may not have been realistic or applicable. For example, the caesarean section rates on the local dashboard showed red (exceeding targets). However, when the local dashboard data was reviewed against the regional performance information, the caesarean rates were seen to be within the average range. We asked senior staff about this. We were told that as national guidance had been updated, such as the management of diabetes, this had impacted with an increase in the caesarean rates. However, the local dashboard rating parameters had not been reviewed and adjusted to account for clinical policy updates. Therefore, the local dashboard was not effective as a tool to monitor governance and performance of the service.

Processes to share governance information were not all fully effective. Staff told us governance information was shared during handovers and team meetings. Quarterly clinical governance newsletters were emailed to all maternity staff. We looked at the newsletter dated autumn 2017. This included audit information and related policy and practice updates in relation to babies born small for their gestational age. Team leaders used sign off sheets that all maternity staff had been required to sign to confirm that they had read and understood information. Focus on follow up and learning from the still births review had clearly been given priority and staff of all levels were familiar with the learning points, including amendments to practice and policy. However, other governance issues were less well understood and shared. For example we noted that not all staff we spoke with understood or were familiar with the maternity dashboard. This included: what information had been monitored, how this information was used to inform ongoing governance of the maternity service and where and how the service was performing well or required improvements.

Management of risk, issues and performance

The management of risks and performance was monitored but improvements were required to increase the processes to increase the level of scrutiny and interrogation. There were two midwives and one obstetric consultant who led on risk and governance information for the maternity service. All reported incidents were monitored and reviewed by one or more of these clinical staff. Each week a multidisciplinary meeting was held. When possible this was attended by the head of midwifery, consultants, matrons and specialist midwives. We attended one of these meetings and saw current safety and risk issues were reviewed. This included; incidents, audit outcomes and complaints. Actions taken in response were discussed and an electronic data base updated. We were concerned about the level and depth of examination of some incidents. We looked at two recent serious incident investigations and identified issues in clinical practice that had not been followed through and included as part of the action plans. This suggested a lack of scrutiny and challenge, although the trust did have processes to ensure investigations were reviewed and signed off. These included a check by the head of midwifery and clinical director, as well as external review by the clinical commissioning group and a serious incident review panel.

A maternity risk register was maintained and we saw records of service reviews and audits that had been completed to monitor risks and standards of clinical care. However, as with the governance processes, there had been an emphasis and focus on risk management actions related to the still birth reviews. Whilst this was appropriate, other governance and risk management processes had not been completely effective. For example; during our inspection we had identified consistent gaps in safety checks of medicines and equipment throughout the maternity service.

There were systems to share obstetric risk management information and learning. Monthly senior midwives meetings were held to discuss, share and action risk, quality and performance information. We reviewed meeting minutes dated October 2017, November 2017 and January 2018 which also recorded between nine and 13 senior midwives attended. The meeting minutes recorded summaries of discussions regarding: clinical issues, staffing gaps and cover arrangements, projected births for the month ahead, escalation and emergency response, mandatory training, screening, infant feeding, safeguarding, compliments, audit information and learning from complaints and incidents. Learning from serious incidents was discussed and actions taken. For example; staff had been asked to show increased sensitivity and awareness when having conversations at the midwives station. This related to both confidentiality and language that had the potential to be distressing if overheard by women. The meeting minutes documented that information was to be shared by emailing staff (midwives, medical staff and midwifery care assistants) or to be disseminated via team leaders. Governance newsletters were sent to all staff as a way sharing maternity and trust information. We looked at the obstetrics clinical governance newsletter dated January 2018 and the trusts newsletter (‘datixdigest’) dated February 2018. Both provided summaries of the numbers and type of incidents reported and complaints and compliments received.

Information management

The accessible information standards were mostly met (NHS England). These aim to ensure that people who have a disability are provided with information that can be easily read or understood with support. This promotes effective communication with services. During our inspection we observed staff worked with familiarity with a range of resources aimed to include all women, regardless of needs attending the maternity service. This included: access and support to other professionals and services to support women with a learning disability or mental health. Practical resources were available and used to aid the explanation of procedures. We saw dolls and knitted

body parts used to aid understanding. However, whilst easy read resources were available, for women who had a learning disability; these were generic and not specific to maternity care.

Engagement

Feedback from users of the maternity service was encouraged. Women were asked to complete the NHS Friends and Family survey and to access and provide feedback through the maternity service Facebook page. Positive and negative feedback in the form of formal compliments and complaints were monitored on a monthly basis and documented in meeting minutes as discussed.

There had been a maternity staff survey in response to concerns about culture and leadership. The results of this were not available at the time of our inspection. Staff told us they contributed feedback through various meetings and had been encouraged to participate in the trusts annual staff survey. We looked at the action plan dated 2016- 2017 in response to the staff survey completed during 2016. A range of actions had been documented as ongoing or completed. For example; refocusing and redesigning paperwork to be used for staff annual appraisals. The head of midwifery had recently introduced quarterly newsletter which had been emailed to all maternity staff and placed in meeting rooms. We reviewed the newsletters dated Summer 2017 and Winter 2017/18. Information shared included; staffing and mandatory training updates and issues related to clinical practice.

Learning, continuous improvement and innovation

There was evidence continuous learning was embedded in practice. Medical staff and midwives, including junior staff had been continuously supported to participate in audit programmes and meeting minutes documented shared learning. Since the still birth review (2017) staff had worked positively to achieve the requirements of the action plan. Staff of all grades demonstrated understanding of the still birth review, the actions being taken and why. The learning had been shared widely through though trust meetings and an external obstetric team had been scheduled to visit Torbay in order for findings to be shared more widely.

End of life care

Facts and data about this service

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

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

Staff providing end of life care included ward nurses and doctors, the chaplaincy service, ward housekeepers, porters, administrative staff and allied health professionals. End of life care is also provided by a hospital specialist palliative care team and cancer nurse specialists for patients needing difficult symptom management. A palliative care service is provided by the trust to support the management of pain and other symptoms and provide psychological, social and spiritual support. The purpose of the palliative care service is to achieve the best quality of life for patients and those close to them. Support is provided to help patients live as normal routine as possible until death and to offer support to help the family cope during the patient's illness and in their own bereavement.

The hospital palliative service is offered six days a week, from 9.00 am to 5.00 pm. The specialist palliative care team work closely alongside a local Hospice to provide specialist palliative care and supports areas in the Torbay & South Devon NHS Foundation Trust area.

The trust had 1,212 deaths from October 2016 to September 2017.

(Source: Hospital Episode Statistics)

From 01 February 2017 - 31 January 2018 the end of life care team saw 514 patients diagnosed with cancer and 189 patients where end of life care was related to non- cancer diagnosis. There were 14 outpatient referrals during the same period. All referrals to the hospital specialist palliative care team were seen within two working days. The team visited patients following a phone call or email from ward staff, Monday to Saturday 9.00 am to 5.00 pm. Outside those times a 24-hour on-call telephone advice service was provided by the local hospice. Nurse cover from the trust specialist palliative care team is provided on Easter bank holiday Monday and Boxing Day. There is consultant medical cover available by telephone 24 hours, seven days a week.

For this acute inspection we visited the following wards and departments: Simpson, Cheetham Hill, Turner, Forest, Cromie and Allerton wards, the mortuary, chapel, and multi-faith or quiet room. We spoke with three patients who were receiving end of life care and three relatives. We also reviewed 12 patient records. We spoke with 22 staff, including, ward nurses, and ward clerks, mortuary technicians and doctors. We visited the chaplaincy and the bereavement office. Before and during the inspection we reviewed data relating to end of life care at the hospital from the trust.

Is the service safe?

Mandatory training

The trust provided mandatory training in key skills to all staff and made sure everyone completed it. End of life training was provided as part of staff induction and some end of life training was also provided to junior doctors and new doctors.

All end of life nursing staff were up to date with their mandatory training. Mandatory training was a rolling programme of classroom and electronic learning suites that staff felt met their needs.

However for medical staff, only two of the five staff had completed mandatory Training. This meant that not all medical staff were aware of what was expected of them in the subject which they had not completed.

Mandatory Training completion

The trust set a target of 85% for completion of mandatory training apart from information governance which was set at 95%. A breakdown of compliance for mandatory courses from April to October 2017 for medical staff in end of life care is below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Trust Target (%)	Met (Yes/No)
Moving and Handling	5	5	100%	85%	Yes
Conflict Resolution	5	5	100%	85%	Yes
Equality, Diversity and Human Rights - 3 Years	5	5	100%	85%	Yes
Health and Safety - 3 Years	5	5	100%	85%	Yes
Fire Safety - 1 Year	2	5	40%	85%	No
Infection Control	2	5	40%	85%	No
Information Governance - 1 Year	2	5	40%	95%	No
Resuscitation - 1 Year	4	5	80%	No target	N/A

In addition to trust staff, this table includes data for trainee medical and consultant staff who worked predominantly at a local hospice.

A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff in end of life care is shown below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Trust Target (%)	Met (Yes/No)

Information Governance - 1 Year	2	2	100%	95%	Yes
Conflict Resolution	2	2	100%	85%	Yes
Equality, Diversity and Human Rights - 3 Years	2	2	100%	85%	Yes
Moving and Handling	2	2	100%	85%	Yes
Fire Safety - 1 Year	2	2	100%	85%	Yes
Health and Safety - 3 Years	2	2	100%	85%	Yes
Infection Control	2	2	100%	85%	Yes
Prevent WRAP - No Renewal	1	1	100%	No target	N/A
Resuscitation - 1 Year	1	1	100%	No target	N/A

Nursing staff in end of life care met training targets for all applicable courses.

(Source: Trust Provider Information Request P14)

Safeguarding

There were clear systems, processes and practices in place that safeguarded patients from abuse. Staff we spoke with understood their responsibilities and followed safeguarding policies and procedures. Staff were able to demonstrate the process for referring a patient to the safeguarding team. Staff were able to explain what signs might alert them to safeguarding issues, how to escalate these concerns and who to escalate them to.

There were people who volunteered for the trust in roles which assisted the end of life care team, such as visiting patients and supporting those close to them. These staff had undergone DBS checks in line with the trust's recruitment processes aimed at safeguarding vulnerable patients.

Records showed that the majority of members of the end of life care teams had in date mandatory safeguarding vulnerable adults and safeguarding children training.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April to October 2017 for medical/dental staff in end of life care is below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Trust Target (%)	Met (Yes/No)
Safeguarding Adults Level 1	5	5	100%	90%	Yes
Safeguarding Children Level 1	5	5	100%	90%	Yes
Safeguarding Adults Level 2	4	5	80%	90%	No
Safeguarding Children Level 2	4	5	80%	90%	No

In addition to trust staff, this table includes data for trainee medical and consultant staff who work predominantly at a local hospice.

A breakdown of compliance for safeguarding courses from April to October 2017 for nursing staff in end of life care is below:

Name of course	Number of staff trained	Number of eligible staff	Completion (%)	Target (%)	Target met (Yes/No)
Safeguarding Adults Level 1	7	7	100%	90%	Yes
Safeguarding Adults Level 2	6	6	100%	90%	Yes
Safeguarding Children Level 1	6	7	86%	90%	No
Safeguarding Adults Level 3	0	1	0%	90%	No

For nursing staff, training targets were met for two out of four applicable courses.

(Source: Trust Provider Information Request P18)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. Staff used control measures to prevent the spread of infection. On one ward cubicles were being deep cleaned after contamination from influenza.

Staff followed trust policies on infection, prevention and control. For example, staff were bare below the elbows in line with trust policy, used antibacterial hand gel between patient care, wore personal protective equipment and disposed of waste correctly. This ensured that patients receiving end of life care who could be more susceptible to infection were cared for as safely as possible.

Inside the mortuary the hand gel dispenser had run out of sanitiser. During our time in the mortuary, porters, doctors and builders all entered the mortuary and none attempted to use the sanitiser. When we returned on the morning of the second day and on the day of our unannounced visit a week later, the dispenser remained empty.

We observed staff in the mortuary wearing personal protective equipment when they were involved in post mortems. They also adhered to the trust policy of bare below the elbow. Staff in the mortuary had access to hand washing facilities and protective clothing. This included gloves and aprons.

A member of mortuary staff told us ward staff informed them if a deceased patient had an infection and this was included in the records transferred with them. This information was also recorded in the mortuary to ensure staff were aware of any risk. A manager for the porters also confirmed that ward staff notified them if a deceased patient was an infection control risk. Porters had access to protective clothing on the wards.

In the mortuary we found two spray bottles that had no labels on them. A member of staff told us they used the spray to clean the trolleys and inside the fridges. This was an unsafe practice, if the contents were swallowed or inhaled or if it got into a member of staff's eyes no one would know what this substance was. There was a risk that the solution contained in these bottles fell under the COSHH regulations. However as there was no indication of what the substance was, it was not possible to determine whether it should have displayed safety warnings. This was identified to the staff member at the time and shared with the mortuary manager on our subsequent visit, which he assured us had been addressed.

We saw different coloured bags for different types of waste were being used, for example clinical and non-clinical waste on the wards and in the mortuary. This was in line with trust policy.

Environment and equipment

The service did not always have suitable premises but equipment was well maintained. The mortuary area was undergoing refurbishment following a recent Human Tissue Authority inspection. Once completed the capacity for storage of deceased patients would increase to enable them to meet demand.

We found a well-established system for monitoring and recording fridge temperatures daily. We observed this being followed and saw records to demonstrate this.

The mortuary's permanent fridges were connected to a fail-safe system which alerted switchboard if the temperature dropped out of a defined range. If this was out of hours, the on call member of staff would be called in to investigate and take appropriate action. Audits were undertaken of the refrigeration temperatures and the manager told they had found issues with gaps in the recordings. Once identified, actions were taken to remind staff of the importance of recording temperatures.

While the building work was in progress a temporary refrigeration unit was in place. This needed to be mobile to facilitate the building works; therefore it was not connected to the fail-safe system. Staff told us they monitored it during their working hours but out of hours this was done by the porters as and when they visited. We fed this back to the trust who immediately established a rota

system where porters attended the mortuary out of hours and recorded the temperature of the temporary refrigeration unit. We saw a copy of these records on our return visit.

Equipment was available to assist the mortuary staff with moving and handling deceased patients. We saw records of servicing on the hoist and this was up to date. Facilities for bariatric deceased patients were also accessible and included hoists and mortuary scissor lifts.

In the emergency department there was a room for relatives and a private room where they could see their deceased relative. There was an entrance to this room where ambulance staff could bring in a deceased patient without going through the main department.

The mortuary viewing room was visibly tidy and appropriately located and furnished. The bereavement office was easily accessible. The bereavement room had a quiet side room, away from the main office for persons close to the deceased to discuss emotional subjects with the bereavement officer.

Processes were followed to safely maintain equipment. For example all syringe driver pumps in use were maintained and used in accordance with manufactures instructions.

The trust used one brand of syringe driver across all wards. This reduced the likelihood of confusion or error by staff, particularly temporary (bank or agency) staff.

Syringe drivers were checked regularly whilst being used and documentation was completed to show this. Nursing staff were able to explain the process on what to do if a syringe driver was faulty.

Staff on the wards told us they had access to equipment to meet the needs of patients. For example, specialist beds which adapt to the shape of patients.

Syringe drivers were stored and delivered from the equipment library, which staff told us made sure they were safe to use and the syringe drivers were serviced and maintained.

Staff told us the equipment needed for syringe drivers, for example syringes and giving sets, were stored on the wards which ensured no delays in accessing equipment for the patient.

Assessing and responding to patient risk

Staff assessed and responded to patient risks, but these were not always recorded. Staff had mostly completed skin integrity assessments to evaluate patients' likelihood of developing pressure ulcers. These were more likely to occur at the end of life due to changes in the body. Patients were regularly repositioned and pressure-relieving aids were used where appropriate to lessen this risk.

We found in the 12 patients records we examined not all had their risk assessment document completed. This booklet included risk assessments for example around, pressure ulcers, moving and handling and malnutrition. This meant staff had not always assessed their patients against these risks using the trust tools. Venous thromboembolism (VTE) risk assessments were also not always completed on admission and reviewed within 24 hours as per trust policy.

We also found no advance care planning documentation. Advance care planning is a process that enables individuals to make plans about their future health care**.** Advance care plans provide direction to healthcare professionals when a person may not in a position to either make and/or communicate their own healthcare choices.This meant patients care needs and preferences at the end of their life may not be met by the staff.

Nurses and health care assistants monitored all inpatients regularly using an Early Warning Score (EWS) to identify patients who were deteriorating. This used a system of raising alerts through

numerical scoring of patient observations. This meant staff could manage symptoms early before they became worse.

End of life patients were not admitted under the sole direction of the specialist palliative care team. The patients we saw during our inspection were admitted under the medical and surgical teams and a consultant from one of these was in charge of their care. This ensured patients who were near their end of life had timely access to the specialist palliative care team.

Staff on the wards were aware they could access advice and request support from the specialist palliative team if their patient had been identified as requiring palliative or end of life care. Staff could call or email the specialist palliative care team or request them to speak with staff face to face.

Nurses and health care assistants monitored the comfort of patients who were in the final phase of dying. Nursing staff reported changes in condition, such as signs of discomfort or agitation, or changes in breathing to medical staff. We saw this was documented in patients nursing records.

Nurse staffing

The staffing levels and skill mix of the nurses and other staff in the end of life care team were reviewed and planned to support safe practice. The trust had an in-patient end of life care team.

The specialist palliative care team had four whole time equivalent (WTE) clinical nurse specialists covering the inpatient wards Monday to Saturday, between the hours of 9 am and 5 pm. There was also a lead nurse and a practice educator. The nursing staff felt that they had enough staff at the present time and would only need an increase in staffing if they moved to seven day working.

Handovers took place every morning. These were comprehensive and focused on the full holistic needs of each patient, discussing not only their condition and comorbidities, but also ongoing assessments of the patients' needs as their condition changes, such as updating family members. The nursing team used the handover to plan their visits for the day and anticipate any possible discharges or new referrals.

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate for all nursing staff of 12.5%. The trust did not provide vacancy rates for end of life care.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

The trust set a target of 10% to 14% for turnover rate. Between November 2016 and October 2017, the trust reported an annual turnover rate for nursing staff of 22.3% in end of life care, which was over the trust target. The trust told us following the inspection this figure was inflated because of the low numbers involved.

(Source: Routine Provider Information Request (RPIR) – P18 Turnover)

Sickness rates

From November 2016 to October 2017 the trust reported a sickness rate of 0.0% in end of life care for nursing staff. This is better than the trust target of 3.8%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical staffing

The staffing levels and skill mix of the medical staff in the end of life care team were planned and reviewed to meet patient needs. There was no use of agency or locum staff.

Overall staffing rates

The trust employed one consultant in palliative medicine full time. Out of Hours cover was provided via telephone from trust and hospice consultants (weekend and nights)

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates

From November 2016 to October 2017, Torbay Hospital reported a vacancy rate for medical staff of 8.2% in end of life care. The trust did not provide a target for vacancy rates.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

The trust set a target of 10.0% to 14.0% for turnover rate. Between November 2016 and October 2017, the trust reported an annual turnover rate for medical staff of 16.6% in end of life care which was over the trust target. However this figure is inflated because of low staffing numbers; turnover only occurred in October 2017 when staff leavers were 0.8 WTE with there being 4.8 WTE substantive medical staff employed that month.

(Source: Routine Provider Information Request (RPIR) – P18 Turnover)

Sickness rates

From November 2016 to October 2017 the trust reported a sickness rate of 1.3% in end of life care for medical staff. This is better than the trust target of 3.8%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

The trust reported that they had not used any bank staff in the period from November 2016 to October 2017 for end of life care.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

The mortuary manager told us they were using a locum technician whilst they advertised for another member of staff.

Records

Staff did not keep appropriate records of patients' care and treatment. We reviewed 12 medical records and found none of them had care plans in place. Further to this, the records all had uncompleted assessment of care needs forms from which nursing staff would have been able to create the care plans. One ward nurse we spoke with said they just didn't have time to create the care plans. Therefore the trust could not be assured that patients at end of life were having their needs identified or delivered.

The Critical Care Unit was in the process of devising a new pathway for patients who were end of life. They had involved the specialist palliative care team in their planning of this. The Critical Care Unit pathway was aligned with the specialist palliative care teams work but had critical care specific detail within the pathway.

In the mortuary there was a record book where all deceased patients' details were entered. This included their date of birth and full name. Following a recent Human Tissue Authority inspection, the mortuary staff introduced a more concise system to ensure the correct deceased individual was removed from the mortuary. This involved making sure each deceased patient was given a bar code and a copy of this bar code was placed in the record book as well, therefore when the undertakers collect a deceased patient they must come with a specific form created by the trust

containing all the patient details. The undertaker would sign the mortuary record book to state they had received the deceased patient. This information was then recorded into the computer system.

Medicines

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. We observed medications being handled, recorded and stored correctly.

The lead specialist palliative care nurse was able to prescribe certain medications as they had completed a non-medical prescribing course. Non-Medical Prescribing is the prescribing of medicines, dressings and appliances by health professionals who are not doctors. We observed patients who were at the end of their life were mostly prescribed anticipatory/crisis medicines. These medicines were prescribed in advance to manage any change in the patient's pain or symptoms.

In the records we reviewed we saw that patient's needs were met with anticipatory medication being prescribed appropriately. Anticipatory medications are medications prescribed 'just in case' or for when symptoms known to occur at end of life are predicted to occur.

Nursing staff had to undergo a syringe pump competency assessment prior to using the pumps in practice. Syringe driver training was carried out with assistance from the specialist palliative care team and by staff that had completed a train the trainer course.

Wards kept stocks of commonly used end of life medicines so they were available for prompt use. Records we reviewed showed that patients had medication provided when needed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Since the last inspection in 2016 one of the leads for end of life care told us that the coding for end of life care had been reviewed and amended. This had improved the ability for them to see incidents directly relating to end of life care and meant they could better review and be involved in any investigations as required.

Feedback from incidents was shared with the staff member who reported it, their team and wider teams if there was learning identified. This was then discussed at the end of life care committee meetings to share learning and share with the community end of life care staff if appropriate. If the committee felt learning was required across the community and other agencies the incident was able to be discussed at End of Life Care Board meetings where representations included the local Clinical Commissioning Group, GP's and the local hospice.

There were systems and processes that maintained safety in relation to the care and transfer of the deceased. A system had been implemented since our last inspection to mitigate incidents during transfer of the deceased. A three stage check now ensured the deceased were transferred safely and appropriately when leaving the mortuary to funeral directors and other agencies.

The end of life care team discussed incidents and planned actions during regular meetings. Actions taken were recorded when they had been fulfilled. Information and actions were shared during staff one to one meetings or via email updates. Staff said this ensured feedback and learning was shared and understood by the whole team. Issues were escalated to the quality and performance committee when required.

The mortuary manager told us that staff reported any incidents via the trust's electronic reporting system. They also had to report certain incidents to the Human Tissue Authority (HTA) who also

regulated them. They told us they had reported two incidents to them. One incident resulted in learning for other staff that used the mortuary in moving and handling and use of their equipment. They were able to review this specific incident as there was CCTV in all rooms.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2016 to October 2017, the trust reported no incidents which were classified as never events for end of life care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from November 2016 to October 2017.

(Source: Strategic Executive Information System (STEIS)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. The mortuary staff followed the Human Tissue Authority guidelines. When post mortems were conducted all staff followed the Coroners and Justice Act 2009.

The mortuary manager showed us the schedule of audits they undertook. This included security of the mortuary, traceability audits of deceased patients. There were also audits for following a deceased patient's pathway through the mortuary and schedules of air pressures in the post mortem rooms.

Following a Human Tissue Authority inspection the mortuary staff updated their policy on admission and release of deceased patients to include further safety checks.

The trust had introduced a new end of life care pathway based on the 'five priorities of care' that were introduced. These were:

- The possibility that a person may die within the coming days and hours is recognised and communicated clearly,
- Decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.
- Sensitive communication takes place between staff and the person who is dying and those important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care.
- The people important to the dying person are listened to and their needs are respected. Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

The aim was to promote a stronger foundation for good care and a culture of compassion in the NHS and social care for patients at end of life. The priorities put patients and those close to them at the center of decisions about treatment.

The new pathway was being trialed on some of the wards at the time of our inspection and the board and specialist palliative care lead were waiting for feedback before considering the full roll out across the trust. The end of life care leads felt this would improve the recording of patients' choices around spirituality as they had identified gaps in the recording of this.

The specialist palliative care team had a similar tool used for self-assessment. This was structured around the six ambitions of palliative care. The Ambitions framework was developed by a partnership of national organisations across the statutory and voluntary sectors. It sets out a vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England. This self-assessment showed significant progress in ambition three "maximising comfort and wellbeing, and Ambition five "all staff are willing to care". Work was still needed in ambition one "each person is seen as an individual and ambition two "each person gets fair access to care". Overall the assessments showed that progress was moving forward to the benefit of patients under their care.

The Chaplain had devised a video for staff to use to help them start the conversation with patients about this. Feedback we received from staff was very positive about the video. This video had

been created after staff had fed back that they found it hard to initiate emotionally powerful subjects with patient's, or those close to them.

National Institute of Health and Care Excellence guidance includes staff recognition of patients thought to be approaching the last days of life. We saw evidence of staff understanding of this during our inspection. For example, we saw staff managing symptoms presented by patients in the last days of life and also putting into place the preferences and needs of the dying person, such as preferred place of dying or having those close to them present.

Staff we spoke with understood that end of life care could include patients with non-cancer diagnoses such as dementia. Staff understood patients could benefit from conversations about their care and wishes early on in the end of life care pathway.

The palliative care team in conjunction with the end of life quality group were responsible for leading improvement and setting standards of end of life care used. This was achieved through using evidence-based guidance, standards, best practice and legislation to develop how services, care and treatment were delivered.

End of life care was provided in line with the principles of the Priorities for Care of the Dying Person. For example, the possibility of dying had been recognised and talked about clearly with the patient and those close to them. We saw in patients notes when these conversations had taken place and the people involved such as consultants and family members.

The trust had participated in the National Care of the Dying audit published March 2016 and had created an action plan where improvement was identified as being needed. Some actions had already been completed such as improved monitoring of the number of patient on wards, receiving assessment of spiritual needs and the development of the end of life quality group.

A recent audit of prescribing medication in the last few days of life showed that the trust displayed good recognition of patients who were close to death. This audit showed any actions to be taken from data found; additionally it recognised the audit sample taken was too small to reflect the full scope of patient needs. While small, the audit did identify areas, such as managing diabetes in end of life care, which could be improved.

