Torbay and South Devon NHS Foundation Trust

Evidence appendix

Torbay Hospital, Lowes Bridge, Torquay TQ2 7AA

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Date of inspection visit:

10 to 12 March 2020

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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.

Acute services

Urgent and emergency care

Facts and data about this service

Urgent and emergency care services are provided at Torbay Hospital, they are delivered as part of the Newton Abbot Integrated Service Unit (ISU) which is the system providing urgent and emergency care. The emergency department operates 24 hours a day, seven days a week.

Adult patients receive care and treatment in two main areas; minors and majors. Patients with serious injury or illness, who usually arrive by ambulance, are seen and treated in the majors' area. This includes; a resuscitation area with four cubicles, and 16 cubicles and side rooms, additionally there are four allocated areas which are used, when needed, on a stretch of corridor. The majors' area is accessed by a dedicated ambulance entrance.

Self-presenting patients with minor injury are assessed and treated in the minors' area.

There is a dedicated children's unit within the main emergency department with a small separate waiting area. A further waiting area for children is designated in the main waiting room.

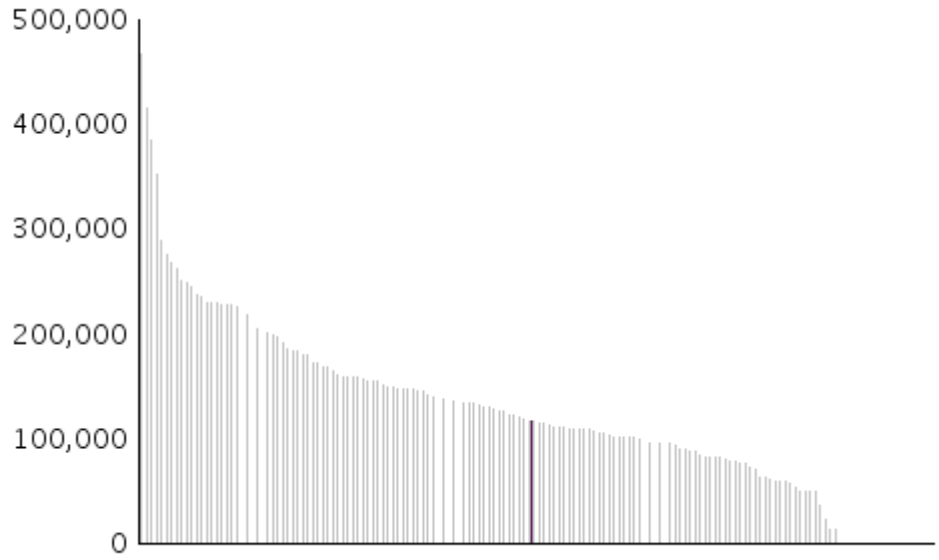
The emergency department is a designated trauma unit and provides care for all but the most severely injured trauma patients, who would usually be taken by ambulance to the nearest major trauma centre. If the patient is not suitable to travel immediately, they may be stabilised at Torbay Hospital and transferred as their condition dictates. The department is served by a helipad.

There is a clinical decision unit adjacent to the department which accommodates eight seated patients. This area is for patients who do not require admission but who are awaiting results of diagnostic tests or for discharge arrangements to be made.

Torbay hospital provides services to a resident population of approximately 375,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

Activity and patient throughput

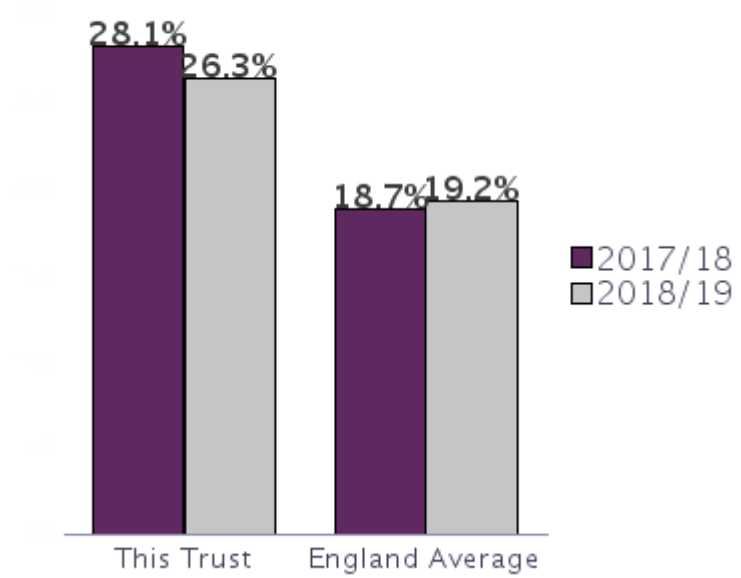
Total number of emergency department attendances at Torbay and South Devon NHS Foundation Trust compared to all acute trusts in England, October 2018 to September 2019



From October 2018 to September 2019 there were 116,844 attendances at the trust's emergency department as indicated in the chart above.

(Source: Hospital Episode Statistics)

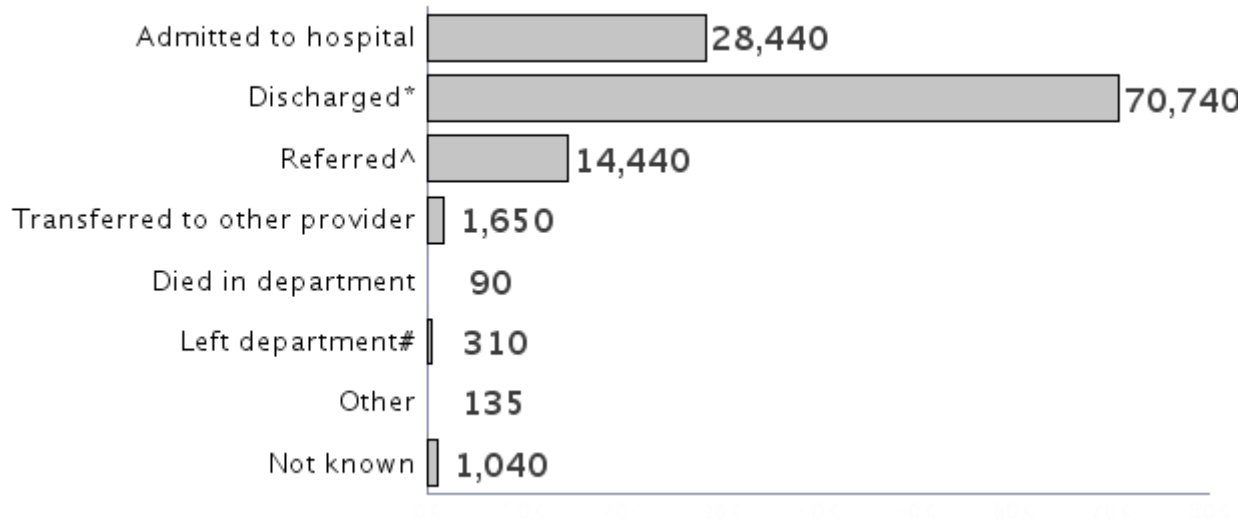
Emergency department attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission decreased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Emergency department attendances from October 2018 to September 2019



* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

We visited the emergency department over three weekdays on the 10, 11 and 12 March 2020. There were a further two follow up telephone calls on the 18 March 2020. Urgent and emergency services were previously rated as good overall with requires improvement for the safe domain

Our inspection was announced (staff knew we were coming). We spoke with 11 patients and eight relatives. We spoke with staff, including 25 nurses, 11 doctors, 2 managers, 15 support staff and ambulance staff. We observed care and treatment and reviewed 11 care records.

Prior to and following our inspection, we reviewed performance information about the trust and data provided by the trust.

Mandatory training

Staff received mandatory training. However, not all staff were meeting trust compliance targets for their mandatory training. Staff were not up to date with trust targets for paediatric basic life support training and had difficulties collating data to evidence staff were compliant with immediate and advance life support training.

Mandatory training completion rates

At our last inspection 2017, we told the trust they should ensure all staff comply with minimum training attainment levels. At this inspection we saw the emergency department did not meet the trust target in all training modules. Staff told us this was due to the heavy workload causing training to be cancelled. Staff told us they had adjusted training scheduling to avoid winter periods of high pressure and had plans to meet the attainment when possible.

The trust set a target of 85% for completion of mandatory training for all courses except for information governance, which had a trust target of 95%.

The compliance for mandatory training modules for registered nurses in the emergency department from December 2018 to November 2019 was 86%. Of the training modules provided three achieved compliance and five failed to reach the trust target.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Basic life support	113	111	98%	✓	→

One module failed to score above 75% as outlined below.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance <75 %	Trust Target Met	Compliance change when compared to previous year
Conflict resolution	113	79	70%	✗	→

The compliance for mandatory training modules from December 2018 to November 2019 was 91% for medical staff in the emergency department. Of the training modules provided five achieved compliance and three failed to reach the trust target. However, no training modules scored below 75%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff were not up to date with trust targets for paediatric basic life support training. Trust data showing compliance on the 29 February 2020 identified for nursing and additional clinical staff in the accident and emergency department, there were only 48% of staff who were compliant, there were 51 staff members where they were not up to date with this training.

The trust had difficulties collating data to evidence staff were compliant with immediate and advance life support training and recognised they needed to hold this information centrally, so they were able to monitor and be assured staff were trained to an appropriate level. There was a risk staff were not all trained at the level required for their role. In addition to basic life support training for paediatrics and adults, which was mandatory for all staff, the trust had a training needs analysis within the resuscitation guideline setting out the required level of training for different staff roles. Emergency department consultants were required to complete adult and paediatric advanced life support, this was a requirement of their role. The trust were unable to supply compliance with this training. Emergency department nurses were required to complete adult immediate life support. However only four out of 53 had completed this. The trust decided to focus on completion of adult advance life support which was recommended, 18 out of 53 staff had completed this training at the time of our inspection. It was also recommended for paediatric immediate life support, but compliance was not provided, and recommended for paediatric advanced life support whereby 50% of paediatric nurses were compliant. For ED shift co-ordinator paediatrics and emergency nurse practitioners it was mandatory to complete adult advanced life support, paediatric immediate life support and recommended to complete paediatric advanced life support. The trust did not supply compliance for this. The trust told us there was always someone on shift who was trained in advance paediatric life support, in line with the Royal College of Paediatrics and Child Health standards.

The mandatory training was comprehensive and met the needs of patients and staff. There was an annual mandatory study day which provided staff with refresher training in a range of mandatory subjects, including safeguarding adults and children, fire safety and infection control. Staff told us the quality of the training was good and suitable for their needs. However, training could not always be attended as planned due to increased demands of the department. Clinical staff received (mandatory) training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. All emergency department staff attended a mandatory training day annually. This one-day training included mental health, Mental Capacity Act/ DoLS, learning disability and autism and safeguarding. There was some bespoke training provided by the Psychiatric Liaison team, this was called “turbo training”, which was 15 minutes chunks of training however this was not mandatory. Staff told us they found this to be useful.

Managers monitored mandatory training and alerted staff when they needed to update their training. The trust told us the department held a register of staff which showed who had completed the training, were booked to complete and who were not compliant. However, this hadn’t been updated since May 2019, because the role of the practice development nurse had not been maintained in the absence of the substantive post holder.

Safeguarding

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. However, safeguarding children training compliance needed to improve.

Safeguarding training completion rates

There was a trust compliance targets for the safeguarding courses for which medical, nursing and qualified allied health professional staff are eligible.

- 90% for safeguarding level 1
- 80% for safeguarding level 2 and 3

The tables below include PREVENT training as a safeguarding course, which had a trust target of 85%. PREVENT training aims to safeguard vulnerable people from being radicalised to supporting terrorism.

Torbay Hospital

Nursing staff received training specific for their role on how to recognise and report abuse. The compliance for safeguarding training modules from December 2018 to November 2019 was 86% at Torbay Hospital for qualified nursing staff in the emergency department. Of the training modules provided three achieved compliance and three failed to reach the trust target.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	113	112	99%	✓	→
Basic Prevent Awareness	113	110	97%	✓	→
Safeguarding Adults (Level 2)	113	108	96%	✓	→
Safeguarding Children (Level 2)	98	54	55%	✗	↓
Safeguarding Children (Level 3)	15	6	40%	✗	↓
Safeguarding Adults (Level 3)	3	1	33%	✗	→

Medical staff received training specific for their role on how to recognise and report abuse. The compliance for safeguarding training modules from December 2018 to November 2019, was 91% for medical staff in the emergency department. This met the trust target. Of the training modules provided four achieved compliance and one failed to reach the trust target.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	35	35	100%	✓	→
Basic Prevent Awareness	35	34	97%	✓	→
Safeguarding Children (Level 2)	17	16	94%	✓	→
Safeguarding Adults (Level 2)	35	32	91%	✓	→
Safeguarding Children (Level 3)	18	11	61%	✗	↑

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff spoke clearly about the processes used to identify patients, including children at risk of abuse. There was a safeguarding lead in the department and all safeguarding alerts were reviewed and an annual audit completed with any learning outcomes.

The emergency department met the Safeguarding Children Standards produced by the Royal College of Emergency Medicine, which states level two training should include training in female genital mutilation. Staff demonstrated a comprehensive understanding of signs of abuse including domestic abuse and female genital mutilation.

The emergency department had access to a senior paediatric doctor 24 hours a day. For example, all skull or long bone fractures in children under one year were discussed with a senior paediatric or emergency department doctor before discharging the child.