Nutrition and hydration

Nutrition and hydration needs were met. All patients were screened on admission to ensure they were not at risk of malnutrition. The MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we saw. However we could not see this extended into the care plans.

The speech and language therapists worked closely with the dietitians to establish the food and liquid consistency a patient may require if they had difficulty swallowing. Assessments and advice from dieticians and therapists were seen in the notes we examined but these too did not follow onto the individual care plan. For example, some patients were started on dietary supplements because of input from the dietetics team.

For patients that were not eating at the end stage of life, the ward staff ensured regular mouth care was carried out to ensure patient comfort.

Pain relief

Patients' pain was well managed but limited records were kept to demonstrate this. In the nursing records for each shift we could see that pain had been managed appropriately. There were no care plans for management of patient's pain. Staff we spoke with were unable to tell us what pain tools were used for end of life patients. Medical notes showed that a numeric rating scale of 1-3

and visual scale, such as grimacing or posturing were most commonly used. Appropriate actions were taken in relation to pain triggers to make patients more comfortable. Staff were encouraged to contact members of the specialist palliative care team for advice in complex cases.

Pain management and symptom control were discussed daily in the specialist team's handover and any queries were fed back to the consultant on call. The specialist nurses visited the wards and regularly reviewed drug charts and spoke to staff about whether patients' pain and symptoms were adequately controlled. Doses of pain medications were increased where necessary.

Patients that we spoke with were generally happy that their pain was well controlled. We observed the specialist nurses routinely talking about pain management and symptom control with patients.

We saw examples in the records of pain control managed with syringe drivers, which delivered measured doses of drugs over the course of 24 hours. We saw examples of suitably prescribed medication in syringe drivers, which nurses checked and that the patient was receiving the correct doses of drugs.

The specialist nurses worked closely with the dedicated pain management service, who offered advice and support to patients who were experiencing pain because of their treatment or illness. The specialist palliative care team had close links with this service and held regular meetings to discuss the management of complex patients.

Patients and relatives were offered support with emotional and psychological pain by the end of life care teams. This included a specialist psychology service, chaplaincy service, ward staff and the bereavement offices. Relatives we spoke with confirmed that they had been offered or received support, and we saw this was documented in care records.

Patient outcomes

Staff demonstrated an understanding that end of life care was for patients diagnosed with any life limiting condition and not solely related to patients' with cancer related conditions. This was also demonstrated in the end of life care team's referral audit information.

We reviewed treatment escalation plans sometimes referred to as TEPs, which described what should be done when a patient's condition worsened or what a patient would like to happen if they needed resuscitation. We looked at 12 records that included discussions and decisions for treatment escalation plans, all were completed appropriately.

The specialist palliative care team had undertaken several audits about the outcomes of patient's care and treatment. The information was being used to further improve the delivery of end of life care.

The trust did not participate in the gold standards frame work accreditation scheme for end of life care (a systematic, evidence based approach to optimising care for all patients approaching the end of life). However, patient's care and treatment outcomes had been monitored through a rolling audit programme. Information collected was used to inform further work within the end of life strategy. We saw evidence of past audit information, such as fast track discharges and how the end of life team planned to improve.

An annual audit that showed performance of the specialist palliative care team showed that 100% of referred patients were seen within the response time of 2 days.

End of life care Audit: Dying in Hospital

The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed better than the England average for all of the five clinical indicators. The trust scored particularly well for

the third measure which asked: Is there documented evidence that the patient was given an opportunity to have concerns listened to?

The trust answered yes to two of the eight organisational indicators which were:

- Is there a lay member on the trust board with a responsibility/role for end of life care?
- Did your trust seek bereaved relatives' or friends' views during the last 2 financial years (ie from 1 April 2013 to 31 March 2015)?

(Source: Royal College of Physicians)

Competent staff

The service made sure staff were competent for their roles**.** Managers mostly appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. However they were not meeting the trust target as shown in the data for appraisal rates.

The palliative care team were all relatively new to post, within the 18 months prior to the inspection. The end of life care leads told us it had taken time to get the team in place and through their induction and competencies training.

There was a plan to have ambassadors established on each ward. These would be members of staff who wanted to learn more about end of life care and pass this on to other staff on their ward. This would include attending meetings and input from the local hospice.

The end of life care leads had identified issues with end of life care training for staff on the wards. they had identified that staff required additional training and so a package of training was delivered. Training consisted of for example, verification of expected death and syringe drivers. Qualified staff had to complete classroom training on syringe drivers. Once the classroom sessions were completed staff competencies were checked on the ward by staff trainers. Following this, a yearly on line skills update was taken and then, every three years thereafter staff assessed by a trainer.

Staff were able to access training at the local hospice. Plans were developed to improve this by devising a training tier based on job role. There would be tiers one to three, with three being more specialist training which would be provided by the hospice.

The palliative care team's annual report showed a drive towards educating staff with a rolling syllabus of education for end of life and specialist palliative care staff. For example, the Enhancing Palliative Care Skills Course' delivered by a local hospice, teaching about rapid discharge from the acute hospital and by providing clinical placements.

Appraisal rates

From November 2016 to October 2017, 60% of staff within end of life care at the trust had received an appraisal compared to a trust target of 90%. All staff received appraisals in end of life care from April 2016 to March 2017. These calculations are based on low numbers of staff with no data reported for medical staff. Following our inspection the trust informed us all doctors for end of life care were up-to-date with their appraisals, although no evidence was supplied for this.

A split by staff group can be seen below:

Staffing group	Number of staff appraised – November 2016 to October 2017	Sum of Individuals required - November 2016 - October 2017	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Support to doctors and nursing staff	2	2	100%	90%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	1	2	50%	90%	No
Support staff	0	1	0%	90%	No

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

Staff, teams and services worked together to deliver effective care and treatment. The end of life care team met every morning to discuss current work and new referrals . Work was allocated based on patients' need and urgency. The team worked closely with the community end of life care team, district nurses and GPs. This reinforced effective transfer of clinical support and follow-up reviews of patients upon discharge.

We accompanied specialist nurses to the wards and saw them supporting the work of nursing staff in a constructive and practical way to enhance the care of dying patients. Staff we spoke with knew the team and said they were visible and readily available to give advice and support to staff and patients on end of life care.

Multidisciplinary working happened between acute, community, and local hospice staff. Increased acute hospital and community hospital multi-disciplinary meetings were held where planning across the whole end of life care process would occur.

A system was established where the emergency department would alert the specialist palliative care team when a patient who was assessed as being end of life attended the department. The specialist palliative care nurse provided advice and support to the doctor and recommended pathways for the patient.

There was a selection of resources for multi-disciplinary personalised end of life care. These resources were available on all wards in the end of life folder supplied by the hospital specialist palliative care team.

Seven-day services

The specialist palliative care team provided a six day service Monday to Saturday within office hours. At the time of the inspection there were no plans to move the SPCT to a seven day service but the leads for end of life care said this was something they would need to review. This was not in line with the recommendations of the Royal College of Physicians. End of life care services from the specialist palliative care team were provided Monday to Saturday 9.00 am to 5.00pm. Outside those times, there was a 24-hour on-call telephone advice service from the local hospice.

The chaplaincy service was available every day of the year, 24 hours a day. The team had arrangements with local faith leaders to provide an on-call out-of-hours service.

Consultant medical cover was available by telephone 24 hours, seven days a week.

The mortuary also had an out of hour's service for evenings and weekends. The mortuary manager told us relatives were able to view their deceased relative outside of normal working hours if needed.

Health promotion

Patients were identified who may need extra support. We were shown examples where patients were encouraged to maintain a healthy life style by continuing their normal life activities, for example, gardening.

There was a focus on empowering patients to make choices about their care, and then decide for themselves where possible, the course of their treatment. This included where active treatment was to be withdrawn, as well as where limits to treatment were agreed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff awareness of and the use of the Mental Capacity Act 2005 was improving. On three of the wards we visited to look at the use of the mental capacity act, no one was subject to deprivation of liberty safeguards. We were told these were used occasionally on Forrest ward. Staff would refer to psychiatric liaison if they needed psychiatric review.

Treatment escalation plans contained details if the patient lacked capacity, indicated by a tick box. On the reverse of the form there was a process for staff to follow

We saw in one deceased patient's records, a completed mental capacity assessment about the decision for nutrition. The patient lacked capacity to make the decision themselves. The consultant in charge of their care had made the decision, in the patient's best interest that they could have certain foods based on guidance from the speech and language therapists.

Mental Capacity Act and Deprivation of Liberty training completion

The trust was unable to provide this information to us during the inspection or within the report writing period.

Is the service caring?

Compassionate care

We spoke with a patient receiving end of life care. We also spoke with relatives of patients who were receiving end of life care. All described being treated with kindness dignity respect and compassion while they received care and treatment.

Staff understood and respected the varied personal, cultural, social and religious needs of people. They also demonstrated an understanding of how this related to care needs and took this into account when delivering services.

Staff took the time to talk with people who received end of life care and those close to them in a respectful and considerate way. We observed sensitive conversations taking place between staff and the dying person, and those identified as important to them.

Mortuary staff cared for deceased patients in a respectful manner. Staff took the time to ensure the deceased were appropriately covered and during the movement and handling of the deceased.

The mortuary had facilities to be able to offer the provision of ritual cleansing after death for patients of faiths where this was needed.

We saw many complimentary cards about how kind and caring staff were and, how the end of life and palliative care team worked so well for patients and their relatives.

Emotional support

Staff we spoke with understood the impact that a patients' care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.

Emotional support was available for patients and relatives through the end of life care team, through a clinical psychologist, social workers the chaplaincy team and bereavement services.

Patients who were receiving end of life care and those close to them received the support they needed to cope emotionally with their care, treatment or condition. Patients were supported to have contact with those close to them and maintain links with their social networks or communities, for example we were told that staff encouraged patients to have visits from their local clubs which they may have frequented before becoming ill. Chaplaincy volunteers were clear that their role was to provide non-religious as well as religious support, sometimes just to chat with patients.

The trust had procedures to support the family and relatives for patients who were identified as being at the end of life. For example, they were able to collect a token to be able to park for free.

Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. We saw staff talking to patients and encouraging them to be mobile and gentle exercise. This included spending time in the social room on the ward.

Understanding and involvement of patients and those close to them

Patients who received end of life care services were involved as partners in their care. We reviewed care records and saw that staff delivering end of life care had recorded some discussions with patients and relatives such as options to make the patient more comfortable. These included discussions about care and treatments and their implications.

Staff spoke sensitively with patients and those people close to them so that they understood their care, treatment and condition. Staff took the time to make sure that what was said to patients and those close to them was taken in understood.

Staff had the knowledge about the services on offer to patients at end of life, this included both the hospital and in the community. This meant they were able to answer questions and make arrangements for patients who wanted to go home, or be discharged to their preferred place of care.

A relative told us about the excellent relationships they and their relatives had with the specialist palliative care team and clinical nurse specialist.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The trust had no designated palliative care wards or beds. Patients were looked after on any of the wards. A side room was allocated wherever possible. Patients with an infection risk would need to be prioritised for the side rooms to prevent cross infection with other patients. Staff explained when patients at the end of their life were cared for in a bay they used curtains to promote their privacy and dignity. They also said they tried to make a room available on the ward where those close to the patient could meet. Staff on the wards told us they provided patients relatives with refreshments and free parking tickets.

The specialist palliative care team worked closely with the local hospice to discuss joint patients and plan their care, support and treatment.

The end of life care leads told us they were looking to introduce a scheme to identify patients at the end of their life. They were looking to introduce a 'butterfly package' which would include a document all about the patient. This was in the early stages during our inspection and therefore, there was currently no feedback to share with inspectors..

There was access to mental health, learning difficulties and dementia expertise. The learning difficulties team only had a small pool of staff available. The dementia champions were not on all wards due to difficulty releasing staff.

The trust had a mental health team that was available for out of hours to support those patients who required it.

End of life patients with mental health needs could access urgent care services within three hours. This was also available for end of life care patients living with dementia and learning difficulties.

Meeting people's individual needs

Individual plans of care were not found. These would have included food and drink plans, symptom control and psychological, social and spiritual support. There were care planning assessment documents but these were rarely completed. We could not be assured that end of life patients were having their needs documented or met. End of life leads told us that these would be recorded on the trust electronic system, however we were shown this system and those records were not apparent.

Where possible, patients receiving end of life care were accommodated in side rooms to increase dignity and privacy for them and those visiting. In one example we saw where staff had created a side room which had been set up to allow a patient to lay with his wife so they could support and hold each other.

The hospital had very limited accommodation for relatives. Staff supported the needs of relatives who were visiting for visiting for extended periods. For example, relatives were offered a pillow and a blanket when staying in chairs.

The chaplaincy team provided spiritual support for different faiths. The team represented a variety of faith traditions and were also supported by a number of pastoral volunteers and an out of hours on-call service. The chaplaincy team promoted an extensive network of connections with faith leaders from other religious traditions who visited patients of varying religions if required..

The hospital chapel did have some Christian symbolism but welcomed people of all or no faiths. There was a separate small multi faith prayer room, separated by screens so men and women could use it at same time. Head caps and prayer mats were available. The chapel and separate multi faith prayer room were open day and night for prayer or quiet reflection.

All clinical staff, volunteers who worked within the chaplaincy, bereavement officers and the mortuary were aware of and acted accordingly on cultural and religious differences in end of life care. For example bereavement office staff were aware of the importance of being able to deliver a death certificate in timely manner because some beliefs required that the body was laid to rest soon after death. Mortuary staff understood the need to be able to release recently deceased patients quickly. This supported the spiritual and cultural wishes of the deceased person and their family.

The viewing room attached to the mortuary was neutral in decoration, holy books and prayer books of different faiths were available for those close to the patient to use on request. Those

responsible for the care and storage of the body took into account various religious or cultural practices such as involvement in laying out the body, night vigils or providing ‘mourners’ to sit with the deceased. In such cases, mortuary staff made every effort to accommodate such requests. Arrangements for release of bodies to funeral directors that needed to be made out of normal working hours (for example, Orthodox Jewish or Muslim burials) could be organised.

Patients at the end of their life did not have their cultural, psychological and spiritual/religious needs assessed fully. In the patient records we reviewed these needs were rarely documented. This issue was identified at our last inspection and was not resolved at the time of this inspection. The service leads for end of life care were aware of this and felt their new end of life care pathway would assist staff to talk with patients and their family/carers about this. There was also a place to record this information. The Chaplain had also devised a video for staff to access on their internet to help them to start these conversations.

Dementia champions were available. All patients were screened on admission using a standardised set of questions, some of which related to dementia. There was an electronic flagging system to identify patients living with dementia on the patient administration system. Patients living with dementia were offered 1:1 nursing care and family members and carers were encouraged to be involved in their care as much as possible.

On Turner ward we saw use of the forget-me-not symbol for some patients. This was used to identify them as having dementia. The dementia educators described some adaptations that could be made to make environments dementia friendly but they were not in evidence on the wards we visited. Following this inspection the trust told us the medical wards had been painted in different colours to aid wayfinding, and signage had also been improved.

There was 24 hours a day, seven days a week access to specialist mental health assessments via the mental health liaison team. Patients were referred by telephone, using a triage form. Attendance by the team was within one hour for the emergency department and within 24 hours for wards.

Staff gave relatives a locally produced bereavement pack that included information which covered all the useful tasks following a death in the hospital. There was advice on registering a death, viewing and funeral arrangements and where to get extra information and support. The bereavement officer we spoke with showed understanding of the emotional support those close to the patient would experience. The bereavement office had a small side room where the bereavement officer would take time to explain the process to ensure understanding on what steps to take.

Translation services were available for end of life patients and relatives. Staff who had used these services said they were prompt and efficient in responding to needs.

Access and flow

Referral into the end of life care service was dependant on staff identifying appropriate patients. The end of life team reacted promptly to referrals, usually within one working day. Ward staff demonstrated they understood how to make a referral to the specialist team and reported that the team responded promptly.

Access to spiritual support provided by the chaplaincy service was audited. This was done to identify areas of high demand and low usage and to understand if staff needed to be made more aware of the support available. This included future planning of the spiritual support department.

Staff we spoke with were aware of processes relating to rapid discharge to enable patients to die at home or in a hospice. Once a patient's preferred place of death was confirmed and a care plan

and package had been agreed, this could usually be achieved within 24 hours. The trust had its own transport system that enabled the patient to be taken to their preferred place of dying and a person of the patient's choice was able to travel with them. When a patient was discharged to their preferred place of dying, hospital staff gave information to ambulance crews about where to take the person if they died while being transferred. The do not attempt cardiopulmonary resuscitation form was sent with the patient on discharge to their home or preferred hospice and could be used until a new form was put in place by their GP or doctor taking over their care.

The administrative arrangements relating to death, including liaising with funeral directors was undertaken by the bereavement office. The bereavement officer liaised with bereaved families or those close to the patient to facilitate the removal of bodies from the body stores within a timely period.

There was a fast track discharge service for patients at the end of life who wished to leave the hospital for their preferred place of dying. This was discussed with both family and patient, this choice was shared to the specialist palliative care team. Staff then commenced various risk assessments and arranged for equipment to be ready. This often meant liaising with community colleagues to secure funding for packages of care to be delivered at home or in the preferred place of care. Overall this functioned effectively for patients at end of life by allowing timely discharge when community services were available.

However there were occasions where discharges were not timely and the patient was unable to be discharged, usually due to funding delays. We were told that performance on this was regularly audited and sent to the clinical commissioning group, however we had requested copies of this but they were not provided.

Learning from complaints and concerns

There were leaflets throughout each ward and department detailing how to access Patient Advice and Liaison Service (PALS) and make a formal complaint, although none of the patients we spoke to had cause to do so.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. The end of life care leads told us about a complaint they had received which involved other agencies. This was shared with the other agencies and the learning from this helped make sure the issues identified did not happen again.

The mortuary service had received no written complaints since the manager joined in 2017. They told us complaints would be directed through the trust's complaints systems and sent to them if required.

The trust received no complaints between November 2016 and October 2017 for end of life care.

(Source: Provider Information Request P55)

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The clinical lead for end of life care well informed and engaged in the work of the specialist palliative care team and was enthusiastic for the continuing integration of the end of life service. The specialist palliative care team was valued by the trust board, we saw evidence that end of life care had significant attention at board level. Ongoing integration and improvement was needed within the trust overall. However, we saw plans for this change to be supported through ongoing education and reinforcement of audit programmes.

The mortuary manager had plans to develop their mortuary strategy. They told us about one of the things they wanted to improve was their decontamination process. The manager told he felt confident he would get the support of the board.

Staff we spoke with said leaders were visible and approachable. The clinical lead for the hospital specialist palliative care team worked regularly on wards and was well thought of. The community and hospital teams were further integrated since our previous inspection. A strategic lead for end of life care was in place. This gave on oversight of issues that were shared and acted on at board level.

The leadership and drive of staff who provided end of life care, and the specialist palliative care team, maintained the vision and values of the trust, and encouraged openness and transparency. This was achieved through regular quality and governance groups.

Vision and strategy

There was a clear statement of vision and values, driven by quality and sustainability. This had been translated into a strong and realistic strategy and well-defined objectives that were achievable and relevant. Developed with involvement from staff, patients, and key groups representing the local community, the trust had developed an End of Life Care (EOLC) strategy which aimed to ensure those in the last stages of life received safe and individualised care as mandated by the five priorities of care (One Chance To Get It Right, 2014).

The strategy also took into consideration the elements of other nationally published documents such as 'Ambitions for Palliative and End of Life Care' (National End of Life Care Programme, 2015) and 'Care of the Dying Adult in the Last Days of Life' (NICE, 2015). The strategy aimed to increase recognition of the dying patient and providing high quality end of life care by 2020. A detailed action plan was drawn up that focused on an education programme led by the specialist palliative care team but delivered by practice educators and ward end of life champions. Once this was embedded, the specialist team planned to look into ways of delivering further advanced care planning and options for community/local support and management at an earlier phase. This would include development of electronic data sharing systems.

The trust End of Life Care (EOLC) Strategy was developed to reflect the National End of Life Strategy and incorporated national guidance to form its objectives over the course of the next five years (2016 – 2020). The strategy was drafted and revised to take into account various stakeholders, such as the executive board, board of governors, staff, patients, other local providers.

Staff we spoke with were aware of the vison and strategy as they were included in the quality groups and the daily management of patients therefore ensuring they practiced the trusts vision for end of life care.

The end of life care leads told us they were proud of their strategy and the integration of their community and acute services. They felt this had improved since our last inspection in 2016 as they had only been integrated for three months at that time.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with had worked at the hospital for a number of years and many patients had used the hospital for a long time, due to the specialist nature of the service. Staff commented how proud they felt to work at the hospital. The specialist team felt they had good working relationships with the ward teams, especially the other specialist nurses in different departments who they worked closely with on a daily basis.

Staff were aware of the need to support each other after a death and the specialist team described how they might support ward staff in the event of a difficult bereavement.

Governance

A clear governance framework ensured that responsibilities for end of life care were able to be identified from the trust board of directors through to key members of staff. We found them to function effectively and interact with each other appropriately. We could see from meeting minutes provided that showed information was passed up and down through working groups and from incidents and risks to the service. There were allocated ownerships to issues with time scales for delivery.

The medical director was involved with the quality improvement group and the executive lead for end of life care was part of the end of life steering group. The end of life steering group met every month and included the consultant in palliative care from the specialist palliative care team, the lead nurse from palliative care team, chaplain and other services involved in end of life care.

Processes were followed to provide assurance to the board regarding safety issues. The end of life care steering group and medical director provided regular reports to the board.

Systems were used to learn from incidents that occurred in end of life care for example mortuary incidents and discharge planning for patients at end of life.

Both the acute and community end of life leads worked closely together to improve the overall integration of end of life and specialist palliative care across the trust.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. This was evidenced through the services local risk register.

The mortuary service had a policy about how to respond in the event of a major disaster. The mortuary manager told us this plan required updating. They spoke to us about the plan they had in place for when the local air show was took place. This included other agencies in the local community. They were able to access more capacity in a major incident which included out sourcing and obtaining temporary refrigeration units. For day to day capacity issues they used temporary refrigeration units.

The palliative care team had been included in the major incident planning and training. Staff had to complete the on line training and if called on as part of a major incident they knew their allocated roles. The Chaplaincy service was also included.

The end of life care service had their own risk register and a senior member of staff managed this outside of the palliative care team. This was reviewed at each of their meetings and any risks were escalated to other governance meetings for discussion and shared at board level as required depending on the severity of the risk. We found that risks on the register reflected the concerns of staff we spoke with. For example, the mortuary redevelopment and capacity risks, and the need to ensure all staff were syringe driver trained.

The mortuary service also maintained their own risk register. The manager told us the main risk was to address the issues raised by the Human Tissue Authority (HTA) recent inspection. These had clear timelines for completion and were on course to meet those requirements.

Several end of life performance tools were used to measure against the National Institute of Clinical Excellence guidelines for example, quality standards for end of life care for adults. We

could see from a recent audit of performance where areas for improvement were identified and action taken and dates for completion. During this inspection we could see actions identified and processes put in place to rectify them.

Information management

The trust collected, managed and used information to support all its activities, using a secure electronic system with security safeguards. Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff accessed an electronic system that they could update. Patient records were in paper format and we observed these contained mostly up to date information on the patients care and treatment to include medical and nursing reviews.

Information was available to staff to obtain advice from for example, anticipatory medicines. Policies, procedures and protocols could be accessed through the trust's intranet.

The mortuary had recently improved its patient information management which improved the availability, integrity and confidentiality of patient identifiable data. This process was also shared with third parties such as local and trusted funeral directors.

Engagement

The specialist team actively engaged with staff on the wards and attended various multidisciplinary (MDT) and departmental meetings on a regular basis. This increased the visibility of the team and provided staff across the hospital with easy access to and advice from palliative care services. Ward staff were positive about the knowledge and support they received from the specialist team when caring for dying patients.

Staff in the specialist palliative care team described being engaged by the trust and their views were shared in the planning and delivery of service. This also helped the culture of staff on the wards and specialist palliative care team with a feeling of ownership and pride in the service.

The specialist palliative care team were aware that gaining the views of patients and those close to them involved with end of life care, and those at end of life could be difficult but important to gather the views of patients and those close to them. This was to improve the level of care provided. Feedback forms had been sent out to relatives but the response was limited.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The end of life care leads told us about a new project the local hospice was leading but they were actively involved with. This was for end of life care for patients with heart failure. The hospice had obtained funding for a post two days a week to help devise a multi- disciplinary team pathway. This was in the early stages but the local Clinical Commissioning Group and GP's were also taking part in the project. They also felt this would improve the use of the Electronic Palliative Care Co-ordination Systems (EPaCCS) used locally. This system enabled the recording and sharing of patients care preferences and key details about their care at the end of life. They felt it was not being used to its full potential so the above project should help to include non-cancer patients to this list.

Improvements had been made to the service since the last inspection, such as better integration of acute and community end of life services. Staff had considered developments to services and the impact on quality and sustainability was assessed and monitored.

There was a trust wide end of life care steering group. The group was made up from medical, nursing, allied health professionals, non-executive director, chaplaincy and hospital site management. This group were aiming to implement and improve the end of life care strategy.

Outpatients

Facts and data about this service

Torbay and South Devon NHS Foundation Trust provides outpatient services at Torbay Hospital and four other community hospitals throughout the region. These are Newton Abbot Community Hospital, Paignton Hospital, Teignmouth Hospital and Totnes Hospital. At Torbay Hospital there is a dedicated outpatient department. Outpatient services were structured within four delivery units and into service lines and specialities.

Additionally to this there is a dedicated oncology outpatient department, breast care department, and specialist dedicated outpatient clinics. These include dermatology, ophthalmology and cardiology.