Staff followed safe procedures for children visiting the emergency department. Reception staff were clear and confident in their role to identify any safeguarding concerns. Reception staff alerted the department staff to any known risks recorded on the electronic systems and paper records. The patient records system identified previous child attendances so staff would be alerted to possible safeguarding issues. There were prompts within the electronic patient record to complete safeguarding assessments.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and mostly well-maintained. We observed while the department was cluttered and busy, staff were seen to be wiping down areas between use. There were side rooms where infectious patients could be isolated and staff were clear in describing the infection control procedures used.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Two cleaning staff were allocated to the department each day and they followed a set cleaning programme. Medical equipment and devices were cleaned by nursing staff. Any deep clean required was undertaken by the wider hospital deep clean team. One cleaner was available at night. Cleaning staff felt included as part of the wider department team and were updated about any infection control risks.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

There were appropriately sited hand wash basins and hand gel dispensers in the emergency department. We saw staff washing their hands and observing standard infection control precautions. Staff wore protective clothing when required and observed the 'bare below the elbow' policy.

Policies and procedures were implemented to reduce the risk of possible spread of infection by minimising the contact, advising people to 'self-quarantine' and processing samples in line with national guidance. Staff were informed of updates daily and/or if the advice changed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment and medical devices. Staff managed clinical waste well.

The design of the environment was not suitable for the demand on the service. The emergency department was not designed to accommodate the number of patients who attended and there was frequently not enough physical space to accommodate all patients in a safe and appropriate environment. Staff endeavoured to ensure all patients were as safe as possible.

The main waiting room had a 'triage pod'. This included a glass area so the triage nurse could observe patients in the waiting room and be alert to any deterioration in a patient's condition. However, the nurse had to move from the triage area to see all aspects of the waiting room.

We saw equipment was stored in the ambulance entrance, this was because of a lack of alternative space. Although this did not prevent access to the resuscitation area, the major incident cupboards were not immediately accessible.

Following the inspection in 2017, we told the trust they should ensure children waiting in the main waiting room of the emergency department were provided adequate privacy away from waiting adults.

During this inspection, we found there was a separate children's area within the emergency department which was secure and not overlooked by adult patients or visitors. However, there was limited waiting space which meant some children had to wait in the main waiting room. While children in that area could be seen from the triage area of the waiting room, children were still visible to other waiting patients. This was not in accordance with design guidance set out in Health Building Note 15-01: Accident and emergency departments (April 2013), which recommends the children's waiting area "should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the children waiting." The space available was not conducive to meeting this guidance.

The paediatric environment was age appropriate with toys and books available in the seated area and decorative walls and age appropriate cartoons and films being shown. The nurses' station looked onto the ward area. There were seats for six people, ideal for two families. There were three beds and two cubicles. There was a breast-feeding room available to enable privacy when feeding.

Some areas of the emergency department needed repair. Some walls had been damaged on the main corridor and were being held in place by tape. This was an infection control risk and a risk to patients.

The corridor, where ambulance-borne patients waited for assessment, and the rapid assessment area, located just inside the ambulance entrance, were draughty and cold.

Not all patients could reach call bells, but staff responded quickly when called. We saw patients receiving care in cubicles had access to call bells, however patients in corridors and in seated areas did not have access to a means to alert staff but they were immediately visible.

Staff carried out daily safety checks of specialist equipment. However, there was a risk equipment and medical devices may not be functioning correctly as servicing of equipment was not always completed in a timely manner and some were overdue their annual safety check and servicing. At our last inspection 2017, we saw an inventory and service history of all medical equipment showed there was a significant amount of essential equipment which had no records of service or service was overdue. At this inspection, we saw some equipment had not been serviced within the recommended time frame. For example, a slit lamp in the minor's area was last serviced in March 2016 and a stand lamp October 2017. We reviewed the service records and saw multiple items had no record of service from 2015 onwards, these included pulse oximeters and diagnostic equipment. We were made aware there was a plan to address the systems used to monitor and report equipment service needs.

At our last inspection 2017, we also told the trust they should ensure the emergency department sluice was secured and flammable products were not accessible to unauthorised persons. At this inspection, we saw the sluice was accessible by key pad entry which meant staff only could access.

At our last inspection 2017, we told the trust they should ensure resuscitation trollies and equipment in the emergency department was readily available and kept clean. At this inspection we saw all resus trolleys were fully stocked and checked daily. We saw one airway trolley, which had some stock out of date. We alerted staff to this at the time and this was replaced.

The service had suitable facilities to meet the needs of patient's families. There was a designated mental health assessment room, which was appropriately fitted and furnished in accordance with recommendations by the Royal College of Emergency Medicine and the Psychiatric Liaison Accreditation Scheme to comfortably and safely meet patient's needs.

At inspection in 2017, we saw the bereavement (viewing) room in the emergency department was being used as a storage area and surgical waste bins were visible immediately adjacent to the relatives' room. At this inspection we saw the room had been temporarily reallocated and would be returned to its former use when possible.

The service mostly had enough suitable equipment to help them to safely care for patients. Equipment we checked was clean, accessible and well maintained. Consumable equipment and materials were available and safely stored.

Staff disposed of clinical waste safely. Clinical waste, including sharps, was appropriately segregated, labelled and disposed of. Cleaning staff were clear in their responsibilities in ensuring the safe management of this waste.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. The emergency department used a triage system to ensure patients were

quickly assessed and streamed to the right area to receive the care and treatment needed with the identified level of urgency. All staff who undertook this role were required to complete training and a period of supervised practice. The system, known as ROSE (Rapid Observations and Symptom Evaluation), allocated each patient a triage score according to the severity of their condition, ranging from one (immediately life threatening) to five (not serious). Patients told us they had all been seen and triaged promptly and records showed this had been completed for each person within 15 minutes of arrival.

The Royal College of Emergency Medicine recommends patients are triaged within 15 minutes of arrival. The trust provided data which showed the target was sometimes met. For example, the trust provided data between 18 November and 18 December 2019, where the 15 minute time to triage was met on 13 days. Further data showed an improvement between 29 January and 28 February 2020 when the target was met on 24 days.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Receptionists told us they used their experience to recognise a seriously unwell or injured patients who needed immediate clinical attention and alerted the registered nurse to this. Should they have any immediate questions or concerns they would summon help from the triage nurse by telephone or request urgent assistance from the wider department. Staff told us there was no training for reception staff about 'red flag' symptoms or signs that would help staff understand the severity of conditions. The trust provided us with a standard operating procedure which gave reception staff some indicators for action.

The Royal College of Emergency Medicine Triage Position Statement states: "Some elements of the triage process, such as initial recognition of urgency, may be undertaken by an unregistered health worker, e.g. reception staff using clearly defined 'red flags' which identify urgency. For this reason, non-registered health care workers in emergency settings should have basic training in red flag presentations and how to call for immediate assistance…".

Reception staff confirmed when a major incident occurred, they had Red Bag actions to undertake. However, they had not received any extra training to advise them of what their roles and responsibilities would be. When a recent major incident occurred, it was felt that training for them would have been a benefit. The major incident course records showed training had only been completed by one member of clerical staff.

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from December 2018 to November 2019. However, more recent information provided to CQC by the trust showed 60-minute ambulance handover delays had improved and were almost none in February 2020.

Following initial registration at the front desk, self-presenting patients were triaged by a registered nurse or emergency nurse practitioner. The registered nurse was supported by an appropriately trained healthcare assistant. The triage nurse was able to observe most patients seated in the waiting area so they would be alert to any patients who appeared very unwell.

If the patient was admitted to the majors area by ambulance or on foot, there was a rapid assessment cubicle where patients were assessed. This area was staffed by a consultant or senior doctor from 8am to 10pm, and a registered nurse and a healthcare assistant. An initial assessment was completed, including observation of vital signs, and any required diagnostic tests were arranged. When delays were encountered, patients were assessed by the nurse coordinator in another bay. This assessment included a set of observations if they had not been recorded by

the ambulance crew in the last 15 minutes. Following this initial assessment, the patient was allocated a cubicle or corridor space, depending on the room available.

Children and young people came into the hospital through the front doors of the emergency department. They were initially seen by the triage nurse in the main waiting area then taken through to the paediatric ward in the main department area. However, the triage nurse was not a trained paediatric nurse and so, if the department was quiet, the child or young person would move straight through to the ED paediatric ward and be triaged by a paediatric nurse. Sometimes, a paediatric nurse would come through to the triage area to support the triage nurse with their initial assessment if the triage nurse did not have enough paediatric training or experience.

Following triage, children and young people were taken onto the paediatric are where they were treated or where they waited for a paediatric doctor to come down off the main paediatric ward. Following this, the child or young person was either discharged from the emergency department or admitted onto the paediatric ward.

If a child or young person was admitted with a head injury or long bone fracture, they were assessed in emergency area until a senior consultant came to see them (not necessarily a paediatric doctor). The team decided on the treatment and if concerned, escalated to the paediatric unit upstairs. If there were no concerns about mechanics of the injury, the paediatric emergency department team discharged them from the department. Before discharge, the team rang the paediatric doctor to inform them, so there was an awareness of the patient. When discharged the patient was given red flag information via a leaflet.

Staff knew about and dealt with any specific risk issues. However, some risks in the department were beyond the department staff's control. Risk assessments were carried for falls and pressure ulcers. We saw these were completed in the sample of records we checked. There was a sepsis screening bundle used which prompted staff to consider, identify and manage sepsis. We observed staff using these tools to maintain patient safety.

There were two-hourly safety barometer checks conducted by the emergency department coordinator. This was used to identify any safety concerns and update the escalation status of the department, which was shared with the hospital's bed management team.

There were standing operating procedures which set out actions required if the department became crowded. Crowding could occur either due to a sudden influx of patients or due to patient flow issues in the hospital leading to delays transferring patients from the emergency department to inpatient wards. Should a patient's rapid assessment be delayed, a nurse was allocated to undertake a 'fast registration', including a first set of observations.

The emergency department used a recognised early warning tool used for adults and children. For adults the National Early Warning Score (NEWS) was used, and for children the Paediatric Early Warning Score (PEWS) was used. Staff told us they were not comfortable using the electronic PEWS scoring system as it did not pick up septic children and so staff undertook observations separately as well, to ensure sepsis was considered.

We saw audit results for NEWS which identified prompt response to triggers for sepsis. The audit showed good levels of compliance but did not identify if early warning scores had been escalated appropriately.

Staff managed the risk of too many patients remaining in the department, who were ready for wider hospital admission. Staff confirmed that regularly the department started the morning shift with over ten patients waiting from the previous day and had not been able to clear minors of major patients by the afternoon surge of attendances. This resulted in an increase in the number

of emergency patients in the department. They also had GP referred patients coming in after lunch. There was normally a peak surge around 17:00-18:00, then another surge about 20:00-21:00pm.

There appeared to be a difference of understanding of this risk and how it was safely managed. Staff told us the block in flow between the emergency department and the hospital was in part due to hospital cutting back beds in the wider hospital bed base. If patients were admitted overnight, the hospital filled up and there was no room for new patients in the morning. By holding patients in the emergency department increased the risk in the department.

The emergency department was sometimes told by senior trust staff to use the minors area to house patients overnight. When patients with illness or injury requiring admission could not access the main hospital out of normal working hours, they were cared for on trolleys in the minors area of the department. Patients were assessed and only those with the lowest risks were kept in this area. However, should a patient have a cardiac arrest then a resus trolley would be difficult to manoeuvre into the minors department creating a risk of delayed action for that patient. This was not assessed and was not included in the trust risk register for ongoing review.

We saw incidents recorded by staff demonstrated the minors area was often used for patients on trolleys when this was not appropriate. We saw an incident when a patient deteriorated in the minors department and had to be taken to the resuscitation area. The area did not have the oxygen, suction and call bells needed to support this use. The area was staffed after midnight by a health care assistant without a registered nurse looking after patients who were unwell.

Call bells were accessible throughout the department except for the far end of one area of the department. This had been used for patients arriving on trolleys, but this had discontinued. That area remained difficult to access with a resuscitation trolley. Staff were also aware that if the fire alarms sounded, fire doors would seal and would separate the mental health assessment room from the body of the department.

The service included round the clock access to mental health liaison and/or other specialist mental health support if staff were concerned about risks associated with a patient's mental health. Psychiatric liaison services were available 24 hours a day and had a one-hour response time for calls from the emergency department. Audits showed the one hour target was not met between April 2019 and March 2020.

Psychiatric Liaison services were only available to over 18-year olds, any under patients under 18 years would have to wait for local Children and Mental Health Services (CAMHS) teams to respond. This response was variable, and no audits were available to review how variable, and we were told there was a policy to admit young people to the ward pending CAMHS assessments.

There were delays in patients requiring mental health review. One patient had waited over 12 hours for a review, at the time of inspection this issue was being addressed.

Staff shared key information to keep patients safe when handing over their care to others.

Patients admitted to the main hospital had their records printed out and transferred with them. Patients were escorted to the wards and a handover of patients care and treatment provided.

If the patient was discharged, discharge information was sent with the patient to give to their GP and a letter sent out by post. Some development of discharge paperwork was underway to improve the detail available.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers took place three times a day, and more frequently in times of escalation. These were

led by the senior doctor and nursing, therapy and discharge staff attended. There was a safety checklist used which followed a structured meeting plan to ensure all appropriate areas were covered.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from December 2018 to November 2019.

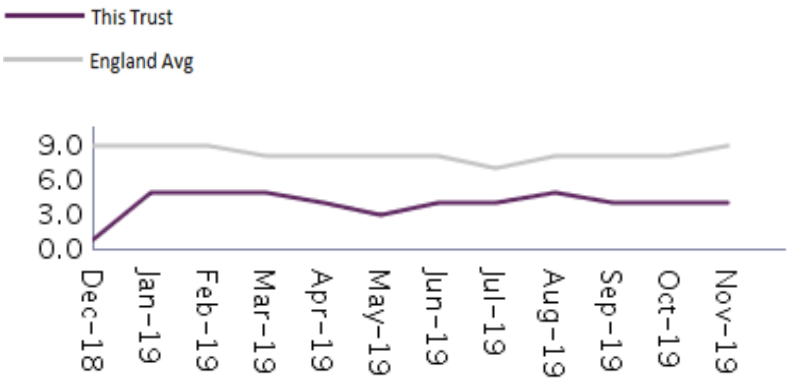
Question	Trust score	Comparison to other trusts
Q5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	7.6	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	5.7	About the same as other trusts
Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.0	About the same as other trusts
Q33. In your opinion, how clean was the A&E department?	8.4	About the same as other trusts
Q34. While you were in A&E, did you feel threatened by other patients or visitors?	9.5	About the same as other trusts

(Source: Emergency Department Survey 2018)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

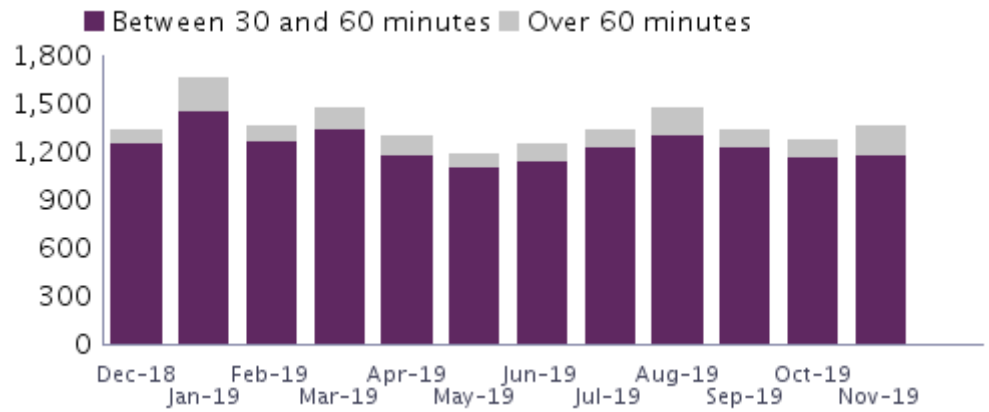
Data on the number and percentage of ambulance journeys with turnaround times over 30 minutes from December 2018 to November 2019 are provided below. The highest numbers of delays over 60 minutes were reported in January, August and November 2019. Almost none were recorded between 17 Feb to 11 March No delays were recorded for February 2020.

Ambulance – Time to initial assessment from December 2018 to November 2019 at Torbay and South Devon NHS Foundation Trust

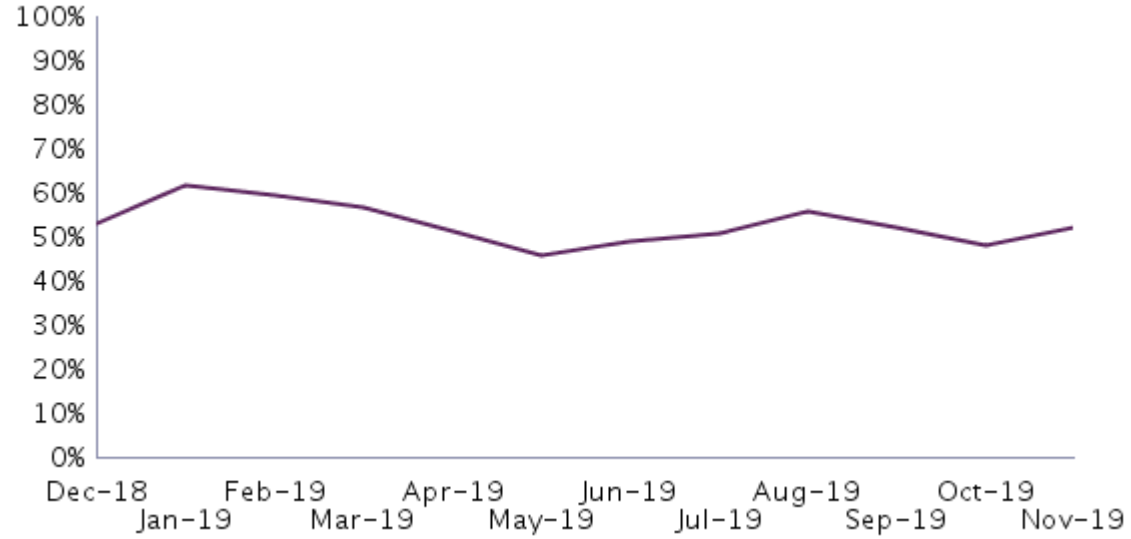


(Source: NHS Digital - A&E quality indicators)

Ambulance: Number of journeys with turnaround times over 30 minutes – Torbay Hospital



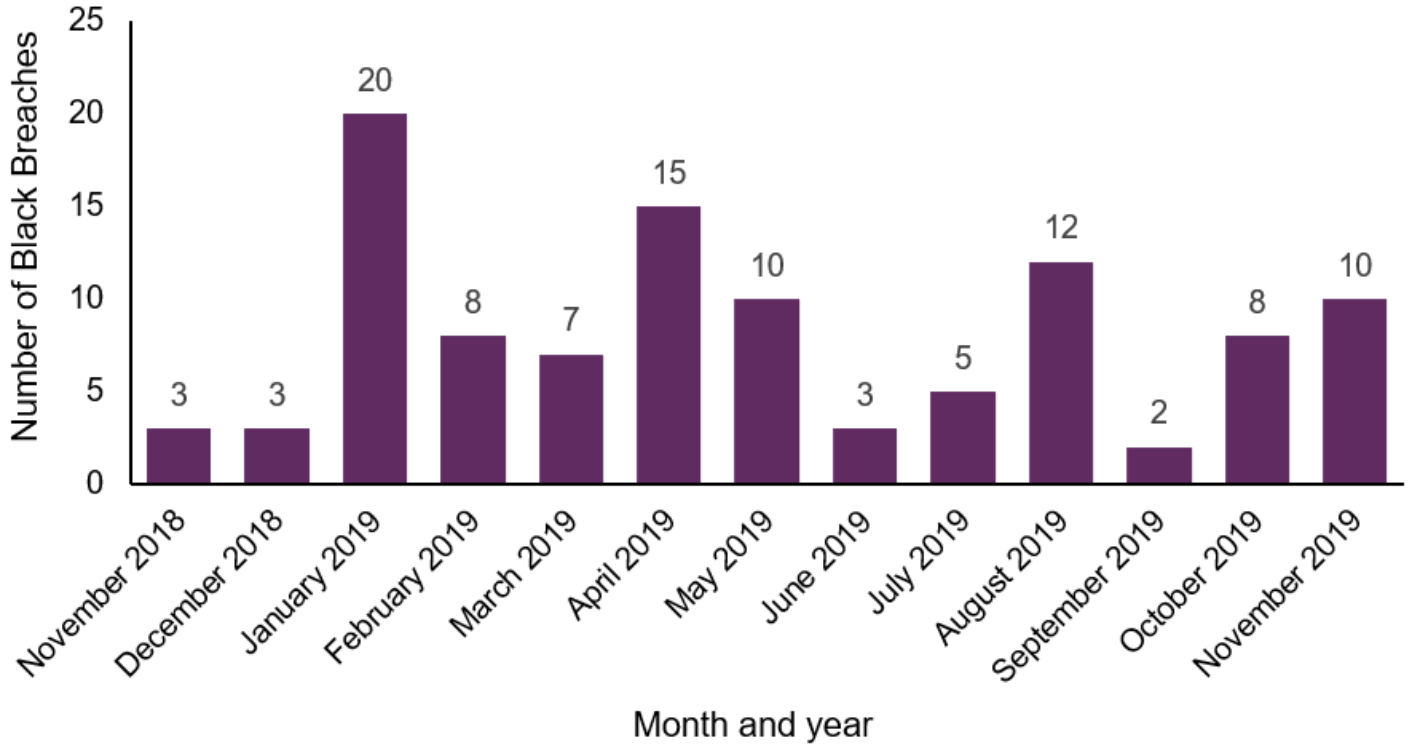
Ambulance: Percentage of journeys with turnaround times over 30 minutes – Torbay Hospital



(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From November 2018 to November 2019, the trust reported 106 “black breaches”, with the highest numbers in January, April and August 2019.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience in all areas to keep patients safe from avoidable harm and to provide the right care and treatment. Staff ensured bank and agency staff a full induction.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, but some areas were not in accordance with national guidance. At the previous inspection in 2017, we told the trust they should ensure staff to patient ratios in the emergency department were always appropriate to keep patients safe. At this inspection we found recruitment was ongoing and staffing ratios were being monitored to meet guidance and patient need, however not all areas of the department were correctly staffed.

Staff skills in paediatric competencies were not always appropriate for their place of work. The paediatric area was not always safely staffed. The paediatric area was not staffed in line with the Royal College of Paediatrics and Child Heath guideline which requires two paediatric nursing staff on duty.

Staffing in the children’s emergency department did not meet the Royal College of Paediatrics and Child Health standards as detailed in the document Facing the Future: Standards for children in emergency care settings. The trust identified difficulties in recruiting and that paediatric nursing levels were reviewed at the start of each shift. The department was staffed by one registered nurse with paediatric competency and one healthcare assistant. The standard requires that every emergency department treating children must be staffed with two registered children’s nurses per shift. There were eight registered children’s nurses in total which meant there were insufficient

staff with paediatric skills to cover each shift on the rota. There were five to six unfilled shifts per four-week rota, which were picked up by the adult team.

Staff told us if the registered nurse was called to the resuscitation area to help resuscitate a child, or to the triage area, or to take a child to the ward then that area had only a healthcare assistant with no paediatric training left in the department. If they needed help, they had to ask one of the adult registered nurses for assistance. We were told by staff those nurses called upon to provide support did not all have paediatric competencies. The trust completed a training needs analysis across band seven and band six staff and identified only three staff needed further up-skilling in paediatrics. Adult nurses working within the paediatric setting received training, completed competencies and undertook supernumerary shifts with a senior paediatric nurse. However, there was a risk adult registered nurses were not maintaining their competencies by seeing enough children.

A document provided to us by the trust showed staff raised concerns about paediatric staffing in December 2019, but staffing was not increased to ensure patient safety. There were no records of this in governance meetings or on the trust risk register.

There was a lack of clinical support to junior nurses and increased pressure of the senior nurse on duty. Staff told us there about shortages of senior band 7 nurses to staff the department. Staff told us there was a risk of exhaustion for staff caused by insufficient support, staff sickness and staff vacancies. Some overseas recruitment was taking place.

The minor injuries unit was staffed by three emergency nurse practitioners between 08:00 and midnight. After midnight it was staffed by a health care assistant. A twilight shift ran from 12:00pm to 00:30am.

Ongoing training and support were not available for staff. Staff also explained since the departments clinical educator had been away, no other clinical development staff member had filled that role.

Staffing in the resuscitation area was measured using recognised acuity tools. Nurse cover for the resuscitation area, was two nurses in line with guidelines from the Resuscitation Council (year).

Staffing levels in the majors and minors areas were between nine and ten registered nurses each shift and between six and ten health care assistants. The band seven nurse acted as coordinator to manage patient flow from 8am to 11pm, seven days a week. However, at the time of inspection a band seven nurse was not always available. A system of using silver and bronze nurse roles had been implemented to ensure an oversight of patient flow. These roles meant the silver nurse retained an overview of the ‘front door’ of the department and the silver nurse focussed on discharges.

Staffing levels in majors were planned to provide a registered nurse to patient ratio of between one to four and one to six. When all cubicles were full and patients queued in the corridor, staff were required to care for up to eight patients. Some flexibility was used to meet demand in some areas. We saw staff moved around the department, for example if needed staff from majors would help in the resuscitation areas. However, no further staff were available in majors. One member of staff was used to cover increased demand, but staff told us that person was often used to staff one area and so was not free to move around. Nurse staffing was reviewed between three and four times daily, and additional staff requested to meet escalated demand. Recruitment remained ongoing to fill nurse vacancies.

The minors area was staffed by emergency nurse practitioners and health care assistants. At midnight the emergency nurse practitioner went home and the minors area was staffed by a health

care assistant only. Support and advice was provided by registered nurses and medical staff from the majors area. The healthcare assistant would require staff off the majors area to give medicines, review observations and cover for breaks.

The triage area was staffed by one registered nurse and one healthcare assistant. Should a paediatric nurse input be needed then they were called from the paediatric department.

Nurse staffing rates within the emergency department at Torbay Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for bank use.