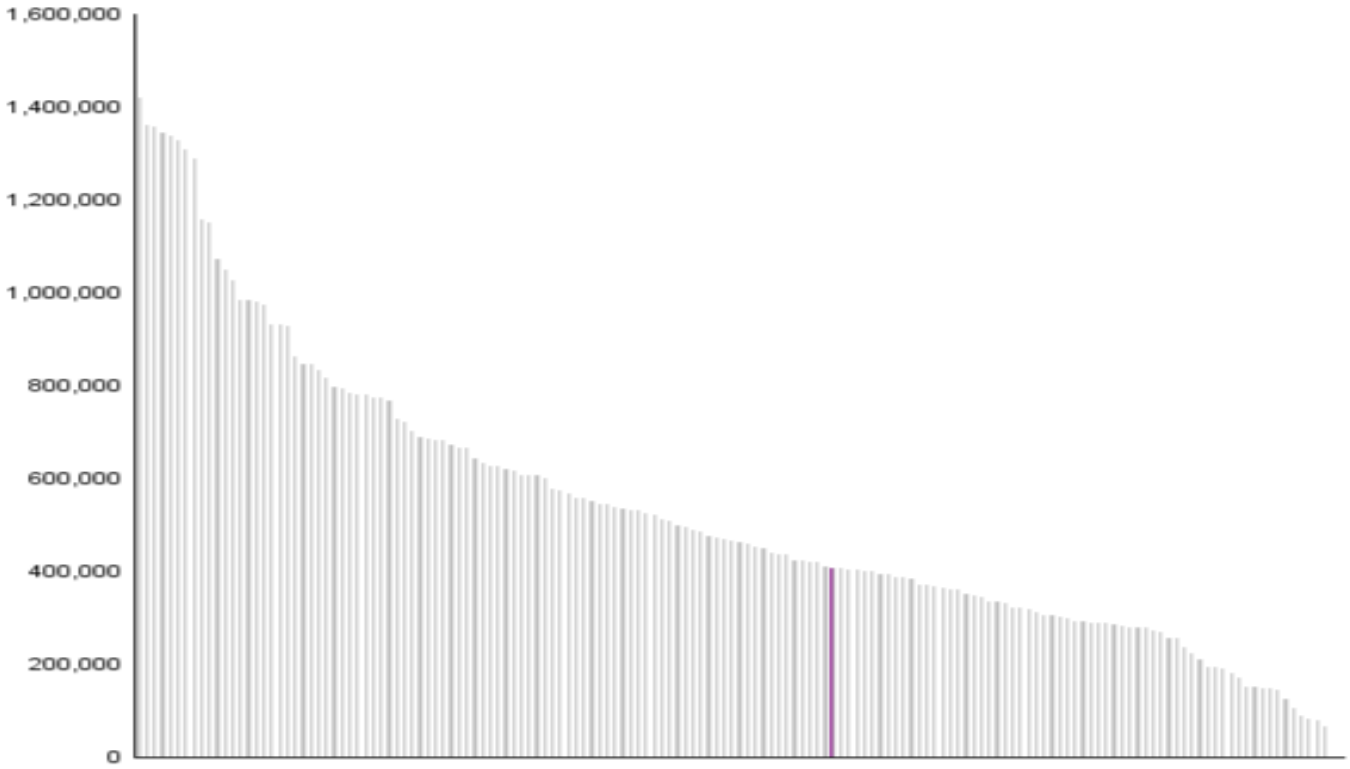
We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We inspected the whole of the outpatients service because at our last inspection we rated them as requires improvement.

During this inspection we inspected Torbay Hospital only but reviewed data about the community hospitals. A team of inspectors and specialist advisors visited the main outpatients unit, heart and lung outpatients, haematology, gynaecology, ophthalmology, oncology (including outpatients, chemotherapy and radiotherapy), dermatology, and fracture clinic. We spoke with 36 members of staff (including managers, nurses, healthcare assistants, healthcare professionals, and domestic staff). We spoke with 21 patients and three relatives and carers. We looked in 12 patient records and observed practice and care throughout the inspection.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

The trust had 407,304 first and follow up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts.

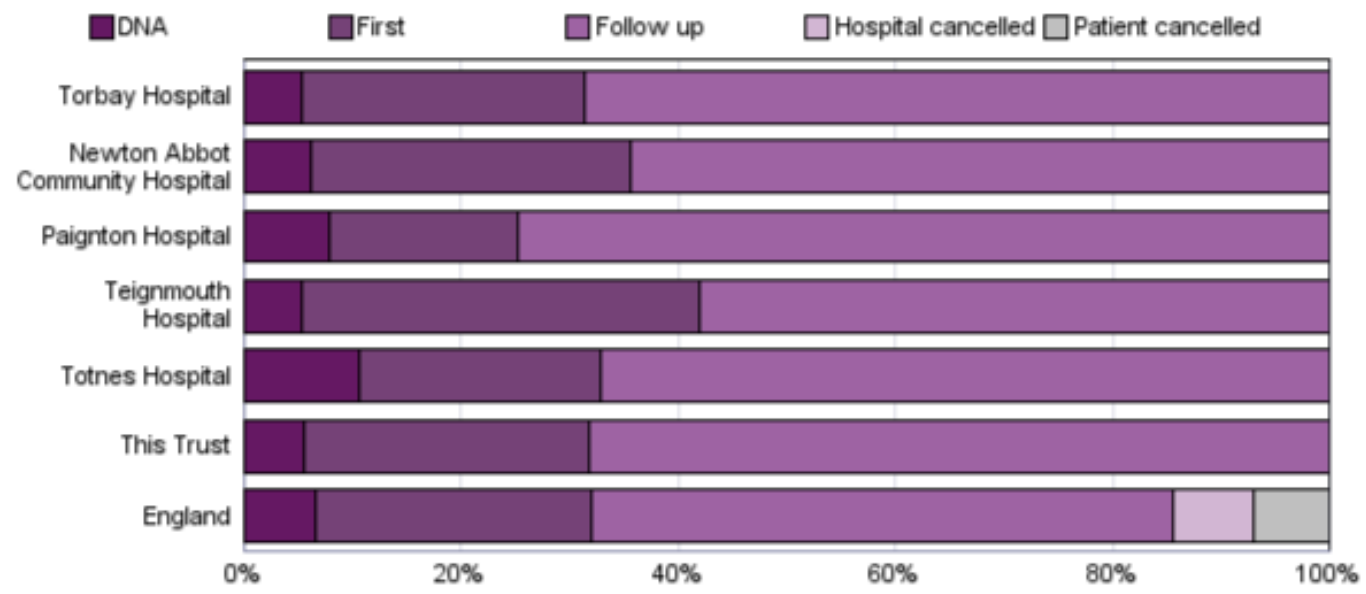


The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from October 2016 to September 2017.

Site Name	Number of Spells
Torbay Hospital	361,990
Newton Abbot Community Hospital	37,477
Paignton Hospital	14,389
Teignmouth Hospital	6,587
Totnes Hospital	5,893
This Trust	431,115
England	103,794,079

The chart below shows the percentage breakdown of the type of outpatient appointments from October 2016 to September 2017. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Torbay and South Devon NHS Trust from October 2016 to September 2017 by site and type of appointment:



Is the service safe?

Mandatory training

There were safety systems, processes and practices to implement and monitor mandatory training. This was developed and implemented through a Core Training Policy which identified statutory and mandatory training needed by the organisation and any legislative duties. It identified that specific training must be completed by all grades of staff and updated in line with requirements. The trust set a target of 85% for completion of mandatory training, apart from the information governance module which had a target of 95%. Resuscitation and paediatric life support training which had a target of 100%.

Not all staff were up to date with their mandatory training. All staff had received training in health and safety through trust induction. However, update targets for most mandatory training modules were not met. This meant that not all staff were fully informed of the latest practices, legislation and guidance, which could have increased risks to patients. When staff had completed the training, they described it (both online and through online courses) as sufficiently preparing them to perform their roles safely.

A breakdown of compliance for mandatory courses from April to October 2017 for medical and dental staff in outpatients is below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)
Conflict Resolution	16	18	89%
Health and Safety	15	18	83%
Equality, Diversity and Human Rights	15	18	83%
Fire Safety	15	18	83%
Information Governance	14	18	78%
Infection Control	14	18	78%
Paediatric Basic Life Support	2	3	67%
Resuscitation	11	17	65%
Moving and Handling	10	18	56%

Medical staff in outpatients met one of nine mandatory training targets. They failed to meet the target for six of nine training courses and were close to target for three modules. Compliance had fallen since the last inspection.

A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff in outpatients is below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)
Equality, Diversity and Human Rights	115	143	80%
Fire Safety	110	143	77%
Health and Safety	105	143	73%
Infection Control	101	143	71%
Information Governance	96	143	67%
Conflict Resolution	93	143	65%
Moving and Handling	92	143	64%
Resuscitation	69	118	58%
Paediatric Basic Life Support	0	2	0%

Nursing staff failed to meet the target for all nine training courses. Compliance had fallen since the last inspection.

Staff knew about the potential needs of people with mental health conditions, learning disabilities, autism and dementia through equality, diversity and human rights training. Staff described how they provided care to ensure the safety of these patients. For example, increasing staffing for patients at risk of harming others as a result of their condition and using the morning safety briefing to discuss specific patient's management plans.

Safeguarding

The trust had policies and processes for the protection of adults and children at risk from abuse. This policy clearly defined individual responsibilities both within the trust and within the local authority boundaries to safeguard adults from abuse. It included detail on the trusts duty to have a 'whole family' approach to safeguarding as defined in The Children's Act 2004. These policies were linked to the Torbay multi-agency agency policies and procedures.

There was guidance for the management of safeguarding concerns. This included domestic violence, abuse and risks arising from self-neglect. It extended to forced marriage, human trafficking and modern slavery, extremism and female genital mutilation. There was a separate policy, which linked to guidance for the management of abuse linked to a belief in spirit possession.

Not all staff had received update training in safety systems, processes and practices relating to safeguarding children and adults. This meant that potential safeguarding concerns could be missed.

The trust had a Core Training Policy which identified statutory and mandatory training needed by the organisation and any legislative duties. Within this was safeguarding adults (as required by the Mental Capacity Act 2005) and safeguarding children (the Children's Act 1989 and 2004). The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses, from April to October 2017 for medical and dental staff in outpatients is below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)
Safeguarding Children Level 2	14	18	78%
Safeguarding Children Level 1	13	18	72%
Safeguarding Adults Level 2	12	18	67%

Safeguarding Adults Level 1	12	18	67%

The trust failed to meet the completion target for all four safeguarding training courses for medical and dental staff in outpatients.

A breakdown of compliance for safeguarding courses, from April to October 2017 for nursing and midwifery staff in outpatients is below:

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)
Safeguarding Children Level 1	134	143	94%
Safeguarding Adults Level 1	131	143	92%
Safeguarding Adults Level 2	80	116	69%
Safeguarding Children Level 2	86	135	64%
Safeguarding Adults Level 3	3	5	60%

Nursing and midwifery staff in outpatients met the completion target for safeguarding training for two of five courses. For three of the five courses, the completion target was not met.

Despite this, staff (including reception staff) knew their responsibilities to safeguard children and adults from abuse. This reflected relevant legislation and local policies and procedures. They could clearly describe an escalation process to ensure that appropriate action was taken. Some knew where they have reported concerns and received feedback from their managers and from other agencies when action had been taken.

Separate to the safeguarding policy, a Female Genital Mutilation policy set out the roles and responsibilities of staff working at the trust. The policy stated that all staff should receive training in female genital mutilation as part of trust induction as well as a web based e-learning module which staff had completed.

Staff knew about the identification of patients at risk of female genital mutilation. They described escalation processes, including referral to support teams both within the hospital and in the wider community.

Cleanliness, infection control and hygiene

Staff ensured they decontaminated their hands before and after every episode of direct patient contact or care. This was in line with The National Institute for Health and Care Excellence Quality Standard 61 Statement Three for hand decontamination. Hand hygiene audits between July 2016 and February 2018 for outpatients staff had a 96% compliance rate for nurses, a 92% compliance rate for medical staff and a 95% compliance rate for healthcare assistants. During the inspection we observed all staff appropriately washing their hands before and after all patient contact.

Matron-led audits for infection control had positive results. Matrons assessed clinic areas each month to ensure they displayed hand hygiene posters, check alcohol gel availability, and assess the environment. Between July 2016 and February 2018, the audit identified appropriate posters and alcohol gel in every clinic room. However, it also identified toilets were not always clean and odour-free, and that some couches and chairs were not clean. This was escalated to the domestic teams who raised awareness for the importance of effective cleaning.

All outpatients departments were visibly clean and tidy in all of the areas we visited. Chairs were clean and toilets were clean. We also found that cleaning sheets were completed in accordance with the trust policy to identify when public areas were last cleaned.

In outpatient areas, precautions were taken to safely manage patients with communicable diseases such as flu and tuberculosis. Staff described processes that ensured that patients went

straight to a consultation room when they arrived at reception when flagged up by the GP. There were processes to clean clinic rooms immediately after use with wipes and if needed a deep clean by the cleaning team. We asked several staff about this process and found it was quick and easy to get a room cleaned and rooms were not used until this clean had taken place.

Fracture clinic

The environment in the fracture clinic did not promote cleanliness, adequate infection control and hygiene.

In the clinic there were ceramic tiles on the floor and partway up the walls with grouting in-between them. The tiles and grouting were stained and appeared dirty. This prevented effective cleaning. It did not meet the Department of Health: Health Building Note 00-10: Part A – Flooring. This stated that the floor should be sheet system or a seamless finish system.

There were retractable plugs in the ceiling which were used for sawing equipment. We witnessed dust falling from the ceiling when the plug was retracted. In another area of the clinic a ceiling tile was broken which exposed the clinic to the unclean environment above the ceiling.

There was no sterile area for staff to prepare equipment in a clean environment or for the care and treatment of wounds. This prevented them from being able to perform aseptic techniques, which increased the risk to patients acquiring infections. This was important for the care and treatment of open wounds, for example, stump care following limb amputation.

Wooden partitions between the clinic cubicles were aged and chipped, some with deep recesses. This prevented effective cleaning. There was no store room in the fracture clinic. Therefore, consumables (such as bandages) were not kept in a suitable environment to keep them clean.

We also noted there was no alcohol gel upon entry to the clinic for patients or visitors to use This increased the risk of cross contamination.

Environment and equipment

The risks around the design, maintenance and use of facilities and premises had reduced since the last inspection, although some still remained.

As identified in the report published in June 2016, the risks around visibility of patients in waiting areas still remained. The general outpatient department was arranged into corridors, with clinic rooms off the corridor. There were multiple sub-waiting areas off these corridors, which were not visible to staff. Staff did walk rounds to check on patients, but could not visibly monitor patients all the time. This increased the risk of a patient not being attended to quickly if they became unwell and were not observed.

During our last inspection it was identified that the corridors were dark and increased risks to patients living with dementia. During this inspection, the lighting had been changed which had significantly improved the light in the corridors.

The maintenance and use of equipment kept people safe. We checked different equipment throughout the outpatients departments and clinic areas and found all equipment to be in good working order. Stickers indicating the date of service were clearly visible for staff to check and all equipment we saw was within its servicing dates.

All resuscitation trolleys were checked daily and weekly. However, one resuscitation trolley in main outpatients did not have a separate weekly check list, which was inconsistent with the others checked. Staff had to indicate weekly checks on a daily checklist, which was not in line with trust policy.

Small surgical procedures were undertaken in the main outpatients unit . There was adequate ventilation and facilities available to do this. During the last inspection, a requirement notice was issued around issues with the safety of this environment. Since then, the rooms had been fully renovated and were now fit for purpose.

Dermatology had moved to a purpose-built building with appropriate facilities for minor operations. This included ventilation for dirty air in the surgical procedure rooms. However, one vent was found to be visibly dirty as it had not been cleaned effectively.

There were also facilities in the gynaecology unit to perform minor invasive treatments such as hysteroscopy, the removal of fibroids or polyps, and colposcopies.

The arrangements of managing waste and clinical specimens kept people safe. Throughout the outpatients service all sharps bins were correctly assembled, labelled and were not over filled. There were specific bins in all clinical areas to separate clinical from domestic waste. In haematology, there was a pod system available for urgent blood samples to be sent to the laboratory and a secure area to store non-urgent blood tests before collection.

Fracture clinic

The environment in the fracture clinic did not support safety. For example. due to the design of the fracture clinic there was no kitchen. Nurses were moving hot kettles through the clinic make drinks to consultants. This increased the risks of burns to patients and staff. Staff used the children's treatment room as storage for medical gasses.

We also found the clinic the area was cold and draughty. One patient had their hood up because they were cold in the waiting area. Staff said they regularly had to get blankets for patients because of the cold.

The automatic doors to the waiting area were opened by patients getting water from a drinking fountain within the department. This increased the flow of cold air coming in.

There were insufficient chairs in both number and type for all patients expected at the fracture clinic. Wheelchairs were difficult to accommodate.

Assessing and responding to patient risk

Patient risk assessments were comprehensive and were in line with national guidance.

Of the 12 sets of patient records we looked at, we found recognition of mental health needs and additional support needed as part of risks assessments. Staff described having good access to a mental health liaison team who were able to attend patients' appointments if staff asked. This allowed the staff to provide a safer service to patients living with mental health conditions.

All reception staff knew what to do if a patient's health deteriorated in the waiting area. They said they would call for a nurse or phone for the emergency response team. Staff were able to give examples of having done this and described how they were fully supported by the nursing staff.

All staff we spoke with knew where the nearest resuscitation trolley was and knew whose responsibility it was to get the trolley in an emergency. We were informed of a recent incident, which was managed well when a patient collapsed in the corridor.

Nurse staffing and Medical staffing

There were sufficient staff to operate a safe service. There were no staff vacancies in outpatients.. This ensured that staffing levels kept patients safe.

From November 2016 to October 2017, the trust reported a turnover rate of 10% for nursing staff in outpatients. This was in line with the trust target of between 10% and 14%.

From November 2016 to October 2017, the trust reported a vacancy rate of 14% for medical and dental staff in outpatients.

From November 2016 to October 2017, the trust reported a staff turnover rate of 30% for medical staff in outpatients. This exceeds the trust target of between 10% and 14%.

From November 2016 to October 2017, the trust reported a sickness rate of 2% for medical staff in outpatients. This was better than the national average of 4%.

Staff skill mix was assessed locally depending on the clinical need, taking in account staff competencies.

Records

All records were accurate, complete, readable and up to date. The trust used part paper and part electronic record systems. During the inspection we looked in 12 patient records and found them to be managed in a way that kept patients safe.

The trust used a flagging system to identify patients with pre-exiting mental health conditions, learning disabilities, autism diagnosis or dementia flagged by GP's. Staff had to click and acknowledge they had read the additional comments before they could proceed. This system was designed so that staff should know patient's additional needs.

In the records we checked, information about mental health needs, learning disability needs and dementia needs were recorded alongside physical health needs.

Patient records took account of patients' medical and social history, which was clearly recorded. There was also documentation of patient information, next of kin and clear information if the patient had carers. Multidisciplinary team involvement was fully recorded and rationale for clinical decisions was clearly described.

Systems and processes meant that medical records were made available for clinics. We spoke to staff about availability of records. Staff commented that there was not an issue about getting medical records and processes to acquire records worked effectively.

Similarly to the last inspection, medical records ran a seven day, 24 hour service, from their on-site medical records library. Outpatient clinics asked for notes one week before the clinic date, and they were prepared for the clinic the day before. The cut-off for requesting notes in the acute hospital was 2pm the day before the clinic. After this time, staff emailed or called through to the service desk in the medical records library, or spoke directly to the team leader in clinic if notes were required.

Notes were regularly audited by the trust. Notes audits assessed against various standards including completion, the use of temporary folders, and the use of unique patient identifiers. We reviewed records audits completed by the trust. We found that in outpatients they were 97% compliant, which was considered as a pass by the trust.

Medicines

All medicines we checked were stored safely and securely. This included medical gases. We checked medicines fridges and found temperatures were appropriately checked and recorded in line with trust policy. Staff spoke to pharmacy if the temperatures were outside the permitted range. We found there were timely actions. This was an improvement since the last inspection report, published in June 2016.

Medicines were checked appropriately in line with the trusts medicines policy by nursing staff. Records of this were stored inside the locked medicine cabinets for ease of access and for staff to gain quick assurance they had been checked and were safe to use. However, weekly checks, which should be conducted by managers as stated in the trusts policy, were not done.

Medicine audits identified some areas of non-compliance (such as security of treatment rooms), there were no actions or follow up processes identified to show improvement. We received the results from three audits completed in June 2017 for the ear, nose and throat clinic, and fracture clinic and from July 2017 for urology outpatients. Despite this there were no concerns found during our inspection.

The ophthalmology service had information guides for patients about medicines, such as eye drops. These leaflets described how to take medicines, the purpose of the medicines being prescribed, and which side effects to look out for. These were available in different languages and in large print where needed.

There was an outpatient pharmacy in the main outpatient area. This meant that patients could quickly get prescriptions during their attendance at the hospital.

NHS prescription forms (known as FP10's) were securely locked away when not in use. When a prescription pad was needed, it was signed for and returned at the end of the clinic to ensure all prescription pads were accounted for. We checked these records and found no prescription pads missing. In oncology, there was an electronic prescription system.

Staff had access to the British National Formulary online, a United Kingdom pharmaceutical reference book.

Incidents

Staff had a good understanding of incidents and felt confident to report them. They all understood their responsibility to raise concerns, report patient safety incidents and near misses. We saw evidence incidents had been investigated and learning identified.

There was a low threshold for reporting incidents which indicated a positive reporting culture. Staff described how they would report faults on scales or a doctor arriving 10 minutes late to a clinic as an incident.

Safety briefings were held daily between the nurses and the outpatient managers to discuss feedback from incidents. Staff said these were effective and ensured they received the most important information for them to perform their role.

Incident reports were reviewed by the management team in outpatients and were investigated if needed. Support was provided by the trusts clinical governance team. All relevant staff, services, and partner organisations were involved in reviews and investigations. Managers discussed themes from incidents reported, and actions taken to improve patient safety and quality. One example related to notes preparation. Staff attended a training session to improve their understanding of notes preparation.

Although the managers in the main outpatients department had a good and clear understanding of risks and themes from incident analysis they were involved in, they were not provided with information specific to their area. When themes were discussed they were based on hospital-wide themes rather than outpatient specific and may not have been relevant.

<u>Never events</u>

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for outpatients.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, from December 2016 to November 2017, the trust reported no serious incidents in outpatients which met the reporting criteria set by NHS England.

Is the service effective?

Evidence-based care and treatment

Care, treatment and support were delivered in line with legislation, standards and evidence based guidelines throughout the outpatient service. Some examples of these included:

- In the multiple sclerosis clinic, all patients were seen by a specialist nurse within six weeks of referral which was in line with National Institute for Health and Care Excellence standards. This was embedded by ensuring that the consultant and the specialist nurse held joint clinics as soon as a patient was identified.
- In dermatology, there was evidence of adherence to best practice guidelines and National Institute for Health and Care Excellence standards. We also found forms and protocols in line with guidance from the British Association of Dermatology.
- Radiotherapy was delivered in line and nationally agreed best practice. This included the use of adaptive radiotherapy such as image guided radiotherapy. The radiotherapy department was the only one in Devon and Cornwall that provided image guided radiotherapy for urological cancers.
- The radiotherapy department was an early adopter of the shortened treatment regime for radical prostatectomy patients. The department was involved in several national clinical trials to develop best practice. This had included reducing treatment to 27 sessions over five and a half weeks. Traditionally these patients would have received 37 daily treatments over seven and a half weeks.

Nutrition and hydration

If patients were waiting a long time in clinic there were processes to ensure they were given a snack box. These contained a sandwich, cake, crisps and a drink and were mostly used for one-stop-clinics where patients may be in the department for several hours.

Staff discussed how they would refer to a doctor if a patient presented with a nutrition or hydration concern or issue.

Pain relief

Patients were not routinely assessed for pain in outpatients, as this was not generally a clinical risk. However, staff discussed simple oral analgesia with patients and its use at home, and gave advice about when to seek further support.

In dermatology, a pain tool was used that allowed staff to watch for non-verbal signals from patients who could not communicate effectively regarding pain.

Patient outcomes

There were no routine outcomes collected in outpatients as many outcomes assessed the surgical and medical elements of the patient's treatment.

Outcomes were collected in physiotherapy. Patients were assessed at every visit to the physiotherapy department to map progress against desired outcomes of treatment. Patients were also asked to keep a diary to show their GPs and other physiotherapists how much progress has been made.

There were specific lower limb, hip and knee and shoulder group scores developed by the physiotherapy pain management team. These were used to measure progress and appropriateness of a referral indicator for surgery.

Outcomes in physiotherapy were audited every six months against best practice. This was assessed by the trust and the Chartered Society of Physiotherapists against best practice guidelines.

Records of these audits were assessed to see how effective and efficient patient pathways were and used them to develop the service.

There were positive outcomes for patients receiving hydrotherapy. A pre and post questionnaire was completed by patients to identify their mobility after a course of treatment. This was in line with best practice guidelines.

In dermatology, patient outcomes were completed for every patient. New patients were asked to complete a survey regarding lifestyle and the preferred outcome from treatment. This would then be used to assess improvements and initiate discharge if outcomes were achieved.

Competent staff

From November 2016 to October 2017, 79% of staff within outpatients at the trust had received an appraisal compared to a trust target of 90%. This meant not all staff had the opportunity to discuss their performance, development or progression at least every year.

A split by staff group can be seen in the table below:

Staff Group	Number of staff appraised – November 2016 to October 2017	Individuals required - November 2016 - October 2017	Appraisal rate (%)
Qualified Healthcare Scientists	21	21	100%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	25	26	96%
Support to doctors and nursing staff	64	73	88%
Support to ST&T staff	7	9	78%
Qualified Allied Health Professionals (Qualified AHPs)	125	169	74%
Qualified nursing & health visiting staff (Qualified nurses)	93	132	70%

In dermatology, staff were trained and assessed against a competency framework. This included various additional courses to allow staff to perform specialist roles.

Nursing Revalidation

Despite not meeting appraisal targets for nursing staff, during the course of 2016/17, all nurses working in outpatients submitted their revalidation successfully.

Revalidation is a process introduced in April 2016 by the Nursing and Midwifery Council to demonstrate nurses are compliant to the nursing code. All nurses need to revalidate every three years.

Managers in the main outpatients department supported staff to revalidate by introducing training sessions and group sessions to develop reflective practice and working.

Supporting students

Students were appropriately supported in the outpatients service. Some staff had undertaken a student mentorship role as a post-graduate course in a university. This allowed them to support students and ensure they gained the appropriate competencies to complete their placements. A student described how they could spend a lot of time with the patients to build their communication skills. They said that staff spent more time with them than they had expected, which gave them the confidence to develop and be involved in more direct care with patients.