The table below shows a summary of the nursing staffing metrics in the emergency department at Torbay Hospital compared to the trust's targets, where applicable:

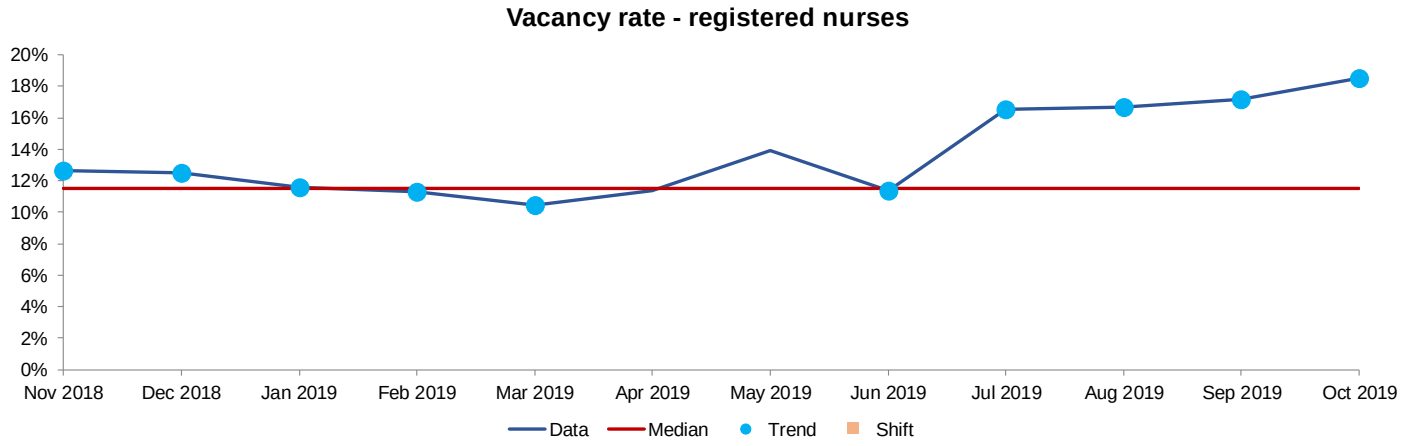
This shows the vacancy rates for the emergency department considerably exceed the trust targets.

	Emergency department annual staffing metrics						
	November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	265	8%	15%	4.8%			
Qualified nurses	119	14%	12%	4.5%	7,331 (5%)	32,564 (21%)	3,751 (2%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Vacancy rates

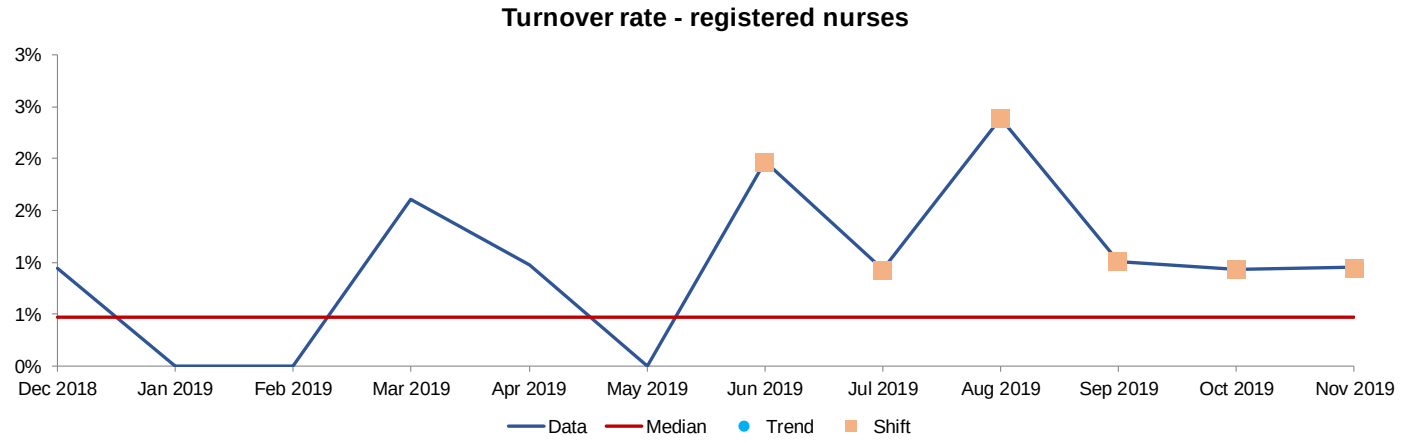
The service had low and/or reducing vacancy rates. Monthly vacancy rates over the last 12 months for registered nurses firstly showed a downward trend of improvement from November 2018 to March 2019 however this changed from June 2019 where an upward trend can be seen until October 2019. This may be due in part to overseas recruitment. There were vacancies for senior bands of nursing staff caused by staff leaving or illness. Because of this on the last day of our inspection one nurse covered both silver and bronze roles.



(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

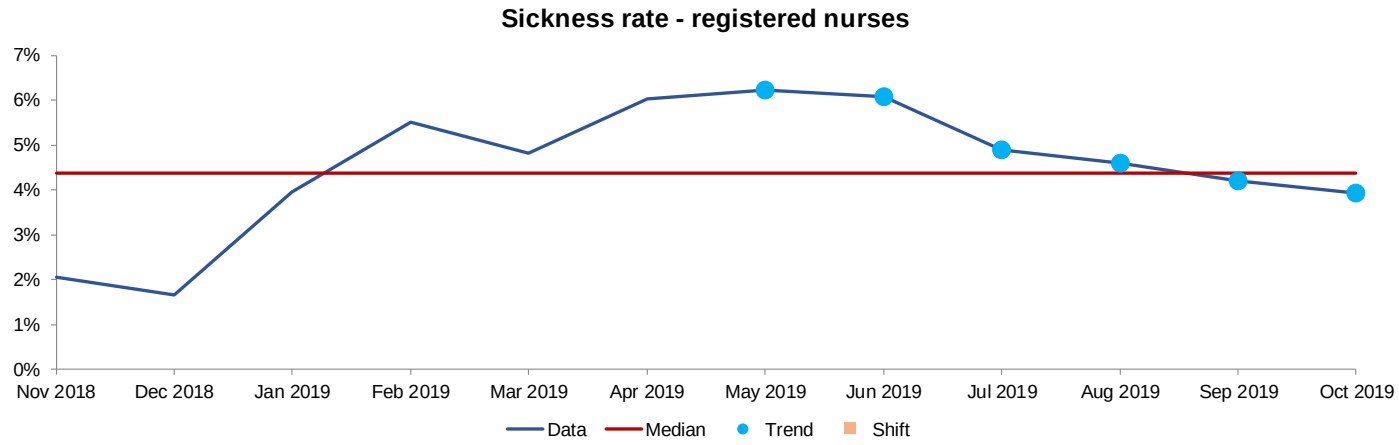
The service had an upward shift in turnover rates. Monthly turnover rates over the last 12 months for registered nurses showed an upward shift from June 2019 to November 2019. Staff told us staffing changes had taken place at a senior nurse level and there was an ongoing shortfall of band six and seven nurses. The Trusts board report for March 2020 confirmed the registered general nurse turnover rate had reached a two year high of 13.6%. Further data from the trust showed emergency department (ED), at the end of October 2019 had registered nursing vacancies of 24% this was excluding Emergency nurse practitioners. This was in excess of the trust vacancy level of 9.8%.



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

Sickness rates

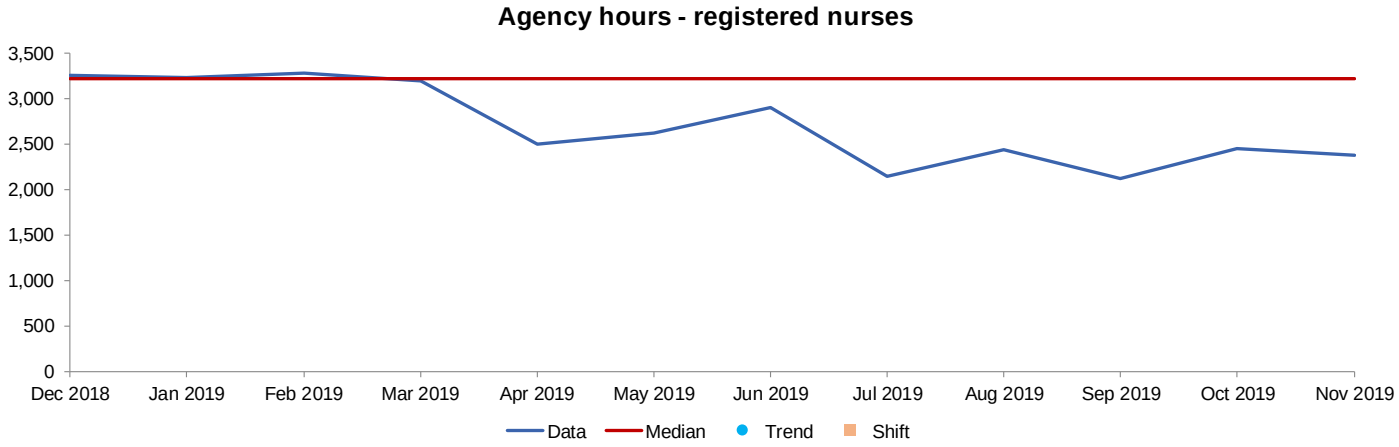
The service had reducing sickness rates. Monthly sickness rates over the last 12 months for registered nurses showed a downward trend from May 2019 to October 2019. The trust board meeting minutes for March 2020 noted while the trust was not an outlier for sickness levels, they were a concern about these levels in the emergency department. Information from the trust said the highest percentage of reason for both trained and unregistered nurses included anxiety and stress.



(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The service had low and/or reducing rates of bank and agency nurses. Monthly agency use over the last 12 months for registered nurses were not stable and could be subject to ongoing change. Staff told us agency staff were used as part of a regular booking to ensure consistency of staff in the department. The department also used bank staff to cover shifts and offered extra shifts to department staff.



(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank staff completed orientation and training on the electronic patient record system before starting work.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Consultant cover throughout the week was structured in two overlapping shifts: 8am to 4pm and 2pm to 10pm. Cover at weekends was one consultant on duty 8am until 4pm and a second from 4pm to 10pm. Outside of these hours there was a minimum of an ST4 (specialist registrar year three) or above, supported by a consultant on call. Staff felt this was not sufficient to be safe. This did not meet the 16-hour consultant cover in line with RCEM guidance.

At the time of our inspection the emergency department did not employ a consultant who was dual trained in adult and paediatric emergency medicine. There was an allocated paediatric doctor for the department during the day. This doctor was not dual accredited as a doctor and paediatrician and provided advice for the paediatrics department as needed. Some delays had been experienced as paediatric doctors were often busy, so it had been difficult to get them to attend straight away. There were no target times set for paediatricians to attend the unit. However, staff told us in most acute or chronic cases, the doctor responded quickly.

There was a medical doctor employed 8am to 5pm to review patients with medical health needs referred by their GP, the staff found this role very supportive.

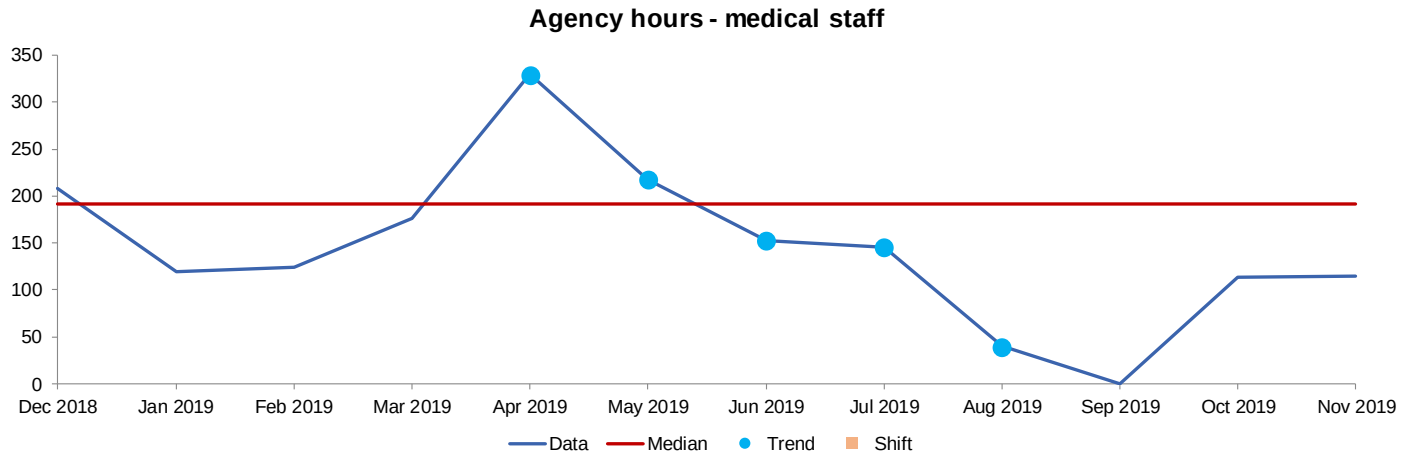
Torbay Hospital

The medical staff matched the planned number. The table below shows a summary of the medical staffing metrics in the emergency department at Torbay Hospital compared to the trust's targets, where applicable:

	Emergency department annual staffing metrics November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	265	8%	15%	4.8%			
Medical staff	37	10%	27%	1.0%	5,882 (2%)	1,742 (<1%)	118 (<1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within the emergency department at Torbay Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank use.



Monthly agency use over the last 12 months for medical staff showed a downward trend from April 2019 to August 2019. This could be an indicator of change.

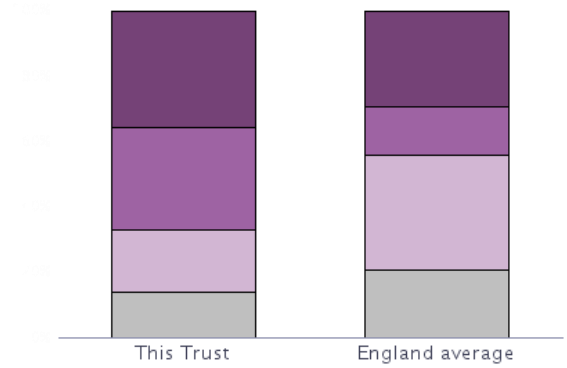
(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. There was limited use of locum staff with the department staff picking up many of the shortfall shifts.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In October 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 29 whole time equivalent staff working in the emergency department at Torbay and South Devon NHS Foundation Trust.



	This Trust	England average
Consultant	36%	29%
Middle career^	31%	15%
Registrar group~	19%	35%
Junior*	14%	21%

^ 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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, there were delays in accessing records for patients transfer and discharge.

Patient notes were comprehensive, and all staff could access them easily. We looked at a sample of 11 patient electronic records. They were legible and well ordered to enable easy understanding of content. The computer used had a shared front screen with a line for each patient. Next to their name was a symbol to indicate what staff should know about the patient at a quick glance. The next column showed staff how long the patient had been waiting in for treatment. We saw each patient had been triaged within 15 minutes and seen by a doctor within the hour.

There were issues previously identified by the trust and reported on their risk register about the IT system in the emergency department. The issues included losing records and some difficulty in opening multiple files. The risks were being monitored on the trust risk register but no clear actions and outcomes including timescales were recorded. The trust had an IT issues resolution plan with a start date for emergency department issues prior to inspection, this work was ongoing.

Risk assessments and observations were correctly recorded. There was a diagnosis and management plan documented in the patient's notes. A nursing assessment had been completed where appropriate for each patient, such as a falls assessment, a pressure ulcer assessment. NEWS scored were documented in each record.

The department had an ED safety checklist as an electronic record of overview of care provided. We saw some data was extracted from the electronic patient record system for audits.

There was evidence of input by multidisciplinary healthcare professionals within patient notes, such as support from other teams within the hospital to assess specific health aspects for the patient. Treatment escalation plans (TEP) were recorded on paper. This was maintained as a paper copy and travelled with the patient.

Staff had access to computers, and we saw staff updating care records as they were going along.

At our inspection in 2017 we saw there was no formal audit relating to records standards, at this inspection audit information was pending.

When patients transferred to a new team, there were some delays in staff accessing their records. There were delays in accessing records for patients transfer and discharge. The electronic system in the emergency department and the system used in the wider hospital were not linked. All patient records had to be printed out into paper format and transported with the patient. We saw and staff confirmed some delays were experienced because the printers used had a delay. For example, we saw the printers in the resuscitation area did not work. This meant everything had to be printed off in the nurses' station. Staff struggled to print off records in time for a patient's discharge.

Staff told us discharge paperwork needed to improve. The discharge summary was basic and on paper. Staff put them into envelopes and sent them out to GPs.

Records were stored securely. At our last inspection in 2017, the trust was told they must ensure the secure storage of confidential patient records in all areas. At this inspection we found records were secure. Paper and electronic records were managed appropriately. Electronic records were managed securely, and paper records were stored in a way to promote patient confidentiality.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines.

Staff followed systems and processes when safely prescribing, administering and recording medicines. At our last inspection in 2017, we saw patient group directions (PGDs), which allowed some registered nurses to supply or administer certain medicines to a pre-defined group of patients, were not all signed by staff or counter-signed by managers. Some emergency nurse practitioners (ENPs) were trained as non-medical prescribers so they could supply and administer certain medicines. There were also Patient Group Directions (PGDs).

At this inspection we saw most PGD's were correctly signed and updated. This was with one exception which we alerted staff to at the time of our inspection.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines.

The electronic records system had a drugs/medication section, but it was not an electronic prescribing tool. All drugs were recorded on drug charts. If patients were delayed in the department there were processes to ensure patients' usual medicines were prescribed and given.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines were appropriately stored in locked cupboards or refrigerators. Records showed refrigerator temperatures were regularly checked, and they were correct at the time of our visit.

There was a security risk the paediatric medication cupboard had a key pad lock which was visible to patients and relatives. We requested a risk assessment from the trust, and they completed an assessment following our inspection date 26 March 2020. This identified control measures and actions to minimise the risk.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were encouraged to report incidents but told us they did not always receive individual feedback or an outcome. Safety briefs were used to disseminate wider learning. We attended one safety briefing after the morning handover and observed incidents and learning were discussed. Items discussed at these briefings were recorded weekly and emailed to staff.

Staff told us there were quarterly mortality and morbidity meetings in the emergency department where the care of patients who had complications or unexpected outcomes was reviewed. Minutes were not consistently available to show these minutes took place regularly. Key learning from these meetings was discussed in governance meetings but a minimal record was maintained of outcomes and learning.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. However, staff did not report all staffing and environmental incidents. During October 2018-October 2019, there were 1266 Incidents in this time period which is in line with the national benchmarking reporting within NRLS, the breakdown of the incidents are as follows:

- 955 incidents affecting patients
- 194 incidents affecting staff
- 14 Incidents affecting visitors
- 103 incidents affecting the trust

Staff told us they sometimes missed reporting staffing and environmental issues because they were too busy, and several staff commented that reporting these issues didn't affect any changes.

Never events

The service had no never events. From February 2017 to the time of inspection the trust reported no never events in the emergency department. 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.

(Source: Strategic Executive Information System (STEIS))

Staff reported serious incidents clearly and in line with trust policy. Managers shared learning with their staff about never events that happened elsewhere. Reflection of a recent major incident had been used to evaluate and improve the response of the department to ensure informed safe future actions

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in the emergency department which met the reporting criteria set by NHS England from December 2018 to November 2019. Staff told us about some feedback learning from serious incidents and how extra training was sometimes provided as a result.

A breakdown of the incident types reported are in the table below:

Incident type	**Number of incidents**	**Percentage of total**
Slips/trips/falls meeting SI criteria	3	37.5%
Diagnostic incident including delay meeting SI criteria	3	37.5%
Treatment delay meeting SI criteria	1	12.5%
Abuse/alleged abuse of adult patient by staff	1	12.5%
Total	**8**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff met to discuss the feedback and look at improvements to patient care. Staff all understood their responsibilities under the duty of candour regulation.

Managers told us investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff told us managers and matrons were tasked to investigate or delegate to senior department staff, but they were not involved. They confirmed they sometimes received feedback personally but generally feedback came to them through safety bulletins and handover of information.

Managers debriefed and supported staff after any serious incident. Staff told us following a recent

major incident they were provided with opportunity to debrief and consider any further actions and learning after the event.

Safety Thermometer

There is no specific emergency department safety thermometer.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Exclusions to the use of safety thermometer includes accident and emergency attendances.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care and treatment in the emergency department was delivered using clinical guidelines. These included National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's Clinical Standards for Emergency Departments. We observed patients following agreed pathways and staff following the trusts policies and procedures. Compliance with pathways and standards was audited as part of an ongoing review process. The policies seen were reviewed and up to date.

Sepsis pathways were followed to ensure patient safety. Sepsis is a serious, potentially

life threatening complication of an infection. There was a sepsis screening bundle in use which prompted staff to consider, identify and manage sepsis. Sepsis audits were undertaken to ensure effective sepsis practice was maintained.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice within their capacity to do so. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

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.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw drinks being provided for patients and relatives. Domestic staff served drinks and snacks under the supervision of nursing staff. Patients told us how much they appreciated being offered food and drinks.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 7.4 out of 10 for the question "Were you able to get suitable food or drinks when you were in A&E?" This was the same as other trusts.

(Source: Emergency Department Survey 2018)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Pain assessment scales were used as a tool to measure pain levels, these tools included those for children to use and for patients with some learning or physical disability. We observed patients being assessed and offered pain relief as appropriate. Patients told us they had been assessed and assisted to be pain free and comfortable.

At our last inspection in 2017, we saw there had been no recent audits in relation to pain relief. Reassessment of pain relief following analgesia was not consistently recorded. We requested data from the trust, which was not available. The trust told us two pain audits in the emergency department were pending re audit.

Emergency Department Survey 2018 – Type 1 A&E departments

In the CQC Emergency Department Survey, the trust scored 7.2 out of 10 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was the same as other trusts.

Question – Effective	Trust score	Comparison to other trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	7.2	About the same as other trusts
Q35. Were you able to get suitable food or drinks when you were in A&E?	7.4	About the same as other trusts

(Source: Emergency Department Survey 2018)

Patient outcomes

Staff did not always monitor effectiveness of care and treatment or use findings to make improvements to achieve good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. Information about patient outcomes was routinely collected and monitored. The emergency department participated in the Royal College of Emergency Medicine audits so they could benchmark their practice and performance against best practice and against other hospitals.

Recent data was not available at this inspection.

Managers and staff did not always use audit results to improve patient outcomes. Sepsis audits undertaken within the department showed that of the sample of 48 patients reviewed; 92% received antibiotics within one hour, 87% received fluids within one hour and an overall review showed performance in the rapid assessment area was higher than other areas. The audit report concluded further work needed to be done to look at delays, but no action plan was available.

The Trauma Audit and Research Network results had mostly positive outcomes, but results showed the proportion of patients with severe open lower limb fracture receiving appropriately

timed urgent and emergency care did not meet the national standard. Staff told us they considered this is due to the high capacity demand on the department.

Trauma Audit and Research Network (TARN)

Torbay Hospital

The table below summarises Torbay Hospital's performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

Metrics ***(Audit measures)***	**Hospital performance**	**Audit Rating**	**Met national standard?**
Case Ascertainment *(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)*	90.9 - 100+%	Good	Met
Crude median time from arrival to CT scan of the head for patients with traumatic brain injury *(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)*	46 mins	Takes longer than TARN aggregate	Met
Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury *(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding*)	87.5%	Higher than TARN aggregate	No standard
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care *(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)*	50.0%	Higher than TARN aggregate	Did not meet
Risk-adjusted in-hospital survival rate following injury (*This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.*)	2.9 additional survivors	Positive outlier	Met

(Source: TARN)

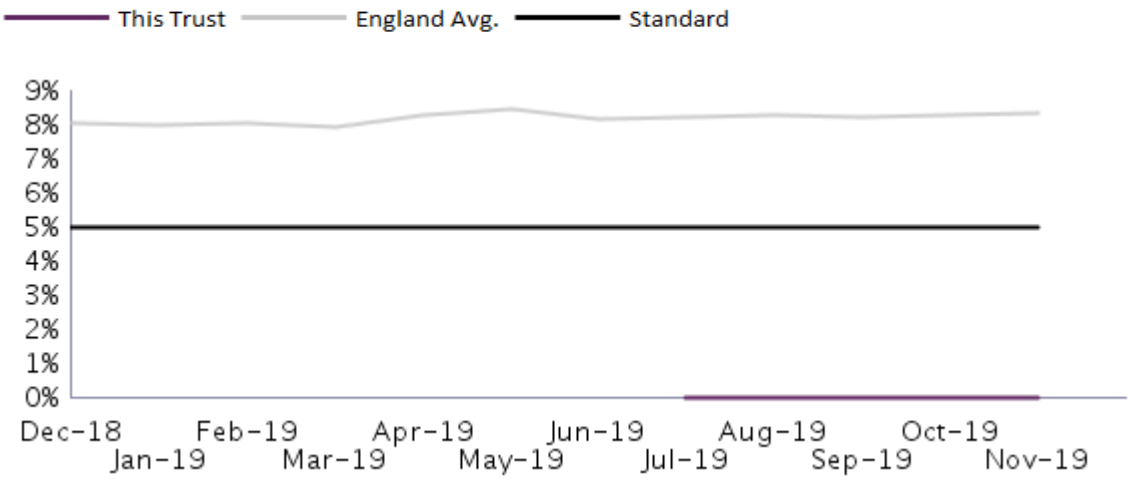
Unplanned re-attendance rate within seven days

The service had a higher than expected risk of re-attendance than the England average. At our last inspection in 2017 we saw the unplanned emergency department re-attendance

rate within seven days was generally worse than the England average and the national standard of 5%. At this inspection we saw that remained the same and was in excess of the national level.

From March 2019 to March 2020 the trust had a higher than National performance level of unplanned reattendances. This data was not being used to change any practices and staff were not aware of any action was being taken to address this.

Unplanned re-attendance rate within seven days - Torbay and South Devon NHS Foundation Trust



(Source: NHS Digital – A&E quality indicators)

Competent staff

The service did not make sure all staff were competent for their roles. Managers did not always appraise staff's work performance and did not regularly hold supervision meetings with them to provide support and development.

Staff were not always supported to develop the right skills and knowledge to meet the needs of patients. Nursing staff were not supported to develop in their roles. However, they told us training was often cancelled due to capacity pressures in the department.

The clinical educator was absent for a period of time, and therefore there was less support for the learning and development needs of nursing staff. Staff told us they missed the opportunity to develop their roles because of this and felt it devalued them. They explained training opportunities were no longer sourced by the development nurse and staff missed opportunities to develop.

Junior doctors had weekly protected time for teaching. In addition, there were daily teaching sessions after the staff handover and informal teaching as the opportunity arises.

Managers gave all new staff a full induction tailored to their role before they started work. However, extra learning to support staff in new roles was not always provided. A full induction was given to all new staff. However, we were aware due to the capacity pressures newly qualified or promoted staff did not always have the extra learning they needed to ensure they felt competent and ready.