Multidisciplinary working

All essential staff, including those in different teams, services and organisations were involved in the planning and delivery of care and treatment. For example:

- In the multiple sclerosis clinic, the specialist nurse described how they worked with other teams such as physiotherapists, neuro-psychology and clinical psychology to manage patients' wellbeing when living with the diagnosis and symptoms. They also gave examples of how they worked with GPs and the anxiety and depression service with another trust to manage patients' depression.
- In physiotherapy, staff worked closely with orthopaedic consultants, podiatry, hydrotherapy and pain management teams to discuss patients' outcomes and pathways. All these specialities attended an orthopaedic clinic to give a multidisciplinary approach to decision making.
- In dermatology, there were multidisciplinary team meetings held between clinical nurse specialists and oncologists to manage care effectively.

In many clinics, staff worked with other hospitals to deliver 'joined up care' for patients. This included in the multiple sclerosis clinic, where there were weekly multidisciplinary team meetings held to discuss complex cases and to share best practice.

Seven-day services

Some clinics were conducted at weekends based upon capacity and demand needs. These were done on an ad-hoc basis and were staff by bank nurses.

Chemotherapy was delivered six days a week with the support from specialist nurses on wards.

The physiotherapy department performed a survey for patients to assess when they would like to attend a clinic. They found that having Saturday and Sunday clinics were not popular so provided a five-day service only.

In radiotherapy, patients were booked before and after traditional clinic times if there was a clinical need to do so. There was a service level agreement that emergency patients (such as a patient

with a spinal cord compression) who required treatment out of hours and at weekends would be transported to another acute trust with appropriate facilities.

Health promotion

There was a wellbeing service available to patients, which was provided by the trust. Patients referred to this service were given advice and support to stop smoking, lose weight, be more active, drink less alcohol, and to manage lifestyle changes.

Patients were encouraged to visit the trusts *Healthy Lifestyles* website, which identified various support groups and regimes to aid patients in living healthier lives. For example, there were links to the NHS 12-week weight loss plan, a NHS calorie checker and body mass index checker. For the management of type two diabetes, a mobile phone application was available for patients to download and use.

There was a team of staff who could be contacted to provide additional support and advise health coaching programmes.

The trust had developed a programmed called Help Overcoming Problems Effectively (HOPE). This was to help local people struggling with long-term health conditions to build self-confidence and learn how to manage their conditions better.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff discussed with inspectors how they would support patients experiencing mental ill health and those who lacked the mental capacity to make decisions about their care. Staff also had a good understanding of best interest decision making. They knew how to seek advice when patients could not give valid informed consent, due to a lack of mental capacity.

There were processes to ensure that patients were appropriately assessed against the Mental Capacity Act. Doctors performed mental capacity assessments and patients were given longer appointment times. There were also several quiet waiting areas for patients to sit away from the main waiting rooms. The safeguarding and learning disability teams were sometimes called to support these assessments and agreeing decisions.

Is the service caring?

Compassionate care

All patients and those close to them described the caring and supportive attitudes of staff. A number said how staff met their expectations in such a busy working environment. One patient said “I feel we have had excellent treatment here” and another said “the staff are all calm and explain everything well.” One patient said that “the staff here are perfect.”

Staff were taking time to interact with patients in a personable, respectful and considerate way. It was clear from the laughter and chatter that reception staff made conversation with patients which had a positive impact on any anxiety. There were patients who were frequent attenders to the outpatients service and staff had taken time to build a rapport with them and their carers. We observed one member of staff asking how a patient’s holiday was and another discussing an event that had happened since their last conversation.

Patients described the interactions with doctors as positive. One patient said that the doctors always took the time to listen and allowed the patient to ask questions. Another patient said that the doctors were “all lovely and very pleasant.”

Due to the environment, privacy and dignity when speaking to reception staff could not always be maintained. For example, in ophthalmology, patients were couldn't speak to the receptionist without being overheard. Also, in fracture clinic, due to the close proximity of the reception desk and the office to the waiting area, conversations could easily be overheard.

The environment in the fracture clinic did not promote patient's confidentiality, privacy and dignity. In the main clinic there were wooden partitions between cubicles which were partly curtained. There were also large gaps above the partitions. Inspectors could hear conversations in several cubicles at once when stood in the corridor. This design was not in line with the Department of Health: Health Building Note 2 Out-patients department. On one occasion there was a child in the clinic undergoing a procedure and could hear clearly another patient shouting as they were in pain. They could also hear sawing equipment in use in another cubicle.

Due to the small size of the cubicles, staff were unable to protect patients' privacy and dignity at all times. While a patient was having a cast removed, staff were unable to sufficiently close the curtain of the cubicle. This procedure could then be seen from the waiting room. On another occasion, a patient was undergoing a procedure outside of a cubicle as there was not sufficient space within it. The casting chair (used to perform arm procedures) was in the thoroughfare of the clinic as there was not sufficient cubicle space.

The trust had a chaperone policy which was explained to patients before an intimate examination or care but this was not widely advertised to patients. There were no posters advertising this to patients. However, staff knew the requirement to offer a chaperone and knew the role the chaperone would be undertaking.

Staff adapted the care they provided based on information on patients' personal and social needs. Staff described how there was a system in the booking records that identified patient's personal, cultural and religious needs. This included ensuring that a translator or sign language interpreter may be needed, ensuring a chaperone was arranged, or booking appointment times around patients requirements and needs.

Staff adapted the care provided to manage patients who might have anxiety in a compassionate way. Staff in the phlebotomy clinic described how, for example, they would manage patients who had a fear of needles. Staff described how they had a separate room away from the rest of the clinic where they could take blood in a quiet and undisturbed environment. Staff described how they would provide support to patients and help them through the process.

The NHS Friends and Family Test results between June 2017 and August 2017 identified that 95% of patients responding would recommend the trust to someone else. This was the same percentage as between June 2016 and August 2016.

Emotional support

Staff understood the impact that a calm and supportive attitude had on patients facing a diagnosis of a life altering illnesses and diseases such as cancer. We observed how staff interacted with patients in this situation. Staff were calm and supportive to patients in the waiting area and ensured that there were no unnecessary interruptions.

There were specialist nurses available after consultations to speak with patients and to spend more time with them to help with any anxieties or questions . A patient said that staff went above and beyond to help them during this time.

Reception staff described how they managed difficult behaviour of patients. They described how they used lessons learnt in conflict resolution training to put patients at ease and ensure they were heard and supported. Staff recognised that people coming to outpatients may have just been

given bad news or were anxious about an appointment. They told us they felt equipped to support patients at these times. There were processes to ensure that if staff knew a patient was distressed because of waiting in the waiting room, they could be taken straight to a clinic room. We were given multiple examples by staff where they had supported a patient in this way and had a positive impact on the patient's wellbeing.

We saw an example of excellent emotional support in the physiotherapy service. A patient who was extremely anxious would not go into the clinic for their appointment. A member of staff went into the car park and provided support and reassurance. Due to the type of appointment the patient was attending, the physiotherapist was could complete the appointment safely and effectively in the car park and allowed the patient to go home.

In dermatology, stress balls were provided to help reduce stress for patients before and during a procedure.

Understanding and involvement of patients and those close to them

Staff were communicating to patients in a way that ensured they understood their care, treatment, condition and advice given. Several patients said that the staff always took time to ensure they understood what was going on. One example of this was in a transient ischemic attack clinic, where patients might have multiple examinations and tests completed in one day. The patients felt they were fully informed and prepared for each process as it happened. One commented, "the staff introduced themselves, explained the investigations and scans." One patient in the main outpatients department appreciated how the doctor offered them tea and coffee. They also included their carer in conversations regarding care and treatment options. Another patient discussed how the consultant explained everything clearly to both the patient and their carer. They felt the doctor "had all the time in the world for them" which they thought was good. They said they "I cannot fault the care given at all".

Within the radiotherapy department, there was a support and information radiographer. This radiographer supported patients through their treatment and had a positive impact on providing support to patients and their relatives. Patients were encouraged to attend half an hour before their appointment time to allow an assessment of a patient's welfare to be taken.

In the multiple sclerosis service, patients were supported by having a direct link to the specialist nurse to have conversations about treatment and the development of new symptoms. The specialist nurse described how they built a rapport with patients and to "pick out what they are not saying" to help them in the best way possible. An example of this was by picking up on how a carer was struggling, listening to their concerns, and discussing with the local authority to amend their package of care accordingly. The specialist nurse also described how by building that rapport with patients and carers, they could have supportive conversations for the benefit of a patient's health and wellbeing.

Is the service responsive?

Service delivery to meet the needs of local people

Services provided met the needs of the population and were fully integrated into the multi-organisational plans for integrated care. There were many initiatives and projects to reduce demand on acute services and to improve patient pathways.

Within ophthalmology, clinics had been recently restructured to improve efficiency for patients. Additionally, the introduction of 'medi-clinics' (specialist clinics led by nurses which were traditionally led by consultants) had improved efficiency.

In rheumatology, the use of 'virtual clinics' had improved clinic effectiveness. These were a consultant-led service where patients (at the time of their one year and two year reviews) would have a review of notes from GP appointments and any tests carried out. This would then lead to a patient being given a new appointment if needed, discharged from the service if appropriate, or receive a telephone consultation to review symptoms and progress further.

A programme of work called 'patient choice triage' has been proven to be effective in rheumatology. This gave patients the option to refer themselves back to the service if they needed follow-up. This programme had reduced the number of unnecessary follow up appointments and reduced the number of referrals by 14%.

In urology, a one-stop clinic has been introduced to ensure all patients had any investigations completed before to their appointment. This has made the process of having a follow-up appointment quicker for patients and improved the efficiency of the clinic.

The trust had been working with other acute hospitals and clinical commissioning groups to "balance risks across the system". The introduction of an 'advice and guidance programme' for GPs had improved capacity. GPs had the ability to contact a consultant regarding a referral before making it. The consultant could review the patient's information and make, for example, a recommendation of a referral, or a community based management plan.

Additionally to this, the trust has hosted various training sessions for GPs on pain management. This had led to a reduction in the number of referrals as GPs were given alternative strategies to manage the patient in the community. Protocols had been agreed between the trust and GPs for the local management of some ear, nose and throat conditions. This meant the trust received fewer referrals for Rhinitis (a condition which inflames the muscles of the nose) as this was being managed in the community more often.

Patients who may have traditionally needed to see a consultant for hip, knee, foot and ankle appointments had a physiotherapist before being referred to surgery. This had improved the efficiency of appointments and ensured that patients are of the best health before being referred. This has meant that only patients who needed surgery were referred to see a consultant, and others were referred to a non-surgical treatment option.

There had been changes to the pathway for patients with cancer to improve the. two-week waiting time process. For example, colorectal and urological patients, once referred to the acute service, went straight for examinations and tests, including biopsies, before seeing the consultant. This meant a faster referral for treatment. Processes had been introduced to allow audiologists to refer patients for a magnetic resonance imaging (MRI) scan before seeing the consultant to improve efficiency.

The radiotherapy department was part of the South West Peninsular group. This meant they worked jointly with other trusts to ensure a responsive service across Devon and Cornwall. There was a service level agreement to share consultants across the various hospitals to ensure patients' needs were met. There were also different treatments performed at different centres. This included head and neck treatments requiring a lead shielding (to protect certain parts of the body from harmful radiation) being arranged by Torbay and South Devon NHS Trust, but delivered by another NHS trust.

The facilities and premises were appropriate for the services that were delivered. The outpatient environments were appropriate and patient centred. There was comfortable seating, and toilet facilities available. There were separate play areas for children in otherwise adult clinics in Ophthalmology and the Fracture clinic. There was a large café in the main outpatients department with access to hot and cold food. It had sufficient tables and seating.

Staff and patients spoke about how the departments can get busy and there may be limited seating. However, we did not see overcrowding while on this inspection.

Patients said there was sufficient car parking available. There was disabled parking outside of the main outpatients area. There was a drop-off point for patient transport and relatives to bring patients to the door of the main outpatients department. Patients receiving radiotherapy or day-case chemotherapy had access to free parking for the duration of their treatment. This parking was directly outside of the oncology department. There was also free parking for patients' carers who were registered on the Devon's carers register.

The outpatients departments were clearly signposted. By the main entrance to the hospital, there were information points, volunteers and hospital maps to help patients and their relatives locate the right department.

The radiotherapy department had recently been renovated. Waiting rooms were light, airy and spacious with pictures of the local area on the wall. One patient described the pictures as "stunning." There were facilities for patients to get a drink and sufficient seating for all patients. There were suitable toilet facilities for disabled patients.

When attending for radiotherapy, patients may need to change into a gown. These changing rooms were suitable for all patients, including those with a disability.

Not all of the physiotherapy environment was suitable for patients' needs. The gym was crowded with equipment and was not ideal for patients' privacy and dignity. Staff found that as the service was becoming busier there was not enough space to see everyone sensibly.

Patient appointments were booked around times available for them. Staff discussed how appointments were flexible to suit the patient's needs. If a patient was unable to drive or get public transport to their appointment, the hospital car service (for patients who were mobile enough to get in and out of a car) and patient transport was available on request.

The outpatient service was appropriate for patients living with a disability. There were automatic doors into the main outpatient areas and access to disabled toilets. Corridors were also clear from clutter. The trust was fitted with lifts with vocal announcements and there was directional signs for visually impaired patients. In the reception areas there were lower desks to allow for better communication with patients using wheelchairs.

In the waiting room of the fracture clinic there were 51 chairs. Of these, only six were high chairs suitable for patients with hip and leg injuries. Staff said this was not enough as they regularly had over 50 patients in the waiting room with arm and leg injuries. We were told that there were regularly over 100 patients in this waiting room. There was no space within the waiting room to put a wheelchair without blocking a thoroughfare.

If a patient was waiting in the wrong area, staff would ask receptionists, who knew where to find the patient.

For haematology clinics, patients routinely had blood tests carried out before their appointment with separate waiting rooms. However, staff used systems to ensure they were knew where patients were.

The outpatient service had developed strong partnership working with other organisations in Devon. This included the introduction of joint recruitment for specialities which were struggling to recruit and developing services which provided a whole service across the south west. One example of this was for dentistry, where the nearest specialist consultant worked for another trust. To ensure patients of Torbay had access to this service, the specialist work was located at the

other trust and some other work was relocated to Torbay Hospital. This reduced waiting lists and improved specialist knowledge and experience for certain dental conditions.

Meeting people's individual needs

The service took account of patient individual needs. Staff could tell inspectors of multiple occasions where they adapted how they delivered care to meet patients' individual needs. This generally meant spending more time with the patient, having support from specialist nurses and teams, such as the mental health team from around the hospital.

When patients had a mental health condition, learning disability, dementia or autism, additional supervision and support was provided. An indicator in the patient's notes meant that staff could arrange for a chaperone or a support worker to be with them. There were also processes to ensure a room was free to minimise the amount of time the patient needed to wait, and to reduce anxiety.

The radiotherapy department had considered how to meet the needs of people with a sensory loss. For patients receiving breath-hold radiotherapy treatment (a treatment which requires the patient to hold their breath at certain points of the treatment), a light system was installed to allow the staff to communicate to the patient when to hold their breath.

The trust had access to cancer support services with staff who spent time with patients. This was to assess, maintain and promote physical, social, psychological and spiritual wellbeing to improve quality of life. This included providing information, advice on symptom control, welfare advice or emotional and spiritual guidance.

There was a cancer support and information centre which was open on a drop-in basis three times a week. It was available to all cancer patients. Staff provided an information service, benefits advice, complementary therapies (such as massage, aromatherapy and reflexology), relaxation classes, genetic advice, and wig fitting.

For patients receiving chemotherapy there was a 24-hour a day, seven days a week, telephone support service for advice regarding symptoms and side effects.

There were translation services available either through access to a face-to-face translator or through the use of a telephone service. Staff could use sign language interpreters. Information could be provided in different languages and in large print and braille.

The trust had a mental health and learning disability team who was could provide care and advice for patients living with a variety of disorders and disabilities. This included depression and anxiety, eating disorders, learning disabilities, autism, attention deficit hyperactivity disorder (ADHD) and personality disorder. The trust also provided a specialist gender identity clinic and alcohol and substance misuse support.

Patients could be referred to liaison psychiatry services. This service provided a mental health assessment, care plan advice and additional training to staff.

Staff could refer patients to the trusts Torbay Drug and Alcohol Service provided. This team could assess patients at risk of drug and alcohol abuse and provide specialist health visitor support, assessments and referral to rehabilitation, signposting and advice.

We were given an example of care which went above and beyond what was expected of staff. A patient that had no fixed abode attended a clinic for a procedure. The staff ensured they had accommodation overnight and transport to and from the hospital to the hotel.

Access and flow

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways

An incomplete pathway is where a referral has been received at the hospital and the patient 'is still waiting for something', for example an outpatient appointment.

From December 2016 to November 2017, the trusts referral to treatment time for incomplete pathways had been worse than the England NHS overall performance. The latest trust board minutes from February 2018 described that at the end of December 2017 82% of patients seen within 18 weeks.

NHS Improvement set the trust an improvement trajectory each month for the percentage of incomplete pathways seen before 18 weeks. The trust met this trajectory once between January 2017 and December 2017. A revised trajectory for delivery of referrals within the 18 week standard had been agreed across the Sustainability and Transformation Partnership (an integrated care system across the NHS and local councils) to encourage a continual reduction of the backlog.

No patients should be waiting over 52 weeks from referral. The latest board paper in February 2018 identified that there were 42 patients waiting over 52 weeks. There were plans to hold additional clinics to provide appointments for these patients. Of the patients waiting, 31 were within the upper gastro intestinal clinic and eight were within urology. One patient was identified as 'other'. There was a trajectory that all of the patients waiting over 52 weeks would be seen by March 2018.

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Eight specialties were performing better than the England average for incomplete pathways referral to treatment time. Ten specialties were performing worse than the England average.

Specialty grouping	England average	Torbay and South Devon NHS Trust
General Surgery	86%	100%
Geriatric Medicine	97%	97%
Gynaecology	91%	95%
Dermatology	92%	94%
ENT	88%	94%
Cardiothoracic Surgery	88%	94%
Oral Surgery	88%	93%
Ophthalmology	90%	93%
General Medicine	94%	93%
Gastroenterology	91%	89%
Rheumatology	94%	84%
Urology	88%	83%
Other	91%	83%
Cardiology	91%	82%
Thoracic Medicine	92%	82%
Trauma & Orthopaedics	84%	81%
Plastic Surgery	86%	79%
Neurology	89%	69%

(Source: NHS England)

Cancer waiting times

Percentage of people seen by a specialist within two weeks of an urgent GP referral (All cancers)

Not all patients requiring an urgent appointment for suspected cancer diagnosis received one in a timely way. An urgent two-week wait referral is a request from a GP for an urgent appointment as

a patient's symptoms may indicate a diagnosis of cancer. The national target is for 93% of patients being seen within two weeks.

The February 2018 board paper identified December 2017 performance data about the two week wait cancer target. In December 2017, 703 patients (76%) were within the target with 218 (24%) were seen outside of the target.

For symptomatic breast cancer patients, the number of patients seen within two weeks was slightly better. In December 2017, 72 patients (92%) were seen within the target with 6 patients (8%) being seen outside of the target.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Most patients received treatment in a timely way. Patients who receive a diagnosis of cancer should wait no longer than 31 days for their first treatment. The national target for the 31 day standard is 96%.

The February 2018 board paper identified December 2017 performance data about the 31 day cancer target. The trust performed better than the national target with 151 patients (98%) having treatment within 31 days with only three patients (2%) breaching this target.

Percentage of people waiting less than 31 days for subsequent treatment (all cancers)

Patients who have already received a definitive treatment may require further treatment. This is known as a subsequent treatment and should be delivered within 31 days. The national target for 31 day subsequent treatment is 98% for chemotherapy and 94% for radiotherapy or surgery.

The February 2018 board paper identified December 2017 performance data about the 31 day subsequent treatment cancer target. The trust performed better than the national target with 55 patients (100%) having chemotherapy within 31 days, with 44 patients (98%) having radiotherapy within 31 days, and 31 patients (100%) having a surgical procedure within 31 days.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

Patients should not wait longer than 62 days between if suspected of suffering from breast cancer and having a first definitive treatment. The national target for this is 85%.

The February 2018 board paper identified December 2017 performance data about the 62 day target. The trust was performing slightly worse than the target with 72 patients (83%) seen within the target and 15 patients (17%) in breach of this target.

Patients should not wait longer than 62 days between the commencement of a screening programme and having a first definitive treatment. The national target for this is 90%.

The February 2018 board paper identified December 2017 performance date about the 62 day target. The trust was performing better than the target with eight patients (100%) having treatment within 62 days.

Patients at risk of being lost to follow-up

The most recent guidance from NHS England was zero tolerance on the number patients who have confirmed cancer and receive treatment after 104 days. When patients reached this threshold they have an increased risk of being lost to follow-up. In December 2017, 14 patients were waiting over 104 days for treatment. A trust board paper identified that all of these patients were patients with an unconfirmed diagnosis and were being closely followed by their GPs and specialists. The trust had established a process when patients waited over 90 days. These

patients were reviewed through a multidisciplinary meeting. In February 2018, this had reduced to only two patients.

Follow up patients

There were patients waiting past their 'to be seen date' for follow up appointments. However, this had improved since the last inspection. These patients were on backlog waiting lists. Specialities with the largest backlogs are indicated in the table below.

Data as of February 2018:

Specialty grouping	Follow up number
Ophthalmology	4,871
Rheumatology	1,176
Audiology	813
Orthodontics	672
Urology	444
Colorectal	263
Orthopaedics	217
Oral surgery	214
Pain management	175
Ear, nose and throat	122
Breast	113

In January 2016 there were 9756 patients waiting past their 'to be seen' date. During this inspection there was 9080 patents waiting past their 'to be seen' date.

Staffing was the biggest factor affecting the management of follow up and new patients and meant that waiting lists were not managed as quickly as the trust would have liked. As a result, some specialities such as neurology and cardiology, have been reported to the divisional risk register for additional support.

All patients on a waiting list were reviewed by consultants to identify patients who were at risk of harm because of waiting. There had been no known serious incidents or incidents of harm for patients because of waiting longer than planned for a follow up appointment.

Actions to reduce the backlog of patients waiting were having a positive impact in some specialities. For example, in rheumatology the backlog in April 2017 was 1,650 patients compared to 1,176 in February 2018. Audiology had seen a reduction from 2,500 patients in August 2017 to 813 in February 2018. However some specialities such as ophthalmology, dermatology and cardiology had seen a gradual increase in follow up backlogs month on month.

Appointments ran on time when we were inspecting the service. Managers said that clinics rarely ran late, and when they did clinicians and service speciality managers were contacted. However, the service did not record how late services were running so could not show that this was not an issue. When clinics were running late, reception staff let patients know when they checked in. If patients were in waiting areas, staff updated patients verbally.

Did Not Attend Rates

Between October 2016 to September 2017, the 'did not attend' rate for Torbay Hospital was better than the England average. In September 2017, the England average was 7% and the trust average was 5.5%.

Learning from complaints and concerns

We spoke with five patients about the complaints process and found they all knew what they needed to do to raise a concern. All five of them said they had seen information leaflets around the

hospital called "*We want to know what you think"* regarding how to make a complaint but said they would speak to their nurse or doctor first. Staff said they would either resolve an issue as it arose or ask the patient to contact the feedback and engagement team.

There was information available for patients for making a complaint. Information was also available on the trust website. This contained information to write directly to the chief executive or to the feedback and engagement team. Leaflets contained additional information on contacting the Parliamentary Health Service Ombudsman or an advocacy service.

Complaints within outpatients were handled well. We reviewed five complaints to the outpatient service and the responses. Investigations to a complaint were thorough and final letters to patients contained a sincere apology. They were transparent and open in their response and contained an explanation of the outcome. There was clear information on what to do if the patient was not satisfied with the apology and advised referral to the Parliamentary and Health Service Ombudsman.

Where possible, learning was taken from patient complaints to drive improvement within the service. For example, changes had been made to the information given to patients for a certain medication. This improved information and guidance around potential side effects.

Is the service well-led?

Leadership

All managers were clear about their roles and understood what they were accountable for, and to whom. This was demonstrated in the level of understanding of both the acute processes for governance and how they integrated into the wider health economy.

Leaders managed the outpatient service well. Managers had the skills, knowledge, experience, and integrity to lead effectively. During interviews, managers at all levels demonstrated they fully understood the outpatient service and worked well together providing a positive and proactive relationship among peers.

Leaders understood the challenges to quality and sustainability. They could clearly and knowledgeably identify actions needed to address quality issues in all areas discussed. Service efficiency was the focus of all leaders within the outpatient service. This was encouraged and supported through the trust and the South Devon Integrated Health and Care Organisation objectives.

Leaders were visible, approachable and compassionate towards staff. All staff described how they could have open and honest conversations with managers (including with the executive team) whenever an issue arose. All managers used an open door arrangement and were available the majority of the time. Staff in the main outpatients department could describe with clarity the leadership of the service and were clear as to whom they should speak to if an issue arose.

There were clear plans to develop and ensure sustainable management of services. As an example, plans in the multiple sclerosis clinics to develop the skills of a nurse when another nurse retired were being developed. There were systems in the main outpatients department to ensure there were senior members of staff available at all times. The development of clinical nurse specialists had encouraged leadership skills and developments. It had led to improvements for services which had high patient demand to meet. This included the ophthalmology services, where nurses were being trained to increase and develop their skills to reduce the workload of consultants.

There was an immediate response by the trust when concerns surrounding the fracture clinic were raised by CQC. The trust was already aware the fracture clinic needed upgrading, but other works had been completed first as these were considered a higher priority following risk assessments. An emergency meeting was held between staff in the fracture clinic and the trust senior team two days after our inspection. The existing plans to relocate the fracture clinic to a temporary building while they refurbished the existing clinic were revisited, and an action plan was provided to CQC. We saw meeting minutes from this discussion and plans for redesign and a timescale for construction with a temporary building. This was initially planned to be in operation four weeks after the inspection and the refurbishment to be completed three months after the inspection. However, the trust subsequently completed a further review of the environment and agreed to include further works to improve the environment. Work was planned to start at the end of April 2018 for a 16-week period.

Vision and strategy

Staff knew the trusts vision and values. The trust had a clear vision and set of values which were available on the website. The trusts values (respect and dignity, commitment to quality of care, compassion, improving lives, working together for people and everyone counts) were displayed throughout all outpatient services. Staff could clearly define the values of the organisation and spoke about compassionate care to patients as their top priority. Staff felt more proud that they could deliver on this value than any of the others. Senior staff were most proud of being able to see this care being delivered in sometimes difficult, circumstances and challenges.