Appraisal rates

Managers did not always support staff to develop through yearly, constructive appraisals of their work. At our last inspection in 2017, we told the trust they should ensure appraisals for nurses are completed. At this inspection we saw updated data which said targets for completion had still not been met with only 53% of registered nurses having received an appraisal. The trusts board meeting in March 2020 noted a review of the appraisals was planned for April 2020.

Torbay Hospital

From December 2018 to November 2019, 73.7% of staff within the emergency department at Torbay Hospital received an appraisal compared to a trust target of 90%. This compares to an appraisal rate of 76.6% in the previous financial year (April 2018 to March 2019).

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Administrative and clerical	30	31	96.8%	90.0%	Yes
Nursing and midwifery registered	60	83	72.3%	90.0%	No
Additional clinical services	49	70	70.0%	90.0%	No
Additional professional scientific and technical staff	1	2	50.0%	90.0%	No
Allied health professionals	0	4	0.0%	90.0%	No
Total	**140**	**190**	**73.7%**	**90.0%**	**No**

Appraisal data provided by the trust for this core service did not include medical staff.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed all staff across all grades, functions and departments working well together. Ambulance staff worked well with the departments administrative and clinical staff to ensure patient safety.

Staff worked across healthcare disciplines and with other agencies when required to care for patients. Care was delivered in a coordinated way with support from specialist teams and services. Doctors in the emergency department reported a good working relationship with specialists who reviewed patients in the department.

Staff reported good working relationships with other departments within the hospital, including the emergency assessment units, paediatrics, the stroke team, radiology and the psychiatric liaison team.

Information around mental health and associated risks was handed over as part of the nursing handover, as well as discussed during safety briefings at the changes of shift and during board rounds.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Patients with mental health issues were flagged up on the system. The psychiatric liaison service gave advice and guidance if a patient attempted to abscond or refused treatment.

While patients waited for a mental health assessment, staff moved patients to a side room to support them with their privacy and dignity and to reduce potential distress. Staff could request one-to-one support if this was required and staff offered food and drink to support people to feel more comfortable. If patients needed one -to-one support this was escalated to clinical site management.

Seven-day services

Key services were available seven days a week to support timely patient care.

Patients were reviewed by emergency department consultants or speciality consultants depending on the care pathway. There was senior medical staff presence in the emergency department seven days a week, although consultant cover was reduced each evening and at weekends. This meant there were always emergency department medical staff available to see patients, and speciality doctors available in the wider hospital.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The department had nearby rapid access to X-Ray and CT scanning facilities. Psychiatric support was available seven days a week, however we saw delays for patients with ongoing reviews.

pharmacy services were available between 9am and 7pm Monday to Friday and between 9am and 1pm at weekends. There was an on-call pharmacist available by telephone outside of these hours.

Staff could refer to local support services for drug and alcohol dependency Monday to Friday each week.

Portering staff were used to transport patients for diagnostic tests and transfers to wards. Porters arrived promptly and were seen to be polite and helpful.

Security staff were accessible to staff who told us when they called for assistance security staff responded promptly.

Health Promotion

Staff gave patients support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had relevant information promoting healthy lifestyles and support on the wards/units. Information was available in leaflet and poster formats. We observed nursing staff talking to patients and relatives about how their health conditions could be managed and improved.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Not all staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patient records. When patients could

not give consent, staff made decisions in their best interest. We observed consent being requested and recorded. We observed staff seeking a patient's verbal consent before undertaking care or treatment. Diagnostic tests and treatments were explained clearly to patients in a way they could understand.

Policies and procedures related to the Mental Capacity Act were available to staff on the trusts internet. The appropriate paperwork was available, and staff followed the trusts policies for patients who did not have mental capacity and needed actions to be taken in their best interest.

Treatment Escalation Plans (TEPs) were always completed by medical staff. Staff routinely completed TEPs if a patient transferred to another hospital. If a patient was dying, staff could refer to the specialist palliative care team and planned around palliative care and completed the TEPs form then.

A cubicle was made available (opposite the nursing station) for patients pre and post Mental Health Act assessment, this room had access to a toilet and had minimal furniture and equipment there for safety.

Patients were only restrained if there was an immediate danger. Security staff weren't trained to restrain. Staff used de-escalation as a preference and the police were called if needed.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff were aware of and considered Gillick competence when consent was sought for interventions concerning children. If uncertain they would discuss with the paediatric team.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing and clinical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust reported Mental Capacity Act training including Deprivation of Liberty standards was delivered as part of the corporate and clinical induction for all new staff. However, no training data for these courses was provided to CQC as part of the Provider Information Request.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The mental health training programme was based on the PLAN (Psychiatric Liaison Accreditation Network Standards) expectations of training. We were told this training was bespoke and highly attended by a range of disciplines within the hospital. The training included information on legislation (including Mental Health Act s136). Staff demonstrated a good understanding of treating patients under a section 136 order. Section 135 of the Mental Health Act 1983 allows for a patient with a mental health crisis to be removed by the police to a place of safety for a restricted period.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Learning around the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) was covered on a mandatory study day which occurred twice a month in short 15-minute bursts. Staff told us this was helpful.

Not all staff had a good understanding of the Mental Capacity Act. Staff did not all understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Several staff we spoke with did not have a working knowledge of the Mental Capacity Act despite them confirming training was delivered in their induction. Staff often confused the Mental Capacity Act with the Mental Health Act and did not know what the five principles were or where to record capacity information on the electronic database. For example,

we saw for a patient identified as having dementia needs, there was insufficient assessment information recorded, to identify the level of patient capacity to make decisions. A mental capacity assessment was not completed and there was no consideration of the patient's mental health. The nurse undertaking the patients care did not have a good working knowledge of the Mental Capacity Act.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Due to patients only being in the department for a short time, formal mental capacity and DoLs applications were normally completed by the ward they were transferred to.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity whenever possible within the environment, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. We spoke with 11 patients and eight carers in the department and there was overwhelmingly positive feedback about the nursing and medical staff and the treatment they had received. Patients said staff treated them with respect and dignity. One patient said they had received a "first star service". Another said the staff had been, "fantastic as always" and felt "100% taken care of". One carer said the staff were "first rate in my eyes". One carer said the staff were very supportive towards her and her mother when her mother was in distress.

There was a visible person-centred culture with all staff putting patients as the centre of discussions. Patients we spoke with said their views and preferences had been considered before they started treatment. Carers said staff had listened to them when assessing their family member. Carers told us staff delivered patient centred care and always waited to seek feedback from the patient.

Staff all spoke passionately about the importance of providing kind and compassionate care to the best of their ability and especially given the environment and high capacity.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. Due to the extremely low number of responses (26 from December 2018 to November 2019) we were unable to analyse performance of this metric over time. We asked department staff if the service had considered why the response rate was so low and staff were unable to provide us with an answer.

(Source: Friends and Family Test)

Due to the environment staff could not always keep patient care and treatment confidential. At our last inspection in 2018, patient privacy was not always protected in the emergency department. The department had not taken any steps to prevent patients at the main reception desk or those seated from overhearing other patient's private conversations. At this inspection, we saw this remained the same. The available space within the department made privacy difficult and staff did all they could to promote patient confidentiality.

The nature of the department did always not ensure privacy of patients. Some patients were cared for on a corridor which did not enable patient privacy and dignity. These patients were sometimes on the corridor for many hours including overnight. Nursing staff told us they would try to make

sure privacy was provided when needed. However, we observed this was not always possible and being cared for on a corridor meant there was no privacy to use washing facilities and the toilet.

The triage area of the main waiting room did not ensure patient confidentiality and privacy. The initial triage took place behind a glass screen, but conversations could be heard in the waiting room. Staff did their best to ensure confidentiality by keeping conversations as quiet as possible but because of the proximity of the waiting room conversations could still be overheard.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff ensured when possible patients cultural and social needs were met. They told us side rooms were available and could be used to facilitate cultural and religious needs. We saw there was a family carer support worker in the department each day. Their role was to provide information and advice to support carers of patients in the community. This meant patients and relatives could talk with this person and discuss how their specific needs could be addressed both in hospital and when discharged to the wider hospital or out into the community.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw several examples of the support and help provided to patients by nursing and medical staff. Staff were polite and introduced themselves by name and by role.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. Staff communicated well with people demonstrating empathy and compassion. All staff including administrative and housekeeping were respectful and understanding. If someone in the department was in distress, staff arranged for them to sit in a separate room away from the main corridor areas, to try and reduce any discomfort or distress. Staff ensured the patient would have a staff member sit with them to support them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff aimed to move people to a quieter area of the department or a side room if they became distressed. They explained which rooms they would use, and how they would look at risks within the room and manage these.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The room used to provide quiet for bereaved relatives was out of use, due to the reallocation of space to support COVID- 19 activity. Staff told us they would ensure another suitable area could be used.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff supported patients to make advanced decisions about their care. We observed staff taking time to explain treatment plans and answering any questions they may have had. We spoke with patients who all confirmed they knew what the plan was for their care. Carers said they had received

essential information for carers from nurses, family, friends and contacts. Patients said they had been given opportunities to contact their families.

Staff understood the importance of involving relatives, including parents of children and young people. We saw young adults and children were included in conversations about their care.

Staff directed patients and worked with other networks in the community to provide a wider network to help patients when they were discharged.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment.

A room was available for relatives to sit and have required quiet discussions with staff, this room was sometimes used when quiet space was needed to have difficult conversations. These rooms were furnished in a non-clinical way with refreshment facilities.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service.

Patients and relatives were given time and opportunity to ask questions and staff waited for the answers. We saw staff offer options and discuss patients care with them. Patients were keen to tell us about the good care they had received. Patients understood the difficulties of the department and were complimentary about the staff and the care they received.

Emergency Department Survey 2018 – Type 1 A&E departments

The feedback from the Emergency Department survey test was positive. The trust scored about the same as other trusts for all the 26 Emergency Department Survey questions relevant to the caring domain.

Question	**Trust score**	**Comparison to other trusts**
Q10. Were you informed how long you would have to wait to be examined?	3.4	About the same as other trusts
Q11. While you were waiting, were you able to get help from a member of staff to ask a question?	7.2	About the same as other trusts
Q13. Did you have enough time to discuss your condition with the doctor or nurse?	8.5	About the same as other trusts
Q14. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.1	About the same as other trusts
Q15. Did the doctors and nurses listen to what you had to say?	8.7	About the same as other trusts
Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.7	About the same as other

Question	Trust score	Comparison to other trusts
		trusts
Q18. Did doctors or nurses talk to each other about you as if you weren't there?	9.1	About the same as other trusts
Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?	8.2	About the same as other trusts
Q21. While you were in A&E, how much information about your condition or treatment was given to you?	8.6	About the same as other trusts
Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.1	About the same as other trusts
Q24. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	8.7	About the same as other trusts
Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.1	About the same as other trusts
Q45. Overall, did you feel you were treated with respect and dignity while you were in A&E?	9.0	About the same as other trusts
Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.3	About the same as other trusts
Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.7	About the same as other trusts
Q28. Before you left A&E, did you get the results of your tests?	7.9	About the same as other trusts
Q29. Did a member of staff explain the results of the tests in a way you could understand?	8.9	About the same as other trusts
Q30. If you did not get the results of the tests when you were in A&E, did a member of staff explain how you would receive them?	6.4	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could	8.9	About the same as other

Question	Trust score	Comparison to other trusts
understand?		trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	4.9	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	5.8	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving A&E?	4.7	About the same as other trusts
Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	6.1	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	7.6	About the same as other trusts
Q44. Did staff give you enough information to help you care for your condition at home?	7.5	About the same as other trusts
Q46. Overall...	8.0	About the same as other trusts

(Source: Emergency Department Survey 2018)

Is the service responsive?

Service delivery to meet the needs of the local people

The service planned and provided care in a way that aimed to meet the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services but did not always meet the changing needs of the local population. The trust worked with other health care providers and stakeholders to look at how system wide strategies could improve the flow of patients through the hospital. For example, the department worked with the ambulance service to try and avoid delays in offloading patients. Predictor tools were used to look at levels of previous attendance to estimate potential demand on the service. However, these predictions had not been linked to increased staffing or planning for potential surges in activity.

Facilities and premises were not always adequate for people using the department. In the majors' area, patients frequently queued in corridors, either while they were waiting to be seen or while

waiting to be transferred to a ward. Patient relatives sometimes had to stand with them as there was no room for seating. Limited storage facilities also impacted on congestion in the department with patients and staff having to manoeuvre around equipment.

There was nearby parking and signposting within the department was clear and easy to follow. There was an information desk, staffed during the day by a receptionist who helped to direct relatives and visitors.

There were vending machines in the waiting room where people could purchase hot and cold drinks and snacks. The department was equipped with toilets suitable for adults and children, including those with disabilities. There were also nappy changing facilities and an area for breast feeding mothers.

The department had a clinical decisions unit with eight chair spaces. This room was for patients waiting test results or ongoing observations prior to discharge.

The service had arrangements, known to all staff on duty, to meet patients' urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. There was a mental health assessment room which was equipped to make patients safe. Staff also used a side room for patients requiring further treatment. Staff said the hospital security team could support with patients who were being aggressive to other patients or staff.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences. However, staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. When patients with specialist needs attended the department, staff were only alerted of those needs if the patient had attended previously. The departments IT system had the capacity to alert some patients specialist needs, but this was only if they had been identified previously. The staff and patients were reliant on the reception staff ensuring details were recorded for patients with learning disability or visual or hearing support needs. Once identified patients with cognitive impairments were well supported.

The trust had provided a mental health training programme based on the PLAN (Psychiatric Liaison Accreditation Network Standards) expectations of training. We were told this training was bespoke and highly attended by a range of disciplines within the hospital.

Should a young person require mental health support during their stay, staff had a flow chart to follow about when and how to contact Children and Adolescent Mental Health Services (CAMHS). However, the CAMHS team only operated from Monday to Friday and the hospital's psychiatric liaison team were only permitted to work with adults. This meant if a child or young person attended on a Friday night, they would potentially have to wait in the paediatric unit until someone could see them the following week.

We reviewed one set of notes from a young person who had required mental health support. There were detailed notes and we saw multi-disciplinary team notes from CAMHS on the electronic database. Information was present about the young person's discharge and follow on support from CAMHS.

The department was not designed to meet the needs of patients living with dementia and learning disability. At our last inspection in 2017, we saw the department had taken limited steps to support

people in vulnerable circumstances, such as people living with dementia, or people with a learning disability. There remained limited facilities and support for patients living with dementia.

A specific dementia care plan was not used but staff recorded details of any specific dementia related care needs. The department did not currently have a dementia champion nurse and so extra support was not available to patients and staff.

There a hospital learning disability team, which was one person. When patients came into the hospital who had a learning disability, this did not flag up on the system nor alert the learning disability team. The staff in the department would alert the learning disability team by telephone and record this on the patients notes. This system was reliant on the staff member completing this task. There was a learning disability page on the intranet which provided resources for doctors and patients and information about access to Independent Mental Capacity Advocates.

Patient privacy was not always protected in the emergency department and could impact on the care being provided. Staff told us for patients on the corridor some examinations which required the removal of clothing were delayed while private space could be found.

The emergency department was accessible for people with limited mobility and people who used a wheelchair. Fixed seating in the waiting room could not accommodate bariatric patients but the department had a suitable trolley and could request equipment from within the hospital if required.

The service had information leaflets available in languages and formats to meet patient's needs. There was access to interpreter and translation services. The trust had an accessible information policy, which included information about supplying information in 'easy read' format, interpretation and translation services. The department had access to a service which provided specialist support for deaf patients or parents. There was a hearing loop in reception to assist people who used a hearing aid.

Staff were able to access interpreters for patients whose first language was not English. Staff told us this was a very quick and responsive service. Documents were not available in other languages, but reception staff said they could be accessed electronically.

Patients were given information about the emergency department and what to expect. Self-presenting patients were given an advice leaflet on arrival which explained the various pathways through the department and provided a range of useful information.

There were facilities to display waiting times, but this had not been kept updated. This meant patients in the waiting room were not aware of how long they would have to wait.

There were arrangements to support bereaved relatives. There were bereavement booklets available providing information and sources of support. Information was available for adults and children. There was a chaplaincy service available in the hospital 24 hours a day, seven days a week.

Staff told us they were able to contact agencies for the homeless to ensure discharge planning was safe and appropriate and patients received support in the community.

Emergency Department Survey 2018 – Type 1 A&E departments

The trust scored worse than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain. This would concur with the delayed timescales some patients have been in the department. The trust scored about the same as other trusts for the remaining two questions.

Question – Responsive	Trust score	Comparison to other trusts
Q7. Were you given enough privacy when discussing your condition with the receptionist?	6.8	About the same as other trusts
Q12. Overall, how long did your visit to A&E last?	6.9	About the same as other trusts
Q22. Were you given enough privacy when being examined or treated?	8.3	Worse than other trusts

(Source: Emergency Department Survey 2018)

Access and flow

People could not always access the service when they needed or receive the right care promptly. Waiting times to admit, treat and discharge patients were not always in line with national standards.

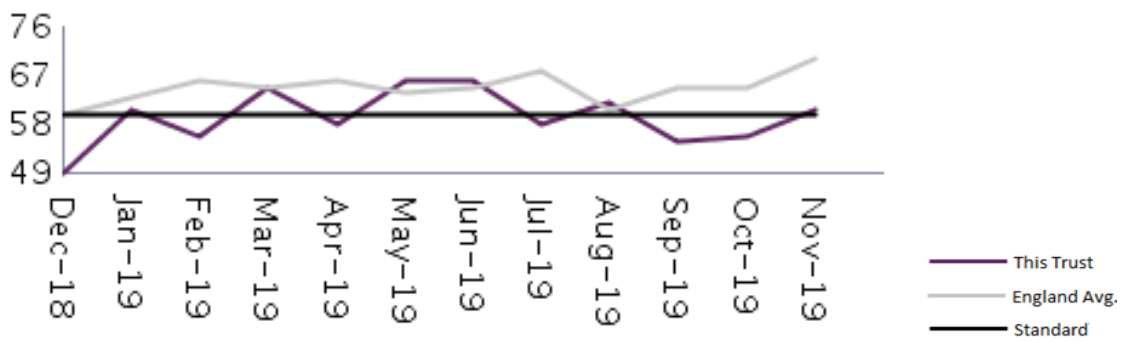
The emergency department was the main access to the hospital with all patients who were self-presenting, brought in by ambulance and referred by their own GP being seen there. This meant the medical and surgical patients seen by their GP and referred urgently were seen in the emergency department. This was referred to as the 'medical and surgical take'. This increased the pressure in the emergency department.

There was no frailty department which meant all elderly frail patients were seen in the emergency department and had to wait if needed to see a speciality elderly care doctor. A frailty unit is a unit that assesses frail older people as soon as they come to hospital. This is to ensure they get the immediate elderly care and treatment when they arrive at the hospital.

Median time from arrival to treatment (all patients)

Managers monitored waiting times but could not ensure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival to receiving treatment should be no more than one hour. From December 2018 to November 2019 the trusts median time from arrival to treatment was similar to the 60-minute expectation. At the time of inspection 11 March 2020, the percentage seen within 60 minutes was 52-63%. All patients we spoke with said they had then been seen quickly by a doctor for an initial assessment.

Median time from arrival to treatment from December 2018 to November 2019 at Torbay and South Devon NHS Foundation Trust



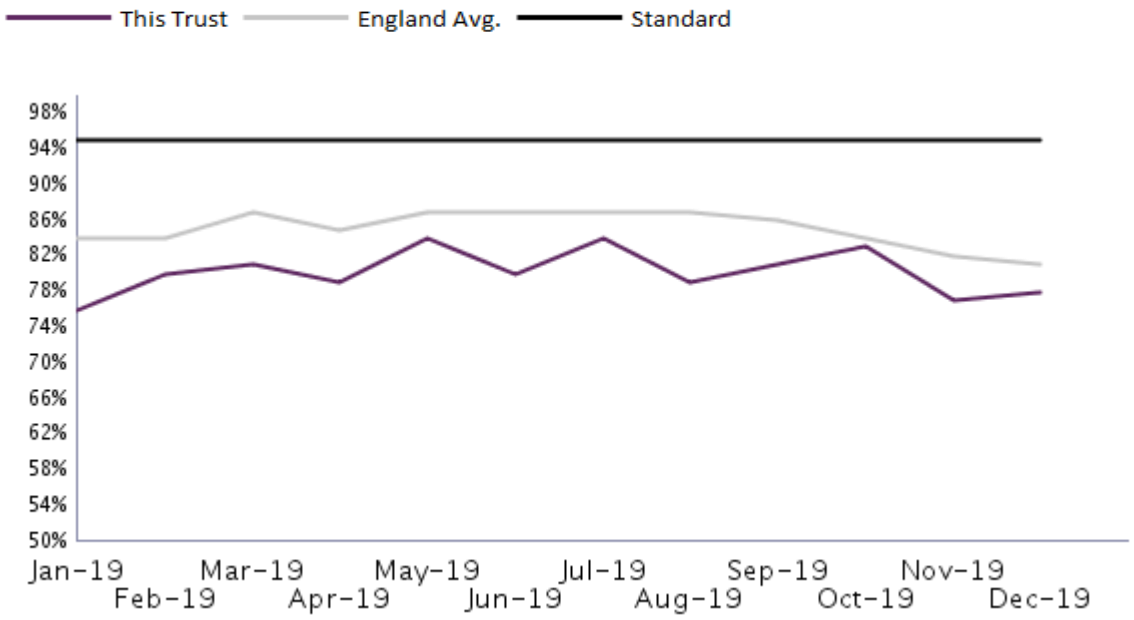
(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

Managers and staff worked to make sure patients did not stay longer than they needed, but standard timescales were not consistently met. At our last inspection in 2018, we saw the emergency department was not consistently meeting the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival. We saw in 2018, a lack of patient flow was compounded by a lack of space, which meant patients sometimes queued in the corridor, where they were afforded little comfort or privacy. At this inspection, we saw patients did not always access care and treatment in a timely way. Patient demand continued to exceed capacity within the emergency department, and this resulted in extended waiting for some patients.

From January 2019 to December 2019, the trust failed to meet the standard and performed worse than the England average. The data available showed the performance was 72-79% and was better since mid-February 2020. Staff told us this was as a result of ongoing capacity pressures and reduction in hospital bed base.

Four-hour target performance - Torbay and South Devon NHS Foundation Trust



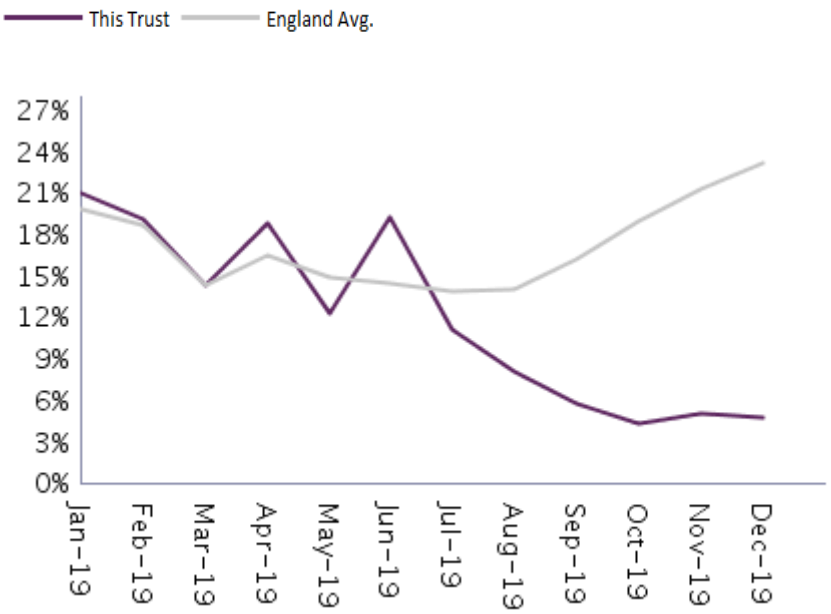
(Source: NHS England - A&E Waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

Another important indicator for patients who require admission to a hospital ward is the time it takes for their transfer to take place from the time of decision to admit. At our last inspection in 2017 we saw some patients spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding. This continued to be the case at this inspection with patients being delayed in the emergency department while beds were sought in the wider hospital and community.

From January to March 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was like the England average. From July to October 2019 performance at the trust improved while the England average worsened.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Torbay and South Devon NHS Foundation Trust



(Source: NHS England - A&E SitReps).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from January 2019 to December 2019, 28 patients waited more than 12 hours from the decision to admit until being admitted. Of those, 24 patients attended in the period from January to April 2019. There was a significant increase in patients waiting over 12 hours in April 2019.

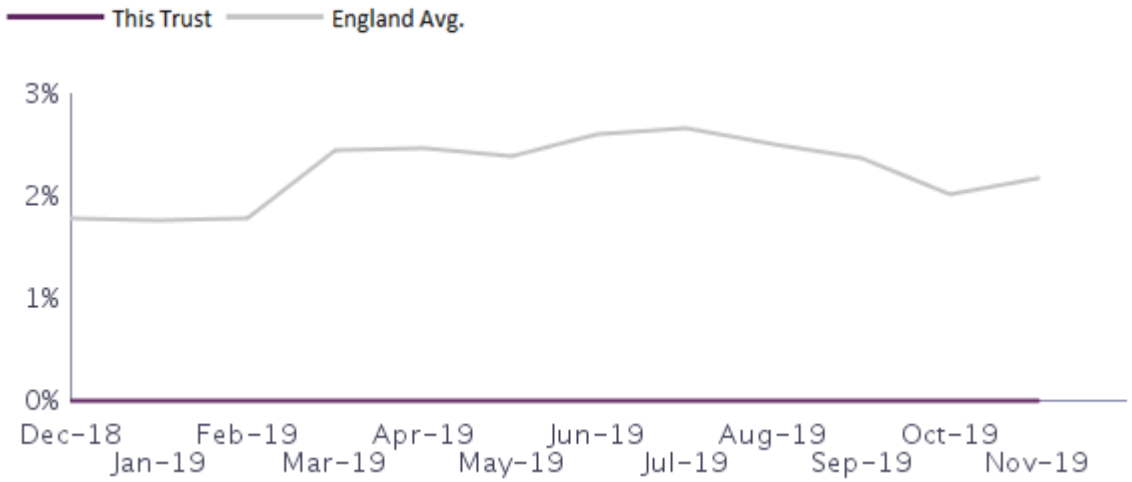
Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
January 2019	539	7
February 2019	434	3
March 2019	358	3
April 2019	472	11
May 2019	310	0
June 2019	465	0
July 2019	265	0
August 2019	202	0
September 2019	139	0
October 2019	106	0
November 2019	127	1
December 2019	125	3

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust's emergency department before being seen for treatment

The number of patients leaving the service before being seen for treatments was low. From December 2018 to November 2019, the trust reported the percentage of patients who did not wait to be seen was less than the 5% performance target, and like the England average.