Quality and sustainability was the top strategic priority within the outpatient service and was developed in line with the South Devon Integrated Health and Care Organisation strategy. These were the top priorities of the corporate objectives which influenced the direction in the outpatient service.

Senior staff understood the strategy for outpatient services and their role in achieving it. Plans were stretching, challenging and innovative while remaining achievable. Senior staff could give examples where they had developed services in line with the South Devon Integrated Health and Care Organisation strategy to ensure improve efficiency and to redesign services into the community.

There were multiple projects ongoing which were fully aligned with the trust's strategy. This included multiple projects to improve risk management of patients waiting for an appointment and working differently within clinics to make them more efficient. The use of virtual clinics, access to advice and guidance services, and patient initiated contact were in line with the area's model of care. Managers described how they were using the wellbeing centres in the community to run clinics and services away from the acute trust. Staff discussed how they were keen to improve services and try different things to ensure that they could manage demand and manage patients in the most appropriate environment. One service was the transient ischaemic attack service for suspected-stroke management. Staff described a clear one-stop-shop pathway to ensure patients were seen and managed quickly.

Progress on projects was reviewed and managed through an outpatient programme board. This reviewed and evaluated efficiencies within specialities and sub-specialities. We were given examples of analysis and evaluation of the efficiency of services in socially deprived areas of Torbay. This had led to changes to process for patients assessed at risk of requiring further support and guidance.

Staff recognised how the strategic plans aligned with the wider health and social care economy to ensure they met the needs of the relevant population. This included working with other

organisations to ensure progress was being made. Staff could give examples where some clinics, which were traditionally held in hospital, had moved into a community setting. Also where patients could attend multiple services (such as GPs and nurses) to meet their needs more efficiently.

Projects and business plans aligned with the service strategy which were ongoing during the last inspection had been completed. The clinic areas in ophthalmology had been extended to provide more clinics. During the last inspection, published in June 2016, there was a business plan developed to relocate all dermatology services to the John Parkes unit. This plan had now been completed and staff were satisfied with the new building.

Culture

All staff felt supported, respected and valued by their peers and managers. Staff described how they could discuss concerns with members of staff without fear of retribution. Some staff spoke about how they had challenged their peers on practice, and had seen and found a positive improvement as a result. All staff discussed a culture centred on patients, their relatives and carers. Everyone discussed the importance to them of good quality care. They spoke highly about being supported to take time with patients and not feeling pressured by a busy clinic.

Staff were proud to work for the organisation. They spoke about the positive working culture within outpatients and that “everyone helps each other out.” Some described the organisation as a “family” and said this had a positive impact on their wellbeing and job satisfaction. Senior staff discussed with inspectors how they addressed behaviours and performance that was inconsistent with the trusts vision and values. This was described as a supportive process rather than being punitive.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. The trust had sufficient processes to follow the duty of candour. Senior staff understood the trusts policy although it had yet to be used with the outpatients service. Nevertheless, staff described how the patient and their families would be involved with any investigation into a serious incident, as well as receiving a formal apology.

Governance

There were clear processes in the main outpatients department to escalate concerns and share information. The managers within outpatients attended senior staff meetings, which went on to raise any concerns upwards to the divisional lead. The divisional leads escalated to various sub-boards and to the trust board for the highest risks, such as capacity and demand management. Referral to treatment times’ statistics were represented on the board assurance framework and discussed at trust board on a monthly basis. Outpatients were represented widely through board papers on financial performance and targets set by the local clinical commissioning group.

Governance meetings discussed and reviewed services for complaints, concerns raised, audits, investigations ongoing and learning from incidents. They identified how learning was shared amongst the different services and between clinicians.

The trust had an outpatient risk register which was comprehensive and managed well. The top four risks were all about managing demand within the service (for cardiology, pain service, plastics, and ear, nose and throat) and clearly identified controls, gaps, and progress on actions including:

- For cardiology, there were clear actions ongoing such as the reviewing outpatient appointments to maximise capacity. Business cases were in progress to increase the consultant staffing within interventional radiology to further increase capacity in the service. This risk was also included in the trust-wide risk register.
- For the pain service, there were clear actions for obtaining additional consultant time to manage the backlog in the service. Pathways were being evaluated to look at how to reduce the number of acute referrals and working with GPs to manage pain locally rather than through hospital appointments or admission. The referral to treatment times were being closely monitored as part of this and plans were being made for a Sustainability and Transformation Partnership plan for the management of pain in the wider community.
- For the plastics service, actions had been taken to reduce the waiting list. The trust worked with another acute NHS trust to share services between the providers. This included patients on a two-week pathway immediately being referred to the other acute trust rather than Torbay to manage referral to treatment times where they could easily access emergency treatment.
- For the ear nose and throat service, there were actions taken to focus the management of consultant time to on the riskiest areas.

Performance on referral to treatment times, and backlogs for appointments was reviewed monthly at the trust board. Additionally all referral to treatment delivery plans were reviewed at a bi-weekly *referral to treatment time and diagnostics assurance* meeting chaired by the deputy chief operating officer and with the clinical commissioning group commissioning lead in attendance. The management of the backlog of patients waiting for an outpatient appointment was monitored and managed through the *referral to treatment time risk and assurance* group. The trusts quality assurance group maintained oversight of clinical risk associated with this and provided senior support and guidance where required.

The management of the outpatient backlog was comprehensive. There was a risk register which risk assessed backlogs and the risks of harm to patients. Ophthalmology, with the highest number of patients, was deemed as the service with the highest risk. Actions to manage the risk included detailed and regular monitoring of the patients in the backlog and the management of staff recruitment. For rheumatology, the introduction of additional patient pathways and nurse led virtual clinics had reduced the backlog.

Not all patient records or information were being stored to protect their confidentiality and security.

In some outpatient areas, such as ophthalmology and the fracture clinic, there were paper records stored on shelves, which were in public areas and at risk of being removed or seen without authorisation. The storage was intended to allow staff to have easy access to records, but it was not secure. In ophthalmology, these shelves were in the waiting area itself increasing the risk further. However, in other areas, where records trolleys were in use, they were locked and secure.

<u>Fracture clinic</u>

Governance processes in the fracture clinic did not sufficiently lessen the risks to patients. We reviewed monthly infection control audits between May 2016 and January 2018. None of these audits identified the flooring or the lack of a sterile work area as a risk. We received a copy of the latest infection prevention audit action plan produced in 2015 which identified non-compliance of floors, hand basins, clutter, damaged walls and woodwork. Actions such as the replacement of floors had been identified as completed when they had not. Other actions, such as handwashing basin risks, had no action taken.

We asked the trust to provide evidence of risk management surrounding the fracture clinic and found this was not sufficient. There was only one risk entry related to the lack of a clean environment to prepare sterile equipment. This item was added to the risk register in November 2016 and although meetings had been held there were no actions identified to address this.

Senior managers were unable to provide assurance that the risks in the fracture clinic were being appropriately managed. However, they could describe the concerns and discussed how they knew of them for several years. They discussed how the biggest issue to getting changes made was finance and told us there was an estates priority list but the fracture clinic had never made it to the top.

Engagement

Staff meetings were held in the specialities and in the main outpatients department to ensure that points of view were gathered and, where it was right to do so, acted upon. Most staff said that these were a positive open forum and encouraged team working. Most staff said they felt they would be listened to. Additionally to staff meetings, weekly newsletters were sent to staff with learning from incidents, governance updates, and changes to training and best practice.

The service was engaging positively with staff on the development of the Sustainability and Transformation Partnership. The trust held Sustainability and Transformation Partnership workshops with the staff at Torbay Hospital (to which 90 staff attended each of the three workshops) to develop pathways and systems working between the acute hospital, community and wider healthcare system. This led to the development of refined referrals for surgery which increased efficiency and consultant capacity.

Senior leaders were unable to describe comprehensively how patients were involved in the development of the service. The outpatient service had an active patient participation group involved with the roll-out of projects and changes to patient pathways. However, when asked leaders could describe how these had influenced or changed services. Other than the use of NHS Friends and Family Tests, outpatient specific surveys were not in use. However, there was engagement with GP services when developing pathways and services further as they were involved as part of the Devon Integrated Health and Care Organisation structure.

Learning, continuous improvement and innovation

Managers described various effective ways they worked with specialities to encourage continuous improvement and innovation. Healthy competition was encouraged to promote a shared learning environment between services and specialities to improve efficiency. Staff described discussions and workshops with consultants and teams to improve their services and helped with resources to allow them to proceed.

There were multiple examples of innovation which were as a result of a culture focused on improvement. This included:

- In endocrinology, the trust was piloting the use of video conferencing to reduce the need for patients to attend hospital. This was successfully rolled out in the Parkinson’s clinics.
- In dermatology, the service had developed a one stop multidisciplinary clinic to avoid patients attending on several different days. They had also developed group sessions for patient with hyperhidrosis (a disorder which produces excessive sweating). This reduced the demand on clinic time and provided a forum for patients in which to network with each other.

- In respiratory and neurology clinics, pharmaceutical companies had been involved with providing support for patients with long term conditions. Also, the introduction of a virtual 'nodule clinic' for patients with incidental findings following a computed tomography scan had been introduced. This meant the patient did not need to attend a clinic appointment.
- A Movement Disorder hub with consultants, nurses, physiotherapists, speech and language therapists and volunteers worked together as a one-stop clinic for patients. One Wednesday in each month, the trust has a 'newly diagnosed clinic' to provide information and support to this group of patients.

Community health services

Community health services for children, young people and families

Facts and data about this service

Torbay and South Devon NHS Foundation Trust provides community health services for babies, children, young people and their families in their homes, in GP surgeries, community clinics, children's centres, schools within Torbay and in the child development centre the John Parkes Unit at Torbay Hospital. These services include health visiting, school nursing, community children's nurses, therapy services, services for 'looked after' children, children with a learning disability and sexual health services.

The health visiting and school nursing service is a workforce of Specialist Community Public Health Nurses (SCPHN) who provide expert advice, support and interventions for families and young people from the antenatal period through to 19 years of age. The service is led by qualified health visitors and school nurses, supported by a mixed skill team, and works closely with partner agencies. The service is central to delivering the full Healthy Child Programme and improving public health outcomes.

Torbay's health visiting service is family-focused with a strength based approach. A Family Health Needs Assessment is completed in partnership with family or carers, and a level of service is agreed. Service levels include Communities Offer, Universal Offer, Universal Plus Offer or Universal Partnership Plus. Torbay's school nursing team has two main key responsibilities: To assess, promote and protect the health and well-being of children and young people, and to offer confidential advice, care and support on an individual or group basis.

Details of the locations at the trust that offer community services for children are below.

Location site name	Team/ward/satellite name
Brixham Community Hospital Greenswood Road Brixham TQ5 9PT	Child Health Development, Child Health Drop-in Clinic and School Nurses
Totnes Community Hospital Coronation Road Totnes Devon TQ9 5GH	Children's and Adolescent Services
Newton Abbot Community Hospital West Golds Road Jetty Marsh Newton Abbot Devon TQ12 2TS	Children's and Adolescent Services

At our last inspection in February 2016 we rated the three domains of safe, responsive and well-led as requires improvement. Effective and caring were both rated as good.

Our inspection was short-notice announced. The trust were given two weeks' notice of our inspection of community services.

Before the inspection visit, we reviewed information we held about children's community services and information requested from the trust.

During the inspection visit:

- We visited clinics, the children's assessment centre, staff offices and accompanied professionals on visits to children and families in the community.
- We spoke with 38 staff, including health visitors, school nurses, community nurses, nursery nurses, therapists, reception staff, support workers and senior managers.
- We spoke with the managers and service leads from the health visiting service and school nursing service, the speech and language therapy service, the occupational therapy service and the manager and staff from the sexual health medicine service.
- We attended handover and multidisciplinary meetings.
- We spoke with four parents and two children.
- We looked at 10 sets of patient records.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Within the services we visited most staff were up to date with their required mandatory training. Staff explained how they managed their updates and that reminders were provided, if necessary, by their managers during supervision meetings.

The trust set a target of 85% for completion of mandatory training, apart from the information governance module which had a target of 95%. A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff within community services for children is below. This does not include non-nursing staff.

Name of course	Number of staff trained	Number of eligible staff	Completion rate (%)	Target (%)	Target met (Yes/No)
Equality, Diversity and Human Rights - 3 Years	74	86	86%	85%	Yes
Moving and Handling	73	88	83%	85%	No
Conflict Resolution	69	86	80%	85%	No
Health and Safety - 3 Years	69	86	80%	85%	No
Fire Safety - 1 Year	67	86	78%	85%	No
Infection Control	66	86	77%	85%	No

Information Governance - 1 Year	62	86	72%	95%	No
Prevent WRAP - No Renewal	74	80	93%	No target	N/A
Resuscitation - Paediatric Basic Life Support - 1 Year	72	81	89%	No target	N/A
Resuscitation - 1 Year	69	81	85%	No target	N/A

The only training module meeting the trust training target was Equality, Diversity and Human Rights - 3 Years.

(Source: Trust Provider Information Request P14)

Safeguarding

There were arrangements in place to safeguard children from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and were aware of the provider's policies and procedures. The provider had a safeguarding policy which applied to all strands of their services, which meant there was a consistent approach to how safeguarding concerns were dealt with.

Staff were completing safeguarding training and the required updates. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The vast majority of staff within the services we inspected were up to date with their safeguarding training. Since the previous inspection a new supervision framework for safeguarding had been introduced. The trust were using a methodology called Signs of Safety. This practice is used to identify children in need and provide early help by identifying risks around poor parenting skills. Staff were positive about this approach. We observed a visit where we saw the health visitor demonstrating their understanding of the practice. We saw a concern was escalated as part of the process, therefore helping to ensure a child was protected. The support needed was identified and the process put into place to access this. All details were clearly recorded in the patient's records.

The named nurse for safeguarding, who had been responsible for implementing the new methodology and providing training and support for staff, was co-located within the looked after children team. This ensured good communication and a consistent approach with the various teams they came into contact with. Staff we spoke with were very positive about the support, advice and proactive approach of the safeguarding staff.

Staff were receiving training at the appropriate level and frequency. All clinical staff completed level three safeguarding children training. Service leads stated they audited safeguarding training attendance and were working to ensure it met with trust targets.

Information about safeguarding procedures was clearly displayed in staff offices, meaning staff were always aware of who to contact for information, guidance or support.

Safeguarding training was included on the corporate induction for all trust staff and was delivered by the service leads. This ensured all new starters were aware of the trust's commitment to the safeguarding process.

Safeguarding was regularly discussed at team meetings and learning from individual cases and concerns could be discussed. Staff we spoke with showed awareness and consideration of the issues around female genital mutilation (FGM). There was good understanding of child sexual exploitation (CSE) risks. Staff received training on these areas and also on domestic abuse.

The trust encouraged staff to share safeguarding lessons within their team and the wider service. The sexual health team met with another NHS provider to discuss safeguarding issues and preventative working measures. They also attended a 'missing and child sexual exploitation' meeting, which was a multi-agency meeting where information about vulnerable people was shared within a confidential arena.

The safeguarding team provided good support to staff across children's community services through training, supervision and monitoring of incidents. Staff reported the safeguarding lead was visible and accessible.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April to October 2017 for nursing staff within community services for children is below. This does not include non-nursing staff:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate (%)	Trust Target (%)	Met (Yes/No)
Safeguarding Children Level 1	84	86	98%	90%	Yes
Safeguarding Adults Level 1	83	86	97%	90%	Yes
Safeguarding Children Level 2	81	86	94%	90%	Yes
Safeguarding Children Level 3	66	79	84%	90%	No
Safeguarding Adults Level 2	67	87	77%	90%	No

(Source: Trust Provider Information Request P18)

However, during the inspection we saw evidence children's services were now meeting the trust target during the final quarter of the year.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines for how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.

The below figures are for Torbay only, as Devon were unable to breakdown their information to fit in with our request:

Referrals		
Adults	**Children**	**Total referrals**
261	747	1,008

(Source: Routine Provider Information Request (RPIR) – P12 Safeguarding referrals)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and premises clean. However, in one of the children's drop-in clinics we found the spillage kit was not readily available within the room, and would need to be accessed from elsewhere in the building. This would increase the risk of infection due to the potential delay in cleaning up any infected waste.

There were clear protocols for staff to follow for cleaning premises and equipment. We observed staff wearing appropriate clothing and following infection control protocols, for example when entering or leaving clinic areas.

Locations and clinics we visited were visibly clean and well maintained. We saw two cleaning record schedules and two cleaning audits. The records showed no missed dates for the previous three months, and both audits recorded all cleaning had been completed satisfactorily. We observed staff following infection control guidance, and observing the trust infection control policies.

Environment and equipment

The service had premises of varying standards of upkeep. The premises at Newton Abbot Community Hospital were modern and up-to-date, whereas community children's nurses worked from a portable cabin office, accessible up a steep flight of external stairs without any lift facility. Staff with any physical disability, or ailment, would struggle to access this facility.

There was an improvement in the availability of computers and desk space compared to our previous inspection. Staff reported positively on this. However, there still remained a problem with accessing and typing up of records remotely whilst out on home visits, due to internet connectivity and firewall issues.

The sexual health team had achieved Young People Friendly accreditation for three of its health centre clinics.

Assessing and responding to patient risk

Risk assessments were completed as part of the assessment process for children receiving a service. This included the home environment and any associated risks depending on the service being delivered. There were mechanisms in place to identify patients at risk. Details were recorded in patients' records, which all staff had access to. For example, we saw an assessment completed by the nursery nurse staff. This was in respect of a child who was to attend the child development centre for a full assessment over several sessions. The staff visited the child and family at home and completed an initial detailed assessment that included potential risks.

The healthy child programme implemented by the health visiting service identified the children, young people and families according to their level of need. The level of service used depended on need and the risk of harm. Alerts could be recorded to indicate specific risks. There were pathways for staff to use when risks were identified.

Reviews were completed regularly on children who were under the trust's care, but placed outside of the local area. The reviews took into account what care and treatment they were receiving and if there were any risks associated with their placement.

Emergency equipment was available within the clinic areas to enable staff to respond to patients who became unwell. Staff told us they would call for an ambulance for an acutely unwell patient.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust reported an overall vacancy rate of 4.4% for nursing staff in community services for children over the period Nov 2016 to Oct 2017.

Staff reported manageable caseloads. Staff generally managed absences and holidays within teams. Bank and agency staff were used as a last resort. Staff were able to take back extra hours worked in agreement with their manager.

The school nursing service had changed to a system of corporate caseloads. This is where caseloads are joined across the team, with a view to prioritising all the work and sharing it out evenly among staff. Staff were positive about this change and said it helped them manage their workload more efficiently.

Service leads reported employing new staff at band five and health care assistant level to improve the staffing mix of teams. Service leads also reported the level of administration support had improved since our previous inspection. The administration team had been moved into a central team, rather than situated with individual teams. This provided greater efficiency and support.

From November 2016 to October 2017, the trust reported an overall sickness rate of 5.5% for nursing staff in community services for children. This was worse than the trust target of 3.8%.

The trust reported an overall turnover rate of 10.2% for nursing staff in community services for children. This met the trust target of 10-14%.

Quality of records

Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. However, we found there were potential risks due to different services using different recording systems. Overall, we found significant improvements had been made since our previous inspection. Action was being taken to address identified shortfalls and records were being regularly audited. These showed that improvements were being made as the new systems were being implemented. Staff were aware of potential difficulties and were proactive in improving recording.

Services kept electronic records, with the exception of the community nursing team, the speech and language therapy team, the learning disability team, children's occupational therapy and children's physiotherapy, which kept paper records. This was an improvement since our previous inspection where concerns had been raised because individual services were using a mix of electronic and paper record systems. The electronic record system had been introduced in March 2017. Staff were provided with three days' training and ongoing support from a team of IT 'floor walkers', who were available for a period of time to provide guidance for staff. Issues were logged systematically and learning was identified and shared.

We were concerned about the potential risks due to the community nursing teams not accessing the electronic recording system used by the school nursing and health visiting teams. There was

no regular formal communication, or handover, between the community nursing team and the school nursing team. There was a possibility a child in mainstream education could have a social health plan in place and a school nurse may be asked for advice on the pupil because of an issue. However, they may be unaware of the background information as this had not been shared. This was a potential barrier to joined-up care for the individual child.

Two different electronic record keeping systems were used across children's services. The sexual health team used an electronic record keeping system that was different to the system used by the rest of the service. The sexual health team stated the electronic system they used was better proven to deal with safeguarding issues.

The community nursing team had a system which kept written safeguarding notes separate from the patient's file. Team members and any relevant health worker accessing the file would identify the patient had safeguarding concerns by a sticker on the first page of the file. This was evidenced in both files sampled.

Staff from the speech and language therapy team reported the paper recording system was a worry, as they did not feel linked in to other services.

Medicines

The service prescribed, gave, recorded and stored medicines well. Medicines were being prescribed safely and the required records were being completed. We saw the correct information was being recorded into the patient record. We looked at a sample of three records where medicines were recorded, and this was all done correctly.

The diabetes service had a PGD (patient group direction) in place that allowed for changes in insulin for a patient of up to 10%. Staff reported consultants were accessible within 24 hours if more than a 10% adjustment was required. If there were any changes in the type of insulin prescribed, this had to be approved by a consultant.

The sexual health team also used a PGD. Members of staff were in the process of being trained and attending the non-medical prescribing course.

We saw checks on various medicines were completed and batch numbers and expiry dates were logged at the locations staff were working from.

Incident reporting, learning and improvement

Staff were aware of how to use the trust's incident reporting system. This was an online incident reporting system. All staff had the necessary access to record incidents and said they felt able and comfortable to submit incidents to the system. There was good awareness of the processes for incident reporting among children's services staff across all services and localities.

Staff shared lessons learned with the whole team. Staff explained how learning from incidents, outside of their immediate areas, was shared through staff meetings and trust bulletins.

Staff described how learning from a serious case review had been shared through the service.

Duty of Candour

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had a policy in place in respect of this regulation.

Some staff we spoke with were aware of the regulation but had not undertaken specific training on duty of candour. Other staff were able to define duty of candour as being open and honest and apologising when this was required

We were told children, families or carers were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Never events reported to STEIS (Strategic Executive Information System)

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

From November 2016 to October 2017, the trust reported no never events for community services for children.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents reported to STEIS

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in community services for children, which met the reporting criteria set by NHS England from November 2016 to October 2017.

(Source: Strategic Executive Information System (STEIS))

Major incident awareness and training

Potential risks were taken into account when services were being planned. Staff we spoke with were aware of the plans to be put into pace in the event of adverse conditions.

The service planned for emergencies and staff understood their roles if one should happen. We saw business continuity plans were in place and available for staff to see in the various office locations. These covered eventualities such as poor weather and the interruption of services due to utility failure.

We saw evidence of the effectiveness of these measures during the inspection. During the inspection a water leak occurred that meant a walk-in sexual health clinic was unable to take place. Patients were informed of the location of the next available clinic, signposted towards any relevant information and given an emergency phone number if they perceived their problem to be urgent. Sexual health clinics were available Monday to Friday at different locations within the locality.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. We saw staff across the services had processes for seeking out the latest NICE (National Institute for Health and Care Excellence) guidance and information from associated professional research. Managers checked to make sure staff followed guidance. Specialist advice and guidance was implemented and recorded, which ensured patients received the most effective treatment.

The service leads had a responsibility for sharing the latest NICE guidance, or delegating this responsibility. We saw evidence this was being done effectively throughout the various specialities. For example, within the sexual health services a consultant took responsibility for sharing the latest British Association for Sexual Health and HIV (BASHH) guidance throughout the team. The diabetes nursing team had a team of four, with each member being responsible for a different area of practice. For example, one nurse held the role for best practice and ensuring the team were aware of any changes in practice, guidance and legislation.

The provider had achieved the full Stage Three Unicef Baby Friendly Initiative accreditation in 2015. The initiative is to protect, promote and support breastfeeding and loving parent-infant relationships. This was due for re-accreditation in 2019.

Children had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based guidance, standards and best practice. Children and families under the care of the health visiting teams had their own named health visitor, in line with best practice. Aside from promoting continuity of care it meant each health visitor had detailed knowledge of the families on their caseload and allowed them to accurately assess the risks associated with each family they visited.

Children with long-term conditions or complex needs who received a service from the community nursing team had detailed care plans in place. We looked at two care plans. They were up to date and being reviewed regularly.

The health visiting teams had implemented the Healthy Child Programme. This is a programme introduced by the Department of Health which covers a child's development from pregnancy to the age of five. It is the early intervention and prevention public health programme that lies at the heart of all universal services for children and families. As part of the programme the health visiting teams had six points of contact with children and families: the neonatal examination, the new baby review (around 14 days old), the baby's six to eight week examination, by the time the child was one year old, and between two and three years old.

The provision of portable devices had improved the effectiveness of staff who had been provided with this equipment. However, the full benefit of this was yet to be realised because they generally did not work whilst out visiting clients. This meant staff could not access records and information, nor update this information for other professionals to receive in real time.

The speech and language therapy team were using an approach called 'Verve'. This was a therapeutic approach that encouraged the parent and therapist to work together. It assumed therapy was a process that should take place within the child's own interactive relationships. The objective was to enable parents to use their inherent skills to support their child's communication development.

The speech and language therapy team had established links with other hospitals in the south west region to peer review changes in working practice.

All staff received safeguarding supervision based on an approach called 'Signs of Safety'. This guided staff to ask a series of questions such as "what are we worried about?" and "what do we know has happened in the past that has caused harm to the child?" Signs of Safety is considered a strengths-based approach, and encourages staff to ask what the family may be doing well and what strengths they have as family that would keep a child safe. Staff were positive about this approach and the supervision that supported it.

The learning disabilities team had a clear staged approach for dealing with patients. The first step was advice; the second step was assessment and identification of need plus linking in to other

services. The third step was more help, and step four concentrated on enabling and self-care. This approach was introduced to the service 12 months ago and since its introduction there had been a good improvement in re-referral rates. The service has completed a lot of work on its website and produced educational videos on subjects such as sleep hygiene. It also had an active social media page, which amongst other uses shared information about educational events.

The learning disabilities team utilised a tool called 'talking mats' in order to gain the child's voice and opinion on their treatment. The learning disabilities team had provided training sessions on talking mats to staff in the acute hospital, as well as a community resource centre. They had found it an effective way of communicating with a child with learning disabilities

The learning disabilities team had strong links with the acute ear and eye clinics. This had helped children have more effective and successful consultations. The team had made short 'Hello I am….' videos of the staff who worked in these clinics. Staff reported these videos saved clinical hours, as by doing this pre-work the actual face-to-face consultation ran much more smoothly.

The learning disabilities team attended a learning disabilities nurse forum. This was a multidisciplinary forum which met four times a year to share good practice and learning from each other's experiences.

Pain relief

The learning disabilities team used a pain assessment tool for children with a disability. They used the 'Face Legs Activity Cry Consolability scale' (FLACC) and the 'Disability Distress Assessment Tool' (DisDAT) for identifying pain. This was explained to parents to try and help staff decide when to offer simple pain medicines, such as paracetamol. These tools helped parents and staff when working with children who may have communication difficulties.

Patient outcomes

The service monitored the effectiveness of care and treatment, and used the findings to drive improvement. The trust completed a number of audits against key measures and objectives and reported their findings through the governance structures.

The national Healthy Child Programme stipulates various targets for services to meet. For example, a new baby review should take place within 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding. Evidence provided by the trust showed they were meeting the set targets for this programme. New birth visits within 14 days were in line with the national average, with performance at 89% (national average 88%). For children receiving their six to eight week review performance was at 86%, slightly better than the national average of 82%.

The National Child Measurement Programme (NCMP) is offered nationally to two year groups in primary school - reception and year six. Children are weighed and measured by a member of the school nurse team. Trust data showed performance for reception children was at 97.3%, and for year six children performance was at 95.9%. Both of these were above the national average. The schools in the Torbay area were in line with national averages for the number of children scored as overweight and obese, with reception children being at 25% against the national average of 22%, and year six at 34% against a national average of 33%

An action plan included joint working with children's centres to develop healthy eating promotion and exercise promotion. The 2.5 year development review of children was also being more focused on healthy eating and the body mass index (BMI) calculation for children.

The sexual health service audit of chlamydia screening showed 95% of patients received notification of their test results within 10 days, and 95% started treatment within six weeks. Also, 97% of patients were offered partner notification. These outcomes were in line with national averages.

The service undertook an audit of clinical compliance with the recommendations of a serious case review from a different area. The outcome produced an action plan that was shared and disseminated with staff. This included learning around medicine dispensing and a review of certain correspondence that should be sent to parents when there was a safeguarding concern.

Audits – changes to working practices

The trust had participated in five clinical audits in relation to community services as a whole as part of their clinical audit programme. Some of these were more relevant to children's services than others. Where areas for improvement were identified, action plans were put in place. Audits included domestic abuse referrals, mental capacity assessments in community hospitals, and the International Treatment Effectiveness Project (ITEP).

(Source: Routine Provider Information Request (RPIR) – Audits – Changes to working practices)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff across the services we visited spoke positively about the supervision and support they received from their managers. All staff had an annual appraisal and those requiring clinical supervision were having this completed.

Staff received regular supervision throughout the various teams and different specialist services. Managers we spoke with all reported they were receiving regular supervision.

There was evidence the sharing of information and training across teams promoted staff development and improved patient care. For example, a newly qualified heath visitor would be part of a preceptorship/mentoring programme, which would provide input from various professionals, including social workers and midwives. This model of multi-agency learning promoted cross professional understanding of different roles, and helped staff to sign post to the correct agency.

All staff reported improved availability and consistency of supervision, compared to the findings of our previous inspection where some inconsistencies had been identified.

The speech and language therapy team reported improvements in supervision. Following a team restructure to include group leaders staff had clearer reporting lines and this had improved access to regular supervision.

Staff reported the safeguarding lead was visible and approachable for supervision requests.

Positive comments from parents were recorded in the friends and family feedback. One parent said of their health visitor, "totally on the ball, I do not know what I would have done without her" and another recorded, "she was always available on the end of the phone, really supportive with good advice". We spoke with two parents whose children were accessing the speech and language service who told us, "she is great, really explains everything and gets on with my daughter so well" and, "It's an excellent service, all the advice and information is great…we feel much more confident about what we are doing to help our child."

The learning disabilities team had supervision including child and adolescent mental health service (CAMHS), safeguarding, psychology, and clinical & managerial.

Appraisal rates

From November 2016 to October 2017, 89% of staff within community services for children had received an appraisal, compared to the trust target of 90%.

A split by staff group can be seen in the table below:

Staffing group	Number of staff appraised – November 2016 to October 2017	Sum of Individuals required - November 2016 - October 2017	Appraisal rate	Trust target (%)	Target met (Yes/No)
NHS infrastructure support	20	22	91%	90%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	84	94	89%	90%	No
Support to doctors and nursing staff	9	11	82%	90%	No

Only NHS infrastructure support staff met the trust target for appraisal rates. Nursing staff appraisal rates were only 1% below the trust target.

(Source: Routine Provider Information Request (RPIR) - P43 Appraisals)

Multidisciplinary working and coordinated care pathways

Staff, teams and services within and across organisations worked well together to deliver effective care and treatment. Services for children and young people worked together with each other and with external agencies to assess, plan, and co-ordinate the delivery of care. Staff described a patient-centred approach, and included parents where appropriate, as well as all healthcare professionals involved in a child's care. Staff demonstrated a good awareness of the services available to children and contacted other teams for advice and made referrals when necessary. This meant staff from all services shared information appropriately and cross-agency working ensured concerns about vulnerable children were shared and managed.

Effective and professional multi-disciplinary working promoted the delivery of timely treatment through professional referrals and good information sharing. Community nurses and health visitors explained how they worked with GPs and staff from the acute hospital and other specialist community teams.

Staff were clear about how they made referrals and how they accessed information from other professionals. For example, in the child development centre all referrals came via a consultant when it had been identified a child may have two or more needs from different specialities. The care pathway was then started by the nursery nurses, who would complete a home visit to complete an assessment. There were weekly multi-disciplinary meetings at the centre when all new referrals and ongoing assessments could be discussed. This process also supported the tailoring of appointments. This meant, when possible, parents and children made the minimal number of trips to the centre to see the different specialties. Occupational therapists, physiotherapists, the nursery nurses and the psychologist told us the system worked well. This aspect of team working was providing a positive and efficient service and contributing, with other initiatives, to the reduction of referral to treatment times for families.

We spoke with all the different professional teams within the child development centre. All commented on the high quality of multi-disciplinary work and support they experienced when they

worked with the families who were attending the centre to have an assessment completed. A member of the psychology team told us the preparation for this meeting by other staff, such as the nursery nurses, was excellent, and this helped the team to formulate plans and actions effectively and usually within a reasonable time frame.

Two members of the community nurse team split their working week between the children's acute ward and the community nursing team. This supported consistent care and good professional communication.

The diabetes nursing team spoke of a good relationship with community consultants as well as dietitians. The diabetes nursing team provided educational talks on diabetes to the acute children's ward. They had good communication links with the acute children's ward, as this was often the first point of contact with their patients.

The diabetes team improved its service to school teachers by creating a three-hour training course, rather than separate 45 minute school visits. In 2017 they trained 75 teachers from different schools. Feedback was obtained from these sessions, all of which was positive.

There was a clear improvement in care pathways in the speech and language therapy team compared to our previous inspection. The team had produced clear and concise pathways which produced clarity for patients, and proved effective in streamlining processes and improving referral to treatment times.

The sexual health team reported an increase in young people reporting gender dysphoria and were working towards producing a care pathway to cover this subject. Gender dysphoria is defined as the condition of feeling one's emotional and psychological identity as male or female to be opposite to one's biological sex.

Staff supported children to transition to adult services when this was required. Staff used a system of milestone reviews, which involved the child and family as much as possible in completing the paperwork. This prepared the child and family for the change in services and also aimed to promote confidence in the child as they moved into adulthood. This was particularly relevant when a child was living with a life-limiting illness. The format used was called 'Ready, Steady, Go' and was based on a national service framework and guidance for children transitioning, produced by the Department of Health. The documents were completed in three stages usually from the age of 14, although this could be started earlier if required. We saw one of these that had been completed. We saw the service had involved the child in the planning and recording. A goal was also recorded to support children to take as much responsibility as they could for their own health needs as they moved into adulthood. We saw these transition plans were reviewed and updated.

The lead for the learning disability service attended a six-monthly transition panel meeting, which was chaired by a lead from social care. This focused on the needs of children aged 14 to 17. The service also provided children with a 'hospital passport', which provided detailed information about health needs. This was used to support the transition process and ensure any adult services being accessed had the required information to meet an adult's health needs.

The learning disabilities team reported good multi-disciplinary working. They gave an example of how they obtained a diagnosis of ADHD for a child. In order to diagnose ADHD they used the Connors scale tool. This involves a questionnaire for the parent, child and teacher to complete. The consultant paediatrician was given this information and in discussion with the team, patient and parents made the diagnosis of ADHD that enabled the child to start on medicine, which significantly helped his condition. The learning disabilities team stated they often worked with families who had a social worker and that information between the teams was shared in an appropriate manner.

Health promotion

Staff working with families and children took action to promote good health and enable parents to to better meet their children's needs.

Various teams had produced short videos that provided advice and information to promote health and manage various needs ,which could be accessed by families.

The occupational therapy service ran a six-week course for parents around 'sensory processing'. This promoted understanding around the issue. Children with sensory processing issues can be oversensitive to sights, sounds, textures, flavours, smells and other sensory inputs. They can therefore be oversensitive to their surroundings, undersensitive, or both. Negative reactions can be triggered. The course helped parents identify possible issues and gave advice on strategies to manage them. It had also facilitated the sharing of information between parents. The team also ran a course for teaching assistants in schools and was soon to trial another course aimed at parents with older children.

The physiotherapy team made videos available that helped parents to improve a child's core stability and looked at issues of gait variance. Gait is the technical term for walking.

The learning disability service provided a lot of information for parents around promoting health and understanding of the management of behaviours and the environment. They ran a parenting course and also had videos available online for parents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the need to ask for consent and for this to be appropriately recorded. We saw care plans where consent was clearly recorded. The trust had recently updated its process on consent for staff working with children and families. There was a link on their website which acted as a reminder for staff.

Staff in the learning disabilities team stated there were questions around mental health in the initial assessment of the child.

The trust was taking action to ensure staff were aware and up to date with the latest data protection legislation, which was due to come into force in the coming months. An updated message was displayed on the trust website and training was being provided for managers. Training was also being planned on 'implied consent'.

Speech therapists explained how they used different types of communication to engage with children with complex needs who had limited capacity to consent. This included signing, talking mats, and the use of symbols.

Two records from the diabetes team were checked for consent. In one of the records it was recorded that consent was obtained. In the other record consent was implied, as it was a school that contacted the service with the parents' permission in order to obtain its services.

The learning disabilities service had produced a flow chart to explain mental capacity for families, and also a DVD which provided more information. The team used easy-read consent forms and easy-read literature for parents, who may have a learning disability. They also attended the Devon restrictive practice panel. This reviewed and measured restrictive equipment practices such as five point car seats and stairgates, to make sure any equipment introduced was necessary and proportionate.

The health visiting and school nursing services had moved from a paper-based record keeping system to an electronic record keeping system on 13 March 2017. The paper records were closed the same day. An audit of these electronic records in November 2017 showed 91-95% of staff were not compliant with obtaining consent and 73-91% of staff were not filling in the lone working risk assessment. It was believed staff were obtaining consent, however due to the system being new they did not know to tick the consent box. It was also felt the lone working risk assessment figure was overstated as this was a process only carried out once and this may be contained in the written records. An action plan was put in place to address the audit findings, which included one to one training and discussions at team meetings.

Staff were knowledgeable about the Fraser guidelines and Gillick competence. Fraser guidelines refer to a legal case which found doctors and nurses were able to give contraceptive advice or treatment to under 16 year olds without parental consent. The Gillick competence is used in medical law to establish whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness. All staff we spoke with were passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible. We observed staff delivering compassionate and sensitive care that met the needs of children, young people and parents.

The sexual health team respected confidentiality at all times. They explained to young people using the service that their information would be kept confidential, but encouraged them to discuss their issues with their parents, when appropriate.

In the diabetes team, we viewed a large number of thank you cards from parents, children and young people, all of which described staff as friendly, helpful, compassionate and calm. One read ”thank you so much for all your advice, guidance and support since the diagnosis. You do a fantastic job and go above and beyond to make our lives easier.”

Emotional support

Staff provided emotional support to patients to minimise their distress.

The community nursing team that looked after children with life-limited, life-threatening illness offered follow-up services to families following bereavement. They signposted families and carers to aftercare bereavement, support groups and counselling. The aftercare was provided for as long a time as was necessary.

We observed part of an assessment being completed on a Looked After Child. The nurse took time to assess any emotional needs, through sensitive questioning and the use of a happy/sad scale tool.

The sexual health team were also available by phone and text. Staff said they often worked out of hours to provide the emotional support their clients required. One example was when a patient made a disclosure out of hours on a bank holiday, about being trafficked. The member of staff went out of their way to offer the emotional and professional support this client needed in order to report their situation to the authorities.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

The diabetes team fundraised and held events for patients and family members throughout the year. Examples provided were bowling, kayaking and build a bear events. Patients and family members benefited from mixing with other families who had a child diagnosed with diabetes. Siblings without diabetes also attended, which was beneficial as this group often did not get as much attention as the child that was diagnosed with diabetes. The diabetes nurses provided education around 'eating out' at these events.

The learning disabilities team had a social media page to promote understanding and involvement, which could be accessed by families. This provided information and shared news.

We observed a school nurse and a community nurse both discussing with parents the notes they were completing after a visit. In one instance the nurse read back to the parent a section of the notes to ensure they were clear about what they were planning to try next to meet the child's needs. Nursery nurses explained how when completing an initial home assessment they ensured the family saw what they were writing. They said they explained to parents exactly what they were doing and said families were provided with a copy of the full assessment from the consultant once finished.

We observed two parts of an assessment being completed by a member of the speech and language therapy team. The parents were fully involved and spoken with as the process was completed. The therapist ensured the child was at the centre of the process and the parents understood what work was being done.

Staff told us they supported children and their parents or carers to manage their own treatment needs whenever possible. Staff also encouraged children to describe how they were feeling, and we heard examples from nurses who encouraged children to use 'talking mats' to articulate their thoughts.

Is the service responsive?

Planning and delivering services which meet people's needs

Commissioned services were planned to meet the needs of the local population. We saw the trust discussed with commissioners and local stakeholders the changing demand and needs of certain services in order to review provision. Services reflected local needs and were flexible in providing continuity of care and choice. At the time of this inspection a number of children services were being subjected to a tendering process, which meant there was degree of uncertainty around the provider of some provision. However, the trust had a clear vision of the plans for its services, and these were tailored to what it had identified as the main local needs. This involved the reorganising and restructuring of some services and potential changes to working arrangements with other partners.

Services were provided in child friendly environments that were safe and accessible. Waiting areas and clinics we visited were clean, well maintained and provided appropriate play equipment for children.

The services provided reflected the needs of the local population and ensured flexibility, choice and continuity of care. The trust tried to ensure it provided the range of its services over the Torbay area. For example, by the way it located its clinics and drop-in centres for families.

Staff reported they had good access to translation services when these were required.

Meeting the needs of people in vulnerable circumstances

The service took account of patients' individual needs. There were arrangements to enable access to the service for children, young people and families in vulnerable circumstances. For example, the diabetes team held weekly team meetings where patients who were due to attend forthcoming clinics were discussed. This was to understand the patient's journey, and to ensure if progress had been made in the right direction, this was further encouraged.

The referral process and assessment of children identified those with disabilities, such as sensory loss. The communication needs were highlighted by staff in their assessments and where possible additional techniques or equipment were utilised.

The learning disabilities service had measures in place and took action to reduce the difficulties of children with learning disabilities and their families in accessing and receiving a good service. They kept an up-to-date information folder for staff about meeting the needs of children with a learning disability. This was called the 'purple folder' and was available through a link on the trust's website. The team were also available to provide healthcare needs advice to other professionals within children's services when required. The service ran parenting classes for families and also produced short information videos that parents could access. We saw one that provided advice around sleep patterns and evening routines. The advice was aimed at various audiences, as some of the parents had learning disabilities themselves. The learning disabilities team reported its patients received annual health checks from the age of 14 upwards and this helped the transition to adulthood.

The learning disabilities team were involved in the running of an 'Early Bird' programme to support parents and young children with a diagnosis of an autistic spectrum disorder. This was a three-month parenting course, which had been developed by The National Autistic Society. There was also an Early Bird forum which was a support group for parents. The Early Bird programme was delivered by the speech and language team alongside educational psychology, portage & specialist teachers.

The community nursing team encouraged independence and, where they could, supported families and children to develop these skills. For example, we saw a member of the team provide some training to a group of carers, so they could support a child they were taking on holiday. Another example was support being given to a 15 year old child to help develop skills for self-managing aspects of their health care around PEG feeding.

Access to the right care at the right time

Children and families could generally access services when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice. We saw evidence from services of a proactive approach to try and reduce referral to treatment times. However, there was an average waiting time of 12 months for children waiting for a full autism assessment. This had been reduced from 18 months over the course of the previous year and there were initiatives being implemented to further reduce this. For example, the service was exploring whether staff other than a psychologist could complete developmental assessments. This was because psychologists' capacity was being stretched by the number of assessments required. We were told how the child development centre had provided a more streamlined assessment process which, amongst other improvements, also tried to ensure families had to only tell their story once.

All children referred to the physiotherapy service were being seen within 12 weeks, which was meeting a locally set target of 13 weeks. Urgent referrals were being seen within 48 hours.

Managers explained how the children's services were working toward a single point of access for families and children. One step toward this had been the introduction of a weekly multi-disciplinary referral meeting, called the children's hub meeting. This helped reduce families having to attend multiple assessments, and, if possible, identified who was best to do the initial assessment if there were a variety of identified needs or concerns. In some circumstance an occupational therapist and a physiotherapist would undertake a Bayley's assessment jointly. This assessment covers the five key developmental domains of cognition, language, social-emotional, motor and adaptive behaviour.

Additional staff had been recruited to address identified shortfalls in meeting the national targets for completing health assessments for Looked After Children. There were, however, still vacancies to be filled. There had continued to be an increase in the number of Looked after Children within the trust's catchment area, with the current total being at 300. This was the third highest ratio to population nationally. This had continued to challenge and place a high demand on the team. Routine assessments were recorded at 100% and improvements were being made in the completion of initial assessments. There was an agreed action plan with the commissioners in place, with a risk assessment process to ensure the safety of children. All new referrals were assessed by the named nurse for basic health needs, and any onward referrals to other health professionals could be made if required. The staff vacancy in the team was identified on the trust risk register and the team were using bank staff where they could.

The occupational therapy team had started providing a drop-in advice clinic for families, initially in three locations, usually about three times a month. This helped avoid unnecessary referrals, and provided reassurance and quick advice to families when they needed it.

Action taken by other services to improve referral to treatment times for families included the introduction of an 'opt-in and select' appointment system, which gave additional choice to parents. This had helped reduce the 'did not attend' rates. The speech and language therapy service had started notifying other services when there had been non-attendance at appointments. This co-ordinated approach had led to more efficient use of appointment time. Another action taken had provided some families with the option of attending appointments or clinics at a different location. This was helpful to families during holiday periods or when there were transport issues.

The school nursing service had changed to a system of corporate caseloads. This had enabled the team to respond to all referrals within 48 hours, and to all safeguarding referrals immediately. As all members of the team were equally busy, the system helped them to share the workload evenly and respond better to referrals.

At the beginning of 2018 the community nursing service had 360 active patients. Referrals could come from any other professional or healthcare centre. There was no waiting list for this service at the time of our inspection. Contact was made with a family within 48 hours of receiving a referral. The team worked Monday to Friday 9 to 5, which potentially meant some children could not be discharged from the hospital because clinical care in the community was not available in the evening or at weekends.

Services took steps to ensure families who had received a service could access a speciality if required without having to go through another referral process. For example, families who used the physiotherapy service could self-refer for up to a year after they had been discharged.

The speech and language therapy service had undergone a service restructuring and transformation process in September 2017. Since then, 87% of patients had been seen within 18 weeks, compared to 35% at the end of April 2017. There had also been a decrease in the 'did not attend' rate from 7% to 5%. The service lead and the team spoke positively of the changes and

the improvements in the responsiveness of the service. The service also offered appointments within seven days to a child with complex needs already known to the service. This enabled families to get help when they needed it. The team explained how accessibility was important, and how they used the Verve tool with families whilst they were waiting to access the Early Bird course. They could also use this tool after an assessment had been completed, if the child's needs and challenges had changed.

As part of the aim to address cultural needs of black and minority ethnic (BME) client groups, training had been delivered at board level to raise awareness of the voice of the child from a cultural perspective.

The trust provided British Sign Language (BSL) and language interpretation service in face-to-face, telephone, and in document form.

We observed a health assessment being completed with a child and the nurse considered any cultural differences that needed to be taken into account.

Learning from complaints and concerns

Staff were aware of the complaints process and how to signpost parents to make a complaint or raise a concern. At the locations and clinics we visited we saw information was displayed about the complaints process available to families. Information was also displayed on the trust's website and in the information about the different children's services. The service had taken steps to get more feedback form children, for example from Looked After Children. They were given a brief questionnaire at the completion of their health assessment.

The trust had a policy that recommended complaints be resolved within a six-week period. The exception would be for complex complaints, which required more investigation. Data supplied by the trust showed the community services overall had received 38 formal complaints during the previous 12 months. Of these, 37 had been resolved. However, these figures were not broken down into children's and adults' services. We were told by service leads they received few formal complaints, and that the majority related to delayed assessments for children.

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing quality, sustainable care. There was effective and professional leadership that encouraged and supported the delivery of person-centred care. This was evidenced in the services we visited. However, there were some comments from staff about the visibility of the chief nurse and other board members to community based staff. Some staff commented they felt they were part of an integrated service, but the board was more focused on the acute service. This was reflected in that many staff had not met, or seen, board members visiting the community services and meeting the staff in their working locations.

At our last inspection we had identified a shortfall in the leadership provided in the child development centre. We found action had been taken to improve the delivery of this service and that further ideas were being explored. There had been involvement from the trust's quality improvement team, who worked with all the staff to help redesign some aspects of the service and improve it.

We spoke with therapists, nursery nurse staff, reception staff and psychology staff. All spoke very positively about the working environment, the team working and the leadership provided by the

consultant. Several staff talked about it being a “great place to work” and how the improved processes around the assessment of children referred had been very effective.

We spoke with staff who worked in the various teams. We had positive feedback about all the service leads. Staff felt well supported and able to approach managers for information and support. There were regular team meetings, which were documented, as well as excellent levels of informal support and supervision.

Vision and strategy

At the time of this inspection children’s services were subject to a period of uncertainty. This was due to the recommissioning of certain provision and potential other changes that may result from service restructuring. However, although some staff were concerned about the future, they told us the managers and senior staff had kept them informed and well supported. The trust had a vision for the service it wished to provide. The trust described this as a plan “for investment in a single, integrated and resilient model for children’s services…that will be developed and delivered through a whole system approach”. Staff we spoke with described what this meant to them, with several talking about an integrated service with all staff working across the different professions “working as one team”. Staff were positive about the vision of integrated care and the aim of meeting the needs of children and young people in the Torbay area with such a system.

Staff were aware of the trust’s values of respect and dignity, commitment to quality care, compassion, improving lives, working together, and everyone counts. These were displayed at various locations and offices.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were engaged with the trust and proud of the care and treatment provided. Staff spoke of a culture that encouraged and supported openness and honesty between staff at all levels. In the most recent staff survey available at the time of inspection, from 2016, in response to the question “How likely are you to recommend this organisation to friends and family if they needed care or treatment?” the trust scored an overall satisfaction score of 98% in community services.

Staff we spoke with said they felt positive about the organisation, and were able to challenge ideas. They said managers were visible and approachable. Managers of services and teams we spoke with said there was a positive culture that enabled them to approach senior managers and discuss any aspect of the trust service. Managers told us they were well supported by the senior team and had regular contact with their line managers.

Staff were aware of the open door policy of the chief executive and the role of the speak up guardian, which was advertised on the trust’s intranet. A number of the speech and language therapists told us how they had taken the opportunity to meet with the chief executive. They believed therapies were well represented at board level, and felt well supported knowing the service was valued across the trust.

The trust had a lone working policy that staff were aware of. Staff we spoke with said the trust and their immediate managers promoted safety and safeguarded their well-being. For example, when nursery nurses were completing the initial home visit and assessment this was always done by two staff.

Governance

The trust used a systematic approach to continually improve the quality of its services. There were systems in place to report information gained from auditing and improvement action plans.

There were also weekly waiting list management meetings to identify delays and capacity issues that may impact on the referral to treatment times for services.

The individual services had regular team meetings, and there were daily opportunities for staff to speak with their managers. Staff could raise concerns and ideas and these would be discussed and listened to. Staff received relevant and up-to-date information through their staff meetings.

The diabetes team reported into the team leader for community nursing. The diabetes team consisted of four staff members of the same grade. In the speech and language therapy teams the position of team leader had been created ensuring that there was direct management oversight in each team.

Management of risk, issues and performance

There were assurance systems in place which measured and monitored performance throughout the various children services. There were clear lines of accountability for the performance metrics of services. Children's services produced an integrated performance dashboard that was reported monthly to the trust's finance committee and the performance and investment committee. There were key metrics for the performance of all services and these were reviewed monthly by the executive team. Managers were clear about the processes to be followed and how they followed up on any identified issues or concerns.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks were identified, monitored and appropriate actions recorded. For example, the latest business continuity plans for staff to follow in the event of service disruption, had clear emergency contact details and actions to be followed. All interruptions of service had been correctly reported.

However, there was an identified shortfall in the lone working assessments being completed by some members of the community diabetes nursing team.

The team had not been completing lone working risk assessments as required by the trust's policy. Out of 138 current patients an audit had shown there were only 10 completed risk assessments. The managers had not been auditing the system processes regularly. Staff were not carrying out appropriate risk assessments and adhering to lone working policies and procedures. Staff reported discussions regarding risks of lone working and visits had been held and that the team were now addressing this issue. This had meant there was a potential risk to staff as diabetes staff reported there had been incidents where family members of patients had been aggressive.

The speech and language therapy team had been trialling the use of an instant messenger and video conferencing tool. Staff reported positively on this, stating the benefits of knowing whether people were available and improved contact with managers.