Percentage of patients that left the trust's emergency department without being seen - Torbay and South Devon NHS Foundation Trust

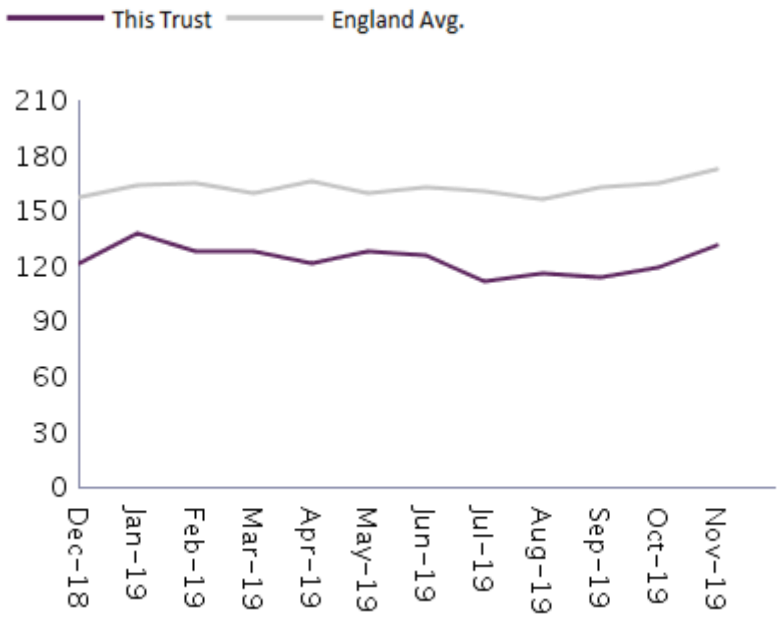


(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From January 2019 to December 2019 the trust's monthly median total time in A&E for all patients was lower than the England average.

Median total time in A&E per patient - Torbay and South Devon NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Managers and staff in the department worked to make sure that they started discharge planning as early as possible, but discharges and transfers were regularly delayed as a result of wider system delays.

Capacity in the department was regularly reviewed by both the department from a safety perspective and by the site team as a view of capacity pressure. The site team role was to monitor the flow of patients through the hospital and coordinate action to prompt the flow of patients. Within the emergency department the nurse coordinator and clinical lead used an escalation trigger tool to determine the escalation status of the department (red, amber, green). For each issue identified there were actions required to mitigate the risk identified. We saw those trigger actions being completed. Also, two to four hourly safety barometer checks were conducted by the emergency department coordinator to identify any safety concerns and update the escalation status of the department, which was shared with the hospital's bed management team.

Operational site meetings took place up to four times a day and increased when the hospital was under pressure. Escalation processes were used to address surges in demand caused by increased attendances in the emergency department. The trust operated a hospital wide 'operational pressures escalation level' (OPEL) response, OPEL is graded one to four, with four being the highest level and identifying that significant levels of demand could leave the trust unable to deliver comprehensive care unless the situation is managed. Actions were required to be undertaken at each level to promote flow through the hospital. We attended the site meetings but did not see enough action undertaken to successfully create flow through the department.

Flow through the emergency department was not consistently managed as part of the wider hospital.

Safety briefings occurred between an allocated and identified nurse and medical consultant every 2 hours. The aim of the safety briefing was to determine the level of patient risk and the internal escalation process. This information was taken to the site meeting.

On the first day of our inspection, the trust OPEL level was 2 and the site meetings were taking place every four hours. We observed staff from the emergency department explaining the departments position at the hospitals site management meeting. We observed there was a disconnect between the emergency department escalation tool and the wider hospital tool. The hospital site team did not respond with any urgency to the staff explaining that while the department was currently stable, they were about to be overwhelmed as a surge of activity was due. Reaction and planning for this identified surge by the site team was to use the clinical decisions unit. The clinical decision unit was located close to the emergency department and had eight chairs. The unit was used for mobile patients referred by the emergency department who were waiting for test results or further medical review.

The emergency department staff explained at the site meeting that a safety briefing has been held and clinical risks considered, and the clinical decisions unit would not be suitable for patients in the department. Actions to try to pull through patients to the wider hospital were not dynamic and the department became very busy with high numbers of patients overnight.

The OPEL status for the wider hospital was not an accurate reflection of the capacity issues in the emergency department. On the second day of our inspection, the department was relatively calm, and the hospital was classed as OPEL two. By the night shift there were 37 patients in the department and no beds available in the wider hospital, the hospital remained in OPEL two despite the emergency department being overwhelmed and crowded.

The site team managing bed state were not responsive in driving the need for flow out of the emergency department. We attended site meetings on two days of our inspection and saw when

potential beds were identified, these did not all come to fruition. On day two of inspection, the trust identified nine potential beds would become available in the medical directorate/care group. However, by 10am none of those beds had become available. In the meantime, the emergency department was still holding those patients while patients continued to arrive at the department and the department became crowded. There was no urgency by the site team or plans to meet the next surge of activity about to take place in the emergency department as the GP referrals started to attend. Advice to the site team included “we need a little bit more push to get flow”. By 11:30 am none of the previously identified nine beds were available.

We saw crowding and caring for patients on a corridor had become normal practice. Staff did not like using these spaces for patients and both patients and staff were distressed by the lack of dignity and privacy for patients. The spaces in the corridor were permanent space, this along with patients in the airlock area had been normalised by its frequent use.

A discharge team was based in the emergency department (ED) and included occupational therapists, nurses and coordinators. Discharges were noted from the electronic system and visited by the team who assessed what was needed to get the patient home again.

We spoke with staff who explained the measures the trust had taken had not improved the pressure in the department. Senior trust staff told us holding the excess of patients in the emergency department was a better risk strategy than admitting patients to the wider hospital as extra to the wards.

Staff supported patients when they were delayed in the department.

There was a rapid assessment area in the majors’ area of the emergency department. This was designed to improve patient flow by ensuring patients were examined promptly by a senior clinician so decisions about diagnostic tests, and treatment plans were made more quickly.

Staff told us patients were sometimes delayed in the department for long periods of time, including overnight while they waited to be seen by a speciality doctor who could admit them to the hospital. NHS England: A&E Attendances and Emergency Admission Monthly Return Definitions (2015) state: “time of decision to admit is defined as the time when a clinician decides and records a decision to admit the patient, or when treatment that must be carried out in A&E before admission is complete – whichever is the later”.

The medical staff in the emergency department could not admit patients directly to the wards without agreement from the specialist doctor undertaking the patients care. This meant patients could be delayed overnight until seen in the morning and a decision to admit made. This situation was being reviewed and there was a plan for emergency department consultants and speciality consultants to work together to prevent this ongoing problem.

There were internal professional standards for in-reach specialty review of patients in emergency department (ED). Specialties were required to respond within two hours of referral from the emergency department. We did not see any evidence this standard was met or monitored.

When the department was struggling with the high numbers of attendance and there were insufficient beds in the wider hospital or delays in patients being seen and transferred to the wider hospital, the emergency department became an area under pressure with patients being held in the emergency department.

There was safety monitoring for some aspects of the service, but some areas lacked safety oversight. The emergency department regularly experienced serious overcrowding, which impacted on patient safety and experience, staff wellness and hospital systems. The department did not experience good flow out into the wider hospital. This meant often, staff were caring for

patients on corridors and commonly in the minors area overnight. While there the minors department became a temporary ward. Several staff told us when under pressure the site management team's efforts to help were principally by managing the emergency department and not looking to the wider hospital to ease the pressure.

Managers using minors area to hold majors area patients for periods of time did not ensure patient safety in the emergency department. When majors patients were held in the minors area, the minors area was not usable for its proper role. Minors patients then had to be redirected to the local minor injuries units.

To mitigate the risk of bedding patients in the minors department, staff would review all patients and try to select patients of the lowest risk. Staff could get trolleys into the minors area although the environment was not ideal or designed for the purpose. There were insufficient call bells or means for patients to summon urgent assistance. After midnight the minors area was not staffed by a registered nurse but with a health care assistant supporting these patients. This presented a risk to patient safety.

We were told this practice only took place out of hours. We reviewed incident reports from March 2019 to March 2020 and saw this was not the case with staff arriving at 09:30am to majors patients being kept in the minors area. We saw instances when patients deteriorated in this area and had to be moved elsewhere as this area was not appropriate. Staff recorded when they felt this management was unsafe and overwhelming. The incident reports noted the decisions to bed patients in minors was a trust decision.

Another major impact of this use of the minors area was staff could not see minors patients. They ended up waiting in the waiting room or were diverted to minor injuries units in a neighbouring town in line with the trust escalation plan to enable patients to access care quicker. Overnight the minor injury unit was closed so patients were not diverted, and patient flow was through the majors area as needed.

The trust told us the pre-emptive transfer process was part of the escalation process. This involved staff identifying patients ready to leave and so safe to sit out and enable their bed to be available for use. Department staff confirmed this was not being used.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Complaints leaflets were available in the emergency department. Staff were familiar with the complaints process and they would try to resolve people's concerns immediately themselves or they would refer to a senior member of staff.

Staff understood the policy on complaints and knew how to handle them. Staff told us they would try to manage concerns before they became complaints. They said to the best of their ability they would seek to resolve patients concerns and complaints. If concerns could not be resolved locally, staff referred people to the Patient Advice and Liaison Service (PALS). PALS information was displayed on noticeboards throughout the department.

Managers investigated complaints and identified themes and shared feedback from complaints with staff and learning was used to improve the service. Formal complaints were investigated by senior staff. Staff told us individual feedback and lessons learned were discussed at regular

handover meetings and communicated via email.

Summary of complaints

From December 2018 to November 2019, the trust received 71 complaints in relation to the emergency department at the trust (24.3% of total complaints received by the trust). The trust took an average of 46.0 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be answered within 30 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Treatment	47	66.2%
Assessment	12	16.9%
Diagnosis	4	5.6%
Care	3	4.2%
Discharge	3	4.2%
Premises	1	1.4%
Referral	1	1.4%
Total	**71**	**100.0%**

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

Number of compliments made to the trust

From December 2018 to November 2019, there were 95 compliments about the emergency department at Torbay Hospital, which was 21% of the total compliments made about the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders within the department had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leadership at department level, was supportive and staff confirmed they felt they had a strong leadership team. There was a medical clinical lead role and a matron of nursing staff who worked together with all staff to cohesively to manage the busy department.

A new divisional leadership structure had recently been implemented which included three operational staff. The operational support manager for the emergency department had been in post since December 2019 and was part of that leadership team. Their role was direct line management of this team, analysing data metrics and looking for improvements in the department. These were early days for the new divisional team and structures and processes were still being implemented and assessed. Staff feedback suggested there may be disconnect between the department and the board level.

We saw some areas of disconnect between the department and board level, with the department

feeling most of the hospital risk was held in the emergency department, with the wider hospital not being aware of the pressure they were under.

Several staff in the emergency department told us senior trust staff did not demonstrate an understanding of the feeling of isolation by staff in the emergency department.

The emergency department staff voiced concerns about how decisions about the department were made by non-clinical executives on call without clinical consideration or inclusion. The decisions then meant pressures for the emergency department were not considered. Staff felt a wider hospital view may ease those pressures, for example by opening escalation areas or managing wider hospital solutions.

The trust board clinical lead responsible for the mental health strategy was not visible to staff. Staff did not know who this was but were confident there was a clinical lead within the board responsible for mental health strategy.

Vision and Strategy

The service had a vision for what it wanted to achieve and an early strategy to turn it into action.

At our last inspection in 2017, we saw staff could not all articulate a trust vision and were not aware of the overall improvement strategy and how it linked with the wider hospital system. At this inspection we saw staff we spoke with were aware of the trust vision values and confidently described how this related to the departments values which underpinned their work.

Staff spoke passionately about patient safety, quality and compassionate care. Staff told us they had been involved in identifying the emergency department values but not in the development of the trust values. There were plans to develop the emergency department, but these were not yet finalised. There had also been changes in the divisional management of the department to include the department with several community locations to promote a trust wide recognition and support of the emergency department. The changes in divisional structure were in their infancy and any identified improvements had not yet been measured. No staff were aware of any plans to develop a wider trust strategy to ease crowding.

Staff were aware of the trust values, however they felt compromised about dignity as a value when patients on corridors did not have access to a toilet.

Staff were not aware of a mental health strategy appropriate for patients with mental illness and which the trust board approved.

Culture

Staff did not all feel respected, valued and supported by the wider trust. However, staff were focused on the needs of patients receiving care.

Staff worked under periods of challenge and great pressure with professionalism and empathy. The department team were observed to be a cohesive and supportive team working under pressure. Staff told us they liked to work together and felt their teamwork was a strength. We saw them looking after each other, checking they were managing, and they were supportive of each other.

At the time of our inspection, the culture in the department was showing signs of strain both within the department and with the divisional and senior management team. The department experienced staffing challenges and staff told us they were physically and emotionally exhausted. Staff felt the lack of training and support left them vulnerable and lacking in value.

A recent listening event and subsequent Supportive Framework report had caused