The diabetes team did not yet have access to lone working devices, despite these being identified as needed in the trust's policy. Staff were provided with panic alarms and mobiles, but these did not enable location tracking if required.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The various children's services collected performance data on a regular basis and used this to improve and inform service delivery. Feedback was provided on referral to treatment times, re-referrals and the timeliness of treatment. Audits were collected and conducted over a range of areas and the information collated into performance dashboards.

Engagement

The trust engaged well with patients, staff and the public to plan and manage appropriate services, and collaborated with partner organisations effectively. Staff were able to contribute their views and said they felt that managers listened to their ideas and opinions on services. However, while some changes had been made there was lack of formal engagement processes and feedback arrangements to gain the views of children. For example, the service had not conducted a formal 'Voice of the Child' survey.

Feedback was sought from families through the NHS friends and families test, though there had been limited numbers of these completed for community services. At the clinics we saw the family and friends test was promoted, with boxes available for parents to provide feedback.

There were a number of parental groups which met around the specialist services, and staff told us how parents often commented on services during these meetings. Managers told us the main feedback and subject of complaints over the previous 18 months had been around the delays in children getting appointments. All the services had reduced their referral to treatment times significantly over the previous 12 months. We saw examples of written compliments from the speech and language service, the occupational therapy service and the community nurses from families. All were positive about the responsiveness of the staff.

After a health assessment had been completed for a Looked After Child the nurse provided them with a stamped addressed envelope and feedback form for them to complete if they wished. We were told this was done after every completed health assessment.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, and by promoting training, research and innovation.

We saw examples in the use of social media to promote information and support for families. For example, videos had been made to promote sleep pattern information, core stability and the Early Bird programme. Social media pages were also promoting general information and providing a forum for parents to share ideas and provide mutual support.

There were plans to provide an improved service for children with an autistic spectrum disorder diagnosis and their families. The plan was to combine the children development centre and the Torbay autism assessment service. One service provided a service to under-fives and the other for children aged five to 18 years. The combining of these services would allow the flexing of resources to provide a more cohesive service. It was hoped to eventually provide an integrated neurological developmental team. This would provide a seamless service for families, which would also be more responsive and have more capacity to meet the identified unmet needs of this patient group.

It was planned to further improve the referral process by adding community paediatrics to the children's multi-disciplinary referral hub. This was the final part of the move to progress to a single point of access for all services.

Community end of life care

Facts and data about this service

End of life care is provided within the community hospitals and by community nursing teams, who in collaboration with the patient's GP, provide end of life care for patients living in their own home. Community nurses support families and carers with all aspects of end of life care.

Community nurses oversee the care and write the care plans for end of life care patients who are to be visited by external organisations such as those providing night sitting and care.

The local Hospice at Home service (which is part of an external organisation) carried out some end of life care for complex patients and provided advice and support to community staff. However, most care is provided by the community nursing teams.

Is the service safe?

Mandatory training

The trust was not able to provide information for training specific to community end of life care when requested prior to the inspection. This was because there was not a dedicated end of life care staff team. End of life care was provided by hospital and community staff as part of their role of caring for all patients. Training compliance was monitored for all staff who worked within community nursing teams and community hospitals through the electronic training records and at a local level within individual teams and departments. Local managers told us they were able to access the individual staff members training records and were aware of which staff were required to complete their mandatory and role specific training. The trust provided mandatory training in key skills to all staff, however not all staff were up to date with this training. Role specific training was provided to staff but again, not all staff were up to date with the required training.

At one location we found 11 of the 23 staff, from the Newton Abbot community nursing team, had completed less than 50% of the required training. Staff attributed this to reduced staffing levels which meant they could not attend.

The community nursing teams risk register identified compliance with mandatory training as a risk. This had been identified and entered onto the risk register in February 2017. The risk had been escalated within the trust and more training made available. The issue remained on the risk register but had been rated as a lower risk.

The training lead for community end of life services had left their post over a year ago. There had been limited training arranged since that time, which meant staff had found it difficult to keep up-to-date with role-specific training, such as syringe driver training. The vacancy had now been filled and the new staff member was due to start soon. As a result, staff were hopeful training provision would improve.

Staff had responsibility for booking their own training. Each ward manager and community nursing team leader monitored the training for their staff. Different systems were in place for doing this. For example, in one team and on one ward an administrator maintained an electronic spreadsheet. In another ward we saw a printed document displayed in the office showing which staff had completed the required training. However, during discussion with staff we were told that neither of these records were up to date.

Safeguarding

Staff understood how to protect patients from abuse and were aware of their responsibilities. The safety briefing handover on wards and within community teams highlighted any safeguarding concerns to the whole team.

The trust provided mandatory safeguarding level two training for the staff on how to recognise and report abuse. Within the different teams, records identified that not all staff were up to date with their safeguarding training. However, staff also told us that the records we were shown were not up to date. Because there was not a dedicated community end of life care team the trust were unable to supply training compliance data specifically for staff providing community end of life care. However, the trust informed us safeguarding compliance reports could be provided at trust, service delivery unit, team and individual level.

Safeguarding referrals

The trust was not able to provide information for safeguarding referrals specific to community end of life care. Following the inspection the trust informed us they did not capture information specific to safeguarding referrals in this way as the source of the referral was captured and discussed with local authorities as they occurred. However, staff we spoke with during the inspection were able to describe how to raise safeguarding concerns and felt able to do so.

We observed a case discussion regarding a patient who was living with dementia. This person was known to social services and there was a discussion around concerns that the patient could not safely be cared for at home. The multi-disciplinary team were working with the family to ensure the safety of the patient once they were medically fit and could leave the hospital. Another patient who had not been caring for themselves safely, but was deemed to have mental capacity, was supported by the multi-disciplinary team to plan their future care.

The community end of life service had not been involved in any serious case reviews.

Cleanliness, infection control and hygiene

Staff controlled risks from infection well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Housekeeping / cleaning staff were employed by the trust and allocated to community hospitals. These members of staff were valued as part of the ward team. All wards and areas in which staff worked appeared clean, hygienic and tidy. We observed the use of ‘I’m clean’ stickers in the community hospitals, which indicated equipment had been cleaned and made ready for use. However, at the Newton Abbot community nursing base, one syringe driver box out of three was soiled. We raised this with staff at the time which was addressed straight away.

Staff had access to hand washing facilities and hand sanitisers at convenient locations within the wards. We observed community staff at Newton Abbot, Totnes and Dawlish all clipped hand sanitisers to their person. This helped promote and control the spread of infection.

The trust carried out hand hygiene audits which consisted of a period of observation during which the hand washing practices of staff were monitored. We reviewed the outcome from 80 audits which had been carried out in 2017 and 2018. All of the community hospital and community nursing staff were seen to wash their hands appropriately with two exceptions. At Totnes Community Hospital during an audit in August 2017, there were two occasions when staff did not wash their hands appropriately and in Brixham Community Hospital in July 2017, one opportunity out of 14 was missed. Feedback was provided to staff teams following completion of the observations to drive improvement.

Following the death of a patient in the community hospitals or at home, staff contacted local undertakers for the removal of the body. The patient remained on the ward until the undertaker was able to attend. Infection control policies and procedures were followed when providing care to patients after death.

Environment and equipment

The service had suitable premises and equipment, with the exception of mobile telephones for community staff.

Community staff had highlighted on the risk register in January 2017 that they were using poor quality mobile phone devices and that some were broken. This had impacted on the clinical assessment and treatment plans for patients as photographs and effective communication could not take place with specialist advisors, for example tissue viability or senior colleagues. While the risk had been accepted and action taken to replace broken devices, the quality of the phones and signal issues had not been resolved at the time of our inspection. This meant there was a difference in the care and treatment provided dependent on the location of the patient. The trust advised us after the inspection the issue was being reviewed and it was planned to move away from using smartphones by replacing them with electronic tablets. Immediate measures to address the issue included the provision of roaming SIM cards made available for staff who worked in affected areas. However, some staff had still experienced difficulties.

The risk register for the community nursing teams had highlighted a risk caused by the process for the calibration of capillary blood sugar machines. This test ensures that the machine recorded blood sugar levels accurately. The system for providing community nurses with the information to check their machines after the test, had been reviewed and improved. This meant the risk from inaccurate results had been reduced.

Wards had access to quiet and private rooms where conversations could be held confidentially. At Newton Abbot hospital there was a room outside of the wards that could be used by visitors and patients seeking a quiet space.

Community hospitals had appropriate equipment which was maintained and serviced regularly to provide end of life care and treatment. Staff we spoke with were positive about the accessibility of equipment when it was required.

Equipment was serviced and maintained by the medical devices department. There was a clear process for sending and receiving equipment during planned maintenance or as a result of faults. Faults were documented on the service log and the repairs were made promptly. We saw two syringe drivers on one ward, which were available for use and these had been serviced within the last 12 months.

Emergency equipment trolleys were located within a central and accessible area in each ward. The trolleys were secured with a tamper evident system. Staff consistently carried out and recorded daily and weekly checks to ensure the equipment and medicines were ready for use.

Community staff had access to an equipment supply service which they found reliable and provided a prompt service. The equipment available included pressure relieving equipment and syringe drivers. One specific comment made about this service was “it lets us look after our patient well”. We were told that from 8am until 9pm each day, equipment could be ordered and delivered within two hours. After 9pm staff had access to equipment through the stock held by the out of hours nursing service and through community hospitals. All staff confirmed that the hospital and community staff worked together to ensure that patients had access to the equipment their care and treatment required.

Assessing and responding to patient risk

Staff assessed and responded to patient risk.

An initial risk assessment took place on receiving a patient referral to identify care needs. Examples of risk factors considered in the assessment were mobility, use of a syringe driver, nutritional status and skin integrity. Patients with complex care needs at the end of life were allocated to a registered nurse whose training was up to date for the use of syringe drivers.

Risk assessments were reviewed and reflected the patients' changing care needs. Patients who received care at home were provided with information so that they were able to contact services out of hours including the out of hours community nursing service, GP and the local hospice.

Patient assessments enabled staff to define when a patient was in need of end of life care. Patients were identified at the monthly multi-disciplinary team meetings as well through updating assessments of patients already receiving care.

The out of hours community nursing service provided visits that were often unplanned and as such did not always receive a handover from the day staff prior to them finishing their shift. However, the out of hours staff we met told us that if a patient was in need of end of life care and would potentially require a visit, a handover by telephone was often received.

There was evidence of escalation of care needs to the GP or specialist palliative care team within patient notes. Discussions at safety briefings also raised awareness of increased care needs or risks identified for individual patients. We attended one safety briefing which was attended by 13 staff. Patients of concern, including those with end of life care needs, were discussed in detail to ensure staff were aware of their care requirements. For example, one patient required changes to their medication to alleviate symptoms. The planned visits for the day were also reviewed and allocated to appropriate staff at this briefing.

There was a fast track process to obtain equipment or change the package of care when patients' care needs changed. Within the integrated care meeting the team recognised when care needs had changed and completed a fast track assessment. For example, one patient needed a different type of bed, and another patient needed a sitter overnight to ensure their safety. The team allocated assessments based on who could carry out the visit soonest, between social workers, OT's and nurses.

Staff in the community hospitals told us that when patients were assessed as requiring end of life care they would ensure that intentional rounding took place every hour. Intentional rounding was a structured approach whereby nurses conducted checks on patients at set times to assess and manage their fundamental care needs. However, the guidance printed on the intentional rounding charts did not define end of life patients as requiring this regular intervention. This could mean that intervals between checks exceeded one hour which could result in the patient not being monitored appropriately.

Staffing

The service did not consistently have enough staff with the right qualifications, skills and training to provide care and treatment to end of life patients in the community.

Staff handovers / safety briefings took place each time there was a shift change on the wards. This provided the oncoming staff with up to date information about the care and treatment of patients. Patients who were receiving end of life care were highlighted within the handover to ensure that their care and treatment needs were made clear to the staff.

Safer Staffing level

The trust was not able to provide information regarding safer staffing specifically for community end of life care. Patients who required end of life care were cared for by the ward staff in the community hospitals and community nurses at home. The trust did, however, monitor the staffing establishments for the hospitals and community teams.

The community teams used an electronic allocation tool to identify the patients requiring visits and on which date. A band six registered nurse triaged patient visits to prioritise new requests for visits together with planned visits. This ensured patients were visited in priority order and staff were provided with a manageable caseload of visits each day. Staff were provided with electronic work lists at midday each day which were printed off ready for the following day.

Staffing levels were an issue in the community nursing teams due to staff vacancies. This meant there were shifts in the duty rota that were not filled. To mitigate against this, the trust used temporary staffing hours, such as from the trusts' nurse bank and from external agencies, together with permanent staff working additional hours to maintain the service. However, despite trying to cover shifts, duty rotas showed that at times there were shifts not filled.

When inexperienced staff, such as newly qualified or newly appointed staff were on duty, supervision was provided or support was accessible from experienced community staff. For example, we observed the rota from the Newton Abbot community nursing team. This showed that ten shifts had been covered by either agency or bank staff within the previous month. On the day of our inspection the rota showed there had been 16 members of staff due to work. However, there were 15 members of staff on duty of which three were newly qualified staff. These staff were working with an experienced member of staff, which meant that rather than 16 staff being available to carry out visits to patients with specific needs, there were only 12. Recruitment was ongoing into the community teams.

Access to social care was at times difficult to obtain for patients. At times, community nurses told us they provided social care services to patients with end of life care needs when waiting for packages of care to be arranged. This then impacted on their caseload management. However, all staff we spoke with commented end of life care was a priority to deliver.

Vacancies

The trust was not able to provide information for vacancies specifically for the provision of end of life care within the community. Patients who required end of life care were cared for by the ward staff in the community hospitals and community nurses at home.

There were nursing vacancies at each of the community hospitals. At Brixham hospital there were two whole time equivalent (WTE) registered nurse and five WTE health care assistant vacancies. There were four health care assistants who had been recruited and were waiting for the completion of the recruitment to start work.

At Newton Abbot community hospital there were two WTE health care assistant and four WTE registered nurse vacancies. The registered nurse vacancies had been temporarily filled by the use of agency staff. Recruitment had taken place and three whole time equivalent registered nurses were due to commence work at the hospital.

At Dawlish hospital there were four WTE health care assistant vacancies and one registered nurse vacancy. Recruitment was ongoing for these posts.

At Totnes hospital there was one WTE registered nurse vacancy and 2 WTE health care assistant posts. Again recruitment was ongoing for these posts.

Community nursing staff we spoke with told us there had been a number of members of staff absent from the teams due to long term sickness, maternity leave and staff leaving the trust. This had been identified as a risk on the risk register. Bank staff were used where appropriate and the risk register provided an update which acknowledged there were still vacancies. Permanent staff were provided with additional hours to cover the gaps although this did not mitigate against the risk fully. Recruitment was ongoing into the community teams.

Turnover

The trust was not able to provide information for staff turnover for the provision of end of life care within the community. Patients who required end of life care were cared for by the ward staff in the community hospitals and community nurses at home.

Sickness

The trust was not able to provide information regarding staff sickness for the staff providing end of life care within the community. However, patients requiring end of life were cared for in the community hospitals which had a staff sickness rate of between 2% and 10%. Dawlish had the lowest staff sickness, with Newton Abbot the highest.

Nursing – Bank and Agency Qualified nurses

The trust was not able to provide information for bank and agency nurses who provided end of life care within the community as there was no specific end of life care team.

Nursing - Bank and Agency Healthcare Assistants

The trust was not able to provide information for bank and agency healthcare assistants who provided end of life care within the community. Patients who required end of life care were cared for by the ward staff in the community hospitals and community nurses at home.

Medical locums

The trust was not able to provide information for medical locums who provided end of life care within the community.

Medical cover in the community hospitals and for patients at home was provided by GPs. Each ward had consistent GP cover. We spoke with two GPs who stated they had access to specialist palliative and end of life care from the hospice consultant and consultants working within the acute hospital.

Consultant cover

The trust did not have a specific community end of life care team and therefore was not able to provide information for consultant cover for community end of life care. There was a consultant who worked within the trust's palliative care services who was accessible to the GPs should they require this support. Additional support was available from the consultants at the hospice as part of the integrated end of life care services.

Suspensions and supervisions

The trust was not able to provide information for suspensions or supervisions for staff who provided end of life care within the community.. Patients who required end of life care were cared for by the ward staff in the community hospitals and community nurses at home.

Quality of records

Staff kept records of patients' care and treatment. Records were clear and available to all staff providing care. However, not all records were completed fully or in sufficient detail to direct and

inform staff of patients individual care needs. This was because care plans were not in sufficient detail or personalised. The trust carried out an audit of patients' records which reviewed if the record was dated and signed. This did not provide oversight information on the content of the care plans and the detail in which they were recorded.

Staff had access to information about the patients' including their medical history through paper and electronic records.

Access to electronic records varied between staff. For example, not all staff had access to the electronic systems used by the local authority social workers and the system used by GPs in the areas. We spoke with a matron who had access and considered this invaluable for planning care for patients, particularly during discharge planning.

Each patient had an assessment of care completed within a pre-printed end of life care needs assessment and associated care plan. The assessment provided information regarding medical history, symptoms, pain, psychological and spiritual needs. The assessment document also instructed staff to speak with the patient and their family and document all significant conversations. A prompt was also provided regarding the provision of "excellent basic care including mouth care, pressure damage prevention, nutrition and hydration and bladder and bowel function".

Based on the assessment, brief care plans were put into place to advise staff on the action they needed to take to meet the patients identified care needs. The care plans did not consistently provide detailed personalised information on how to meet individual specialised care needs. The end of life care plan template also included a series of algorithms. (An algorithm is a list of rules to follow in order to solve a problem). The algorithms provided instruction to staff regarding pain, nausea and vomiting, respiratory tract secretions, shortness of breath and restlessness and agitation in the last days of life. However, the algorithms had not been personalised to provide instruction to staff for individual patients. For example, there were contraindications for some of the medicines detailed in the algorithms but no reflection on whether this was important for individual patients.

Medical and nursing staff maintained detailed and reflective records of the care and treatment provided to patients. This enabled oncoming staff to provide consistency in care delivery.

The trust had developed a preferred priorities for care document and plan for patients which had been based on national guidance. This was a plan where the patients' future wishes for care and treatment could be explored and recorded. We did not see these were used consistently.

New end of life care plans had been developed and were to be introduced into two community teams as a pilot the week after the inspection. These clearly identified the five priorities of caring for patients at the end of life.

There was not a system to ensure that advanced care planning was completed in order to clearly identify, document and communicate the wishes of the patient and those close to them. This meant that there was a risk that during the provision of care patients wishes may not have been known and therefore not respected. However, we did not identify that this had been the case.

Medicines

Medicines were prescribed, administered, recorded and stored appropriately. Patients received the right medication at the right dose at the right time. Staff were provided with policies and procedures to ensure the safe management of medicines.

At the last inspection in February 2016 we found the trust was not complying with Regulation 12 of the Health and Social Care Act 2014 which requires all staff to be trained and competent to check controlled drugs.

We spoke with staff at this inspection and all health care assistants had completed training and were assessed as competent to do so prior to checking controlled drugs. Until the health care assistants had completed this training they were not permitted to check controlled drugs. Ward managers and team leaders held records to identify that the training had been completed. Staff commented that wherever possible the checking of controlled drugs and syringe drivers was carried out by two registered nurses.

Medicines were obtained from the main pharmacy at the acute trust. Regular deliveries were planned weekly and any other medicine could be ordered in between times. These were delivered by courier. If medicines were prescribed for a patient and needed urgently a taxi delivery was arranged. This meant patients had prompt access to their required medicines.

Storage facilities for medicines were secure within the community hospitals. There were locked storage cupboards for the ward stock. With the exception of controlled drugs, patient's medicines were stored in the locked medicines trolleys or in a locked metal cupboard in the patient's room. Controlled drugs were stored in a double locked metal cupboard within a locked clinical room. Medicines which required cool storage were stored in a fridge specifically for this purpose. The fridge temperatures were monitored on a daily basis and action taken should the temperature fall outside of the acceptable limits. The date of medicines which needed to be used within a specified timeframe were documented.

Medication administration records (MAR) identified the medicines that had been prescribed for patients. The MAR detailed the dose, frequency and route of administration for regular and when required medicines. Medication administration records we reviewed were up to date, legible, and signed by the prescriber. Prescriptions were reviewed when the patients clinical status changed to allow good pain management and symptom control. The route of medication was considered in medication reviews when swallowing deteriorated and intravenous medication required.

We observed nursing staff administering controlled drugs to patients both within their own homes and within community hospitals. We saw that where possible two members of staff checked the MAR and witnessed the medicine being given. In the community, the checking was carried out by a registered nurse and where possible an assistant practitioner or health care professional. On occasions within the community setting this was not possible if the nurse was lone working. In the hospital setting two registered nurses generally carried out this task.

Controlled drugs held in a patient's home were counted each day by staff to ensure the balance remaining was correct. Specific paperwork was used to record the controlled drugs in use. The hospital wards checked the balance of controlled drugs against the register each day. This demonstrated the trust complied with the appropriate legislation for the management of controlled drugs.

Patients who required end of life care were prescribed anticipatory medicines. These were medicines prescribed in advance to enable staff within the community hospitals and community settings to manage and control symptoms of the patient's condition and illness.

Anticipatory medicines were provided to patients living in their own homes in 'just in case' bags (JICB) which remained in the patients home until they were required. The trust policy stated that when two doses of medicines from the JICB were used, this served as a prompt for staff to review the medication regime and consider the use of a syringe driver. Staff were familiar with this policy

and had access to syringe drivers. Syringe drivers help reduce symptoms by delivering a steady flow of injected medication continuously under the skin.

There were arrangements to obtain medicines 24 hours a day, seven days a week. However, at times the night community nurses had found it difficult to get prescriptions written for patient. They had formed good working relationships with the out of hours doctors to overcome this.

Within the community, a pharmacist was available in each area to reconcile the medicines prescribed for patients. Medicine reconciliation is the process of creating the most accurate list possible of all medicines a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medicines. A pharmacist or technician visited each hospital once or twice a week to provide this service and review ward stocks. We noted from one MAR that the pharmacist had reviewed the patient's medicine five days before our visit. They had noted that one analgesia (pain relief medication) prescribed for the patient was twice the recommended dose and had advised this be reduced by the doctor. This had not been completed. We raised this with the ward manager who gave assurances they would ensure this was reviewed by the doctor immediately. No patient harm had been sustained as the medicine had not been administered.

Safety performance

The service did not provide safety monitoring results specifically for end of life services provided in the community.

Incident reporting, learning and improvement

The service managed patient safety incidents well; staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff were confident in the action they were required to take to report incidents through the trusts' electronic reporting system. They received feedback and could describe changes made as a result of findings from reported incidents.

Investigations were completed by senior staff. Where the incident affected more than one location, staff worked collaboratively to ensure lessons were learned. For example, following an incident, additional training regarding the discharge documentation was provided so that staff could ensure the patient understood the contents of the patient held records and that staff used a common language when talking to the patient to avoid miscommunication.

Another reported incident shared with us by staff was regarding the tube of a syringe driver which had been trapped in the holder meaning the patients medication was not administered correctly. Information on ensuring that staff checked the tubing when setting up a driver had been shared with staff. This reduced the risk of the incident being repeated.

The out of hours team had on occasions had to use the medicines in the 'just in case' bag in a syringe driver as they had been unable to obtain the required medicines at night. This had been reported as an incident as although the staff had acted in the best interests the medicines in the just in case bag were not usually used in this way but did comply with the trust's policies and procedures.

Staff meetings were used as an opportunity to discuss previously reported incidents and any learning that had been identified following an incident. For example, at the community nurse forum a reminder was shared regarding the process around the verification of death by nurses.

Serious Incidents

There had been one serious incident investigation within a community team when provided end of life services which related to a patient who had experienced pressure damage. Staff had reported this as a potentially avoidable incident and an investigation was ongoing at the time of our inspection. The duty of candour legislation had been instigated and the patient and their relative advised of the investigation. A member of staff from an external organisation had been involved in the care of the patient and that organisation had been contacted for their input into the investigation. This showed that the trust took seriously any reported incidents and investigated to discover the root cause.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment which was not always in keeping with national guidance and the effectiveness of care was not evaluated to assess patient outcomes. For example, the National Institute for Health and Care Excellence (NICE) guidance for Caring For an Adult at the End of Life 2015 requires prompt recognition of the dying phase and that communication and shared decision making with the patient produces an individualised care plan. The care plan should then be monitored and reviewed to manage on-going symptoms. Within the records we reviewed during our inspection, we identified that the decision that the patient may be entering the dying phase was not always clearly documented and individual care plans were not produced.

We were not assured that the Leadership Alliance Five Priorities of Care 2014 (these national guidelines replaced the Liverpool Care Pathway) were consistently met for each patient. The processes in place designed to achieve the five priorities were not always followed which meant evidence based practice could not always be demonstrated, for example individualised care plans. However, we saw examples of good practice in including prompt referral to specialist palliative care teams who gave input to review deteriorating patients or to manage symptoms. There was adequate access to specialist palliative care advice through an advice line which was available to staff, family and patients. The needs of family and those close to the patient were explored and managed, we saw an example where the dying patient was a carer. Staff considered the impact on the family member and sought to ensure their care needs were met.

The processes for supplying anticipatory medication to patients and the use of just in case bags complied with guidelines produced by the National Institute for Health and Care Excellence (NICE).

The Policies, procedures and processes provided to staff complied with national guidelines and good practice recommendations. For example the policy relating to good care of dying patients was reflective of the NHS priorities for care of the dying person.

There was currently no audit carried out on the care planning for patients requiring end of life care. This had not been completed for approximately the last year due to a staff vacancy. This did not provide the trust with assurances that staff were providing care and treatment in line with national guidance. However, one staff member said there had been a care plan review and an audit to review the patients preferred place of death. We requested the audits from the trust but did not receive them.

The trust had participated in a survey of end of life care services in the County, but the report of this survey was not specific in which parts were attributable to the trust.

Staff we spoke with had an awareness of the evidence base which informed their work. Information for staff was displayed on noticeboards in offices and staff rooms. We saw guidance

on how to comply with the national priorities for the care of the dying person and a summary of the end of life care strategy.

The trust did not take part in the national Gold Standards Framework accreditation scheme. The community end of life lead nurse advised us the trust complied with the Gold Standards Framework but had not been part of the accreditation scheme.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patient's religious, cultural and other preferences.

An assessment tool was used to assess the patients nutritional needs. Based on the outcome of the assessment we identified that when required a referral was made to the dietician or speech and language therapist.

Patients in the community hospitals received a varied menu each day which offered choices and catered for a variety of dietary needs. Patients who were receiving end of life care were offered alternatives to the set menu. Each ward had a small budget that had been used on occasions to purchase specifically requested food from a local supermarket. We were provided with an example when the ward had a patient who was a vegan. The patient had wanted sausages for their tea so these had been purchased from the supermarket.

The ward staff had access to a microwave and toaster to make additional snacks for patients when requested. There was a supply of bread, butter, sandwich fillings, biscuits and cereals on the wards. A variety of drinks, both and hot and cold, were available on each ward.

Staff we spoke with were able to provide assurances that they were able to use artificial feeding methods for patients who were receiving end of life care when necessary. Patients required artificial feeding if they were unable to take adequate food by mouth. The staff also discussed when and how they would ensure patients were kept hydrated if unable to drink. We observed a discussion regarding a patient with an artificial feeding tube. A specialist nutritional clinician carried out a joint visit with the community nurse to review the care and treatment plan for the patient.

Pain relief

Nursing staff regularly assessed patients for evidence of pain. We saw staff asking patients if they had any pain. To assess the level of pain, patients were asked to grade the pain they experienced on a scale of one to ten. For patients with communication difficulties such as those living with dementia, a recognised pain assessment tool which used pictures and symbols was used.

The intentional rounding recording template was used to record if patients were comfortable and staff told us they would ask about the pain experienced at each check.

Patients we spoke with told us that staff provided medicines to them to alleviate pain and that they were aware they could ask for additional pain killers if required.

We observed documentation which showed family members had been involved in a discussion regarding the pain experienced by the patient. This discussion included whether the pain was better or worse, and if the prescribed pain killers were effective.

Syringe drivers were in use to deliver medications at pre-set times. Nurses knew when syringe drivers needed to be changed and in safety briefings this was given priority.

Staff were able to access pain relieving medicines for individual patients. Just in case bags (JICB) containing pain relieving medicines were given to patients living at home. Anticipatory medicines were prescribed for patients in the community hospitals.

During a multidisciplinary team meeting we observed a community pharmacist accessing records to confirm what pain relieving medicines patients received. They were able to provide advice on changes which could be made to improve the pain control for the patient.

We saw from patient notes, that when the patient's pain was not controlled at home, the staff requested a patient review with either the specialist hospice at home service or the GP.

Patient outcomes

The service had completed little monitoring of the effectiveness of care and treatment for patients requiring end of life care and treatment over the past year.

The trust was not able to provide us with evidence that patient outcomes had been measured. Two members of staff told us that audits of the quality of care provided to patients had been undertaken by an end of life clinician. This person had left their post approximately one year ago and it was not clear of any action from the audit outcomes.

Staff attended regular team meetings. We were told by various teams that at the team meeting a discussion was held regarding end of life care patients to either improve their ongoing care or how the care provided to a deceased patient could have been improved. We were provided with an example regarding a patient who had sustained pressure damage during their episode of care. Learning had been discussed but it was agreed that the pressure damage had been unavoidable due to the patient not complying with the care and treatment provided.

Following each death the Matron and/or ward manager or team leader plus the GP completed a mortality review. We asked for any learning that had come out of previous reviews but were not provided with any examples. The community end of life lead told us there had not been any actions needed following recent mortality reviews. The mortality reviews were recorded and held by the ward manager or team leader and also provided to the patient safety lead for review. The patient safety lead attended senior management meetings which enabled any issues to be escalated.

Competent staff

The trust provided training for staff to ensure they were competent for their roles. However, not all staff were up to date with their training.

The additional role specific training, known within the trust as essential training, for staff providing community end of life care had been reviewed and outlined in a draft policy and procedure, the End of Life education policy and action plan.

On line self-directed training was available to staff who provided end of life care to patients. topics included: a unified DNACPR (do not attempt cardiopulmonary resuscitation), fast track pathway tool, relationship between palliative care and end of life, advanced care planning, assessment of spiritual wellbeing, care and support after bereavement, communication, good practise in decision making and the management of end of life care.

Staff were responsible for booking and completing their training. It was unclear from records we reviewed and data requested from the trust, the percentage of community based staff who had completed this role specific training. Individual staff and departments held the training records and there was no overall monitoring of compliance.

Registered nurses were required to complete training to enable them to provide verification of expected death. The trust maintained a register which showed a number of staff had completed this training. However, the data provided did not appear to list all registered nurses working in the community and out of the 59 nurses listed, nine had not completed the training. Staff we spoke with said that whilst some nurses had attended the training there had been a delay in their competence assessment so they were not able to undertake this task.

The out of hours nursing team were proactive in ensuring their staff had access to training and development. Registered nurses in the team were completing mentorship, nurse prescriber and non-medical practitioner training. Health care assistants were supported to access developmental training such as Regulated Qualification Framework (RQF), access to university course and end of life training. RQF are work based awards that are achieved through assessment and training, previously known as National Vocational Qualifications (NVQ).

Staff were supported to access end of life training at the local hospice. However, monitoring records were not available from the trust to evidence the percentage of staff who had completed this training.

Training was available for staff to ensure they had the knowledge and skills to care for people living with dementia. This included a video produced by the Royal College of Nursing, information sharing by local dementia champions and online training regarding dementia screening.

Newly appointed staff were provided with induction training. This included a trust wide induction and working locally within their team with an experienced staff member to ensure confidence and competency. We were shown an induction pack provided to a new member of staff within the Newton Abbot community nursing team. The pack contained contact details of internal and external staff and organisations the nurse would need to access. Safety information such as fire and rescue was also provided. An individualised two week training plan was developed to meet the induction needs of staff. Teignmouth community nursing team also provided a formal local induction to their new members of staff.

New staff received direct supervision. We spoke with six registered nurses who had all been in their roles for less than six months. They told us they had been supervised during visits until they and their supervisor considered they were competent to work alone.

There was a preceptorship programme for newly qualified registered nurses, led by the trust. A preceptorship is a short-term relationship between a student as novice and an experienced staff person (such as a professional nurse) as the preceptor who provides individual attention to the student's learning needs and feedback regarding performance

Clinical Supervision

The trust was not able to provide an overview of the clinical supervision for staff providing community end of life care.

The supervision provided to staff varied between teams and districts. Supervision is a process to review case management, reflecting on and learning from practice and provide personal support and professional development to the staff member. The supervision records were held by the staff member and/or manager, in accordance with trust policy. There was no other recording mechanism to demonstrate supervision was taking place regularly, which meant the trust was not able to monitor or audit this. Matrons informed us that they always discussed the staff supervision with the ward and team managers at their monthly meetings and supervision sessions.

The staff from one ward did not have individual supervision with their line manager as they had decided they would prefer group supervision. This was added into the staff meeting. This did not

ensure that staff had the opportunity to formally discuss with their line manager, on a regular basis, any issues or training needs. However, all staff we spoke with said their manager was approachable and they could talk to them when needed.

Appraisals for permanent nursing staff

The trust was not able to provide an overview of the appraisals of permanent nursing staff who provided end of life care within the community. This care was provided by staff based in the community hospitals and community teams.

Staff and managers we spoke with in the community hospitals and community teams were clear that there was a process to ensure staff appraisals took place annually.

Managers told us they were provided with a reminder when a staff member's appraisal was due by the trust's workforce planning team.

However, whilst appraisals within the community nursing teams had been performed or booked they were not always within a 12 month period. There had been a delay on completing appraisals due to capacity issues.

Appraisals for permanent medical staff

Medical cover within the community hospitals and in patients' homes was provided by GPs who weren't employed by the trust. The trust therefore did not carry out appraisals for these doctors.

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care

Multidisciplinary team meetings took place within the community hospitals each week and in doctor's surgeries on a monthly basis. This enabled a group of professionals to review the care and treatment of patients who required end of life care in order to provide appropriate care and treatment.

During the inspection we visited the integrated care team which operated from a wellbeing hub. The hub provided a central point for all staff, patients, and relatives to access help and support. The team operating from the hub consisted of community nurses, pharmacist, physiotherapists, social workers, occupational therapist, well-being volunteers; this was overseen by a locality manager. Staff told us the integrated way of working had improved their ability to meet the needs of patients as they could quickly access professionals and communication was improved through better information sharing.

We observed a multi-disciplinary meeting at the wellbeing hub which was attended by a range of professionals including pharmacist, mental health nurse, GP, community nurse team lead, physiotherapy, occupational therapy, social workers and well-being volunteers. We observed the use of technology which allowed a specialist cancer care nurse from a hospice to join the meeting via video link. The team discussed the health and social needs of end of life patients within their locality. This included diagnosis, previous medical history, symptom management, and psychological well-being. There was also consideration for those close to the patient, their view of the condition of the patient and their own well-being. In cases where the carer may also have long term health needs, for example dementia, this was taken into account when considering current and future health needs. The mental health nurse joined the meeting once a week but referrals could be made at any time.

Staff consistently made positive comments about the working relationships with the local hospice and the hospice at home service. They valued this close effective working relationship for the specialised support provided to themselves, the patients and their families and representatives.

We observed multi-disciplinary working in action through a visit to a patient in their own home. We attended with the community nurse and saw liaison took place between the nursing staff, the patients GP and the local hospice at home team. This ensured the patient received holistic care from the relevant professionals.

Community teams were based across the area. Some teams were co-located with the health and social care coordinators. We were advised this had been invaluable in building positive and strong working relationships.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MCA) 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Although staff demonstrated an understanding of the MCA, written records did not always evidence the appropriate action had been taken to comply with the legislation.

At the last inspection in February 2016 we found that the trust was not complying with Regulation 11 of the Health and Social Care Regulations 2014. This was because requirements of the mental capacity act were not adhered to when a patient lacked the mental capacity to be involved in discussions about their care and treatment.

During this inspection, we reviewed the notes for 16 patients who were receiving or had received end of life care and treatment in the community hospitals or at home. Out of the 16 sets of records we were able to identify that eight of the patients had capacity to make decisions regarding their care and treatment.

Out of the remaining eight patients, the written treatment escalation (TEP) plans were not completed fully or appropriately. A TEP form ensures that every patient has their ceiling of care considered and documented formally, in line with the national initiative. A ceiling of care provides information about, as well as appropriate limitations to interventions which are likely to be futile, burdensome, or contrary to the patient's wishes. The TEP form in use within the trust enabled clinicians to document the assessment of the mental capacity of the patient and their ability to be involved with decision making.

One patient lived in a care home and within their records there was no TEP form to identify how decisions had been made. Staff informed us this information would be held within the care home records or GP records. However, there was no information relating to the decisions made or the person’s mental capacity within the community nurses records. This meant there was a risk that the agreed ceilings of care or the patient’s wishes may not have been known to the community nurses.

The TEPs for two patients identified their capacity had changed. The form was updated and dated and signed where the changes had been made. The forms did not evidence that a new capacity assessment had been completed. Staff we spoke with stated a new TEP should have been completed rather than making changes and risk not including all up to date information. One TEP had been changed a year after it was originally written and the other after one week.

Consent was sought and well documented within nursing records prior to delivering care and treatment to patients. When a patient was unable to consent for simple care procedures such as

personal or catheter care, it was clearly documented that the care was provided in the patients' best interest together with any discussion with the family.

The care planning template prompted staff to gain consent from patients regarding sharing personal and confidential information with other professionals. However, not all of the templates had been completed to ensure that patients were aware that their information would be shared with other professionals when necessary.

In the Teignmouth community nursing team, any concerns regarding the mental capacity of the patient was referred to the multi-disciplinary team. The social workers were part of this team and would complete mental capacity assessments when required. Contact with the GP or other professionals such as the mental health team was made when required.

We saw that staff respected the patients' decisions regarding care and treatment when it was deemed they had capacity to do so in an informed way. At the integrated care meeting we attended one patient had declined some care and treatment. This was respected as they had capacity.

Deprivation of Liberty Safeguards

The trust reported no deprivation of liberty safeguards in end of life community services.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients and/ or their relatives or representatives had expressed gratitude to the staff. Specific comments from thank you cards included: "I would like to thank you all for the kindness and tender care shown to XX while you treated him. It was very much appreciated" and "We are comforted in knowing XX received the best care available".

We observed staff providing care and treatment to patients at the end of life. We saw that staff showed kindness, respect, understanding and empathy to their patients. Privacy and dignity was promoted at all times.

The conversations and interactions we observed demonstrated trusted and respected relationships between the patient and staff.

Emotional support

Staff provided emotional support to patients to minimise their distress

The community nurses were proactive in helping people with a learning disability become involved in their care and treatment. They used care plans in a format suitable for the patient such us the use of smiley faces and pictures to help provide support and information.

Following the death of a patient, the community nursing teams offered support and assistance to the patient's family and/or representatives. This included a telephone call and if wanted a visit to provide emotional and practical support. The Newton Abbot community team also sent a sympathy card to the bereaved family or representative. A bereavement pack providing useful information was shared and the content discussed at this visit.

Visitors of patients who were receiving end of life care were supported with car parking passes to alleviate the worry of the cost and time constraints of the hospital car parking system.

Patients who required additional help with their mental health were referred to the mental health nurse for ongoing support, care and treatment. We heard four patients discussed at an integrated team meeting who were suffering with anxiety. As a result of the discussions one patient was referred to and subsequently received support from the mental health nurse.

Mental health and the need for emotional support awareness amongst the staff was good. Staff spent time with patients talking about any issues the patient may raise. The documentation evidenced these conversations and the support provided. However, we did not see any assessment tools for the assessment of anxiety or other mental health issue experienced by patients who were receiving end of life care. The trust informed us following the inspection, that all patients' health and wellbeing was assessed on admission to the community hospital or community nursing teams and if it was felt that a patient required further assessment this would be raised and actioned accordingly.

Families of deceased patients were treated with dignity and respect. Staff supported them following bereavement and ensured privacy and the opportunity to talk to staff was available to them.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We were able to read thank you cards that patients and their relatives had sent to the community nurses expressing their thanks when they had received end of life care. Specific comments included "the out of hours support which we received as a family gave mum the comfortable death at home she hoped for", "you are a fantastic team who've made a very difficult time both funny and easier than it could have been" and "your help has been much appreciated and I feel that you treated us with great respect and kindness". These comments show that the staff included the families and representatives into the planned care and treatment.

Nursing and medical records clearly evidenced discussions and interactions with patients and their family members and/or representatives. This demonstrated that patients were supported to understand their care and treatment. We saw written records which showed the prognosis of patients was discussed with them and their families when the patient was in agreement.

There was evidence of how staff ascertained the wishes and preferences of patients regarding their care and treatment.

Relatives and representatives of patients being cared for on the wards were able to visit at any time and stay overnight if they wished. Where possible, patients were cared for in a side room with an en suite bathroom. There were also relatives' rooms which were used for breaking bad news or providing a quiet space. Meals and refreshments were provided to relatives who were spending long periods of time at the hospitals. Staff were clear that relatives were supported to be included in the provision of care.

Is the service responsive?

Planning and delivering services which meet people's needs

The trust planned and proceeded services in a way that met the needs of local people.

Staff respected the wishes of patients and their representatives regarding their preferred place of death whenever possible. We were told this had been audited but were not provided with the audit despite requesting it.

We evidenced from one patient's medical records that the initial plan had been for the patient to be discharged to a care home. However, following discussions with the patient and their family it was agreed their end of life care and treatment would be provided in the community hospital.

The community nurses supported patients to die in their own homes if this was their preference. We observed from records that increased care and treatment was provided to patient's in residential care homes to support the carers and enable the patient to remain in their home.

The trust had a work plan which was part of the end of life strategy. This included the principles of end of life care and giving patients choice and preference regarding their care and treatment.

Ward moves

The trust did not provide any information regarding bed moves for community end of life care patients.

Mixed sex breaches

The trust reported no mixed sex breaches in community end of life care.

We saw that staff provided end of life care and treatment to patients in side rooms whenever possible.

Meeting the needs of people in vulnerable circumstances

The service took account of patients' individual needs.

Additional support could be accessed for patients living with a learning disability who required end of life care. A specialist learning disability team were available from the trust to provide support to staff in the community hospitals and those caring for patients in their own homes.

Community nurses used care plans which were in a format suitable for the patient, using smiley faces and pictures to involve the patient. Continuity of the nurses attending the patient was considered where this was deemed beneficial to the patient. We were told that to meet the needs of one patient with a learning disability the nurses did not wear their uniform. This was because the patient was more comfortable with nurses attending them in normal clothes.

Community hospitals provided dementia friendly wards to support patients who were living with dementia. Work which had been completed included art work to help patients identify their beds and removing walls to provide patients with a spacious area to walk around. Signage in the hospital was large and colour coded such as for toilets and bathrooms. The hospitals used the national Forget-Me-Not scheme which alerted staff to the patient living with dementia. A blue flower symbol was put on patients' case notes and above their beds to ensure patients with dementia were easily identifiable by the staff and their care was undertaken accordingly.

Staff within the community hospitals were supportive, when appropriate and safe within the confines of the ward and medical treatment, of recognising patient wishes with regards to alternative therapies. For example, the use of crystals, alternative healing and complimentary medicines. We were provided with an example of when they had been unable to respect a patient's wishes to use candles on the ward due to the oxygen supply. This had been risk assessed and considered unsafe.

Visitors who requested to stay overnight with patients had access to reclining comfortable chairs which could be placed in a room with the patient, or separate side room if there was one available.

Access to the right care at the right time

People could access the service when they needed it.

The community services were provided over the 24 hour period seven days a week. The nurses worked in a shift system. The majority of nurses worked between 8am to 5pm but there was cover provided from 7am until 7pm. The overnight team started work at 7pm and finished at 7am.

Patients were able to request an emergency visit through the out of hours doctors' service.

When patients were identified as requiring end of life care a process known as 'fast track discharge' was put into place to help them achieve their preferred place of death. This discharge process was managed by the multi-disciplinary team together with the input from patients and their relatives/representatives if appropriate.

Accessibility

The largest ethnic minority group within the trust catchment area is Polish making up 0.7% of the population.

	Ethnic minority group	Percentage of catchment population
First largest	Polish	0.7%
Second largest	Tagalog/Filipino	0.1%
Third largest	German	0.1%
Fourth largest	Chinese	0.1%

The trust provided a British Sign Language and language interpretation service in face-to-face, telephone, and document form.

Staff were aware of how to access interpretation and translation services should they provide care to a patient whose first language was not English. One member of staff told us they had accessed this service by telephone whilst another commented they had used family members to help the patient. This did not always ensure confidentiality for the patient. All the other staff we spoke with said they had not needed to use interpretation services. However, there was awareness amongst the staff of colleagues who were able to speak another language and we were provided with an example of when a member of staff who spoke Polish had been able to offer assistance to a patient.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Complaints

The trust maintained a record of any complaints they had received relating to community end of life care. There had been six complaints made to the trust regarding end of life care in 2017. These had included concerns regarding medication, pain control, lack of compassion and transport home.

Where possible any complaints were dealt with by the staff involved in the care and treatment. Patients were advised on how to make a formal complaint and how to access the Patient Advice and Liaison Service (PALS).

There was a process to follow when a complaint was submitted to PALS. This included identifying an appropriate investigator, informing the assistant director of community services and drafting a response. The response included reference to the Duty of Candour legislation and an action plan

was developed. Information was shared at team meetings following a complaint investigation and an action plan being developed. This ensured learning from complaints took place.

Compliments

During our visits to community hospitals and community nursing teams we saw evidence of compliments that had been made following care and treatment. These were provided by patients and/or their representatives.

Managers told us that they provided feedback to the relevant staff on receipt of a compliment.

Examples of comments made included: “just wanted to say thanks for your help. You are a fantastic team who’ve made a very difficult time both funny and easier than it could have been” and “we are writing to express our thanks for all your care towards mum and ourselves. We know that Mum particularly appreciated [staff member] warmth and care in her last days and hours. The out of hours support which we received as a family gave mum the comfortable death at home she hoped for”

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high quality sustainable care.

The chief nurse held the role of executive lead for end of life care supported by the associate director of nursing. The community end of life care service was led by the associate director of nursing for community services, who escalated information to the chief nurse when necessary.

Matrons of community hospitals met monthly with the assistant director for community hospitals and the associate director of nursing for community services.

Senior staff and local managers prioritised end of life care. All staff were committed to deliver good quality care and treatment to those patients who required end of life care.

Staff spoke highly of the local leadership; they felt well supported by their line manager and were able to raise concerns.

All staff agreed that their local managers were available to them and that they were able to access support, either by telephone or in a visit, when they needed this.

Vision and strategy

The trust had a vision for what it wanted to achieve for patients who required end of life care and treatment.

The trust had developed a strategy for end of life care. We saw this displayed on staff noticeboards within one community hospital and one community team base. Not all staff we spoke with were aware of the content of the strategy. However, all were aware that the service was an integrated care service and worked with the acute specialist service.

There had been no formal monitoring of the strategy to establish how embedded this was within the staff teams, although this work was about to start.

The staff confirmed they received update information via the trusts email system. This had included guidance following the implementation of the end of life care strategy.

Culture

Managers across the trust promoted a positive culture that supported and valued staff creating a sense of common purpose based on shared values.

Staff we spoke with were proud to work for the trust and were positive about the teams they worked within and how they worked well together and were supportive of each other.

Staff were able to escalate concerns and were aware of the whistleblowing procedures within the trust. The staff we spoke with were confident they would be able to raise any issues and would be listened to and supported by their managers.

Following the death of a patient senior staff offered support and the availability to discuss any issues experienced by staff. This was achieved by discussions within teams and individually. Each ward held a safety briefing each morning and end of life care was discussed at this meeting to ensure that staff were knowledgeable of the patients immediate care needs and preferences and wishes.

Staff were very proud of the service they were able to deliver to patients and their families. A number of staff we spoke with became emotional at times when describing their work and recalling patients they had cared for. They reiterated again and again how they were proud to work for the trust and were supported to provide a good service.

Staff working within the community setting were protected from the risks of lone working. Known risks regarding the patient, their home and family/friends were assessed and recorded on the trust's electronic record system. This helped the staff plan their visits. For example attending with a colleague not alone.

The out of hours service worked in pairs to negate the risk of lone working at night.

Staff working within the community were provided with mobile telephones to protect them from the risks of lone working and carry out their professional responsibilities. In a number of areas the signal did not enable staff to make or receive calls which had caused issues in the past.

Governance

The trust did not have a systematic approach to monitor and improve the quality of the end of life care provided within the community.

There was no dedicated team providing end of life services in the community setting. End of life services were provided by community based staff as part of their mixed and diverse caseloads. Staff we met and spoke with did not articulate that they were part of the trust end of life care services and referred to an external organisation for their support.

There was an end of life strategy within the trust which was monitored by an end of life committee. The trust informed us following the inspection that end of life dashboards were being developed to monitor and improve care.

There had been no recent audit programme to monitor the quality of care provided to patients in receipt of end of life care within the community setting. The audit information we were provided with related to two audits which took place in 2015. The trust took part in a county wide survey regarding end of life care together with external organisations. However, the report did not provide information which was identifiable to the trust.

There was no clear system to measure the compliance with mandatory and role specific training for staff who provided end of life care within the community. This did not provide assurances that

all staff were competent to carry out the roles for which they were employed. However, the trust were in the process of centralising all training records into the electronic systems.

The trust was unable to provide data or information regarding community end of life care services separately from the general community services, for example the number of safeguarding referrals. This was because the service was integrated within the wider community services and not a dedicated team. Information was regularly collected and discussed, but could not be attributed specifically to end of life care provision in the community.

The trust-wide mortality surveillance group met monthly and produced a report to provide assurance to the board on patient mortality. We saw from minutes of the monthly meetings that case reviews of patients who had died at home or in a community setting had taken place. Learning from these reviews had been shared with the relevant multi-disciplinary staff teams. This helped staff to improve the quality of end of life care by shared learning.

Management of risk, issues and performance

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, it was not always clear that prompt actions were taken to address risks.

Each community hospital and community nursing area maintained a risk register, which included any risks identified during the provision of end of life care delivered to patients. Risk and issues at a local level were understood and managed. The risk registers identified actions taken to reduce the risks which had been escalated. However, a number of risks had been on the register for over one year and had not been resolved, for example, staffing levels and training. A further risk relating to poor signal on portable devices for staff working in the community did not have timely actions recorded to show how this was being managed.

A monthly meeting was held which clinical leads attended with the community associate director of nursing for both the acute and community settings for end of life care. This provided the opportunity for risks, concerns and issues to be raised and actioned. The community associate director of nursing escalated any issues to the chief nurse who was able to raise these with the trust board.

Staff we spoke with were aware of how to respond to incidents which affected the delivery of the service. There was an on-call manager system within the trust which the out of hours service were aware of should they require additional support. During the day there were clinical leads and senior management staff available to offer guidance.

Information management

The trust collected, managed and used information well to support all its activities using secure electronic systems with security safeguards.

Staff were issued with passwords to access electronic systems and records.

Paper records were stored securely in offices and hospitals to ensure patient confidentiality.

Engagement

The trust engaged well with staff to plan and manage appropriate services.

The trust provided relatives and representatives of deceased patients with a bereavement pack. Within this information pack, a survey was included to enable feedback regarding their experience. The trust told us that response to the survey was low but positive comments were made. In 2017

five responses found relatives who responded were satisfied with the end of life care which had been provided.

Staff received a monthly email bulletin produced by the trust to update them on important activity or changes within the trust.

The trust had developed an end of life strategy which set out the vision for their development of end of life care. There was no mention in this document of engagement or consultation with the patients or the public regarding this strategy. However, following the inspection the trust told us the specialist palliative care consultant had shared the document with outside groups and service users.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well or when they went wrong.

Staff were able to develop their skills and knowledge regarding end of life by becoming end of life care 'Champions'. They attended additional training and events which enabled them to share specialist knowledge with their colleagues.

The role of Champions was being developed at the time of our inspection to ensure clarity of role and consistency across teams. This had occurred as part of the end of life strategy implementation. We were told that there was to be a name change from Champions to Ambassadors for end of life care. A written plan had been developed outlining the roles and responsibilities of an Ambassador. This showed that the Ambassador would be expected to share information and cascade learning to colleagues. The first monthly meeting was scheduled for the end of February 2018.

The out of hours service had recently been recognised by Plymouth university as a good learning environment to place nursing students. Two RNs had completed mentorship training and one had recently started this training in order to support the students on their placement.

Accreditations

The trust did not participate in the Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care scheme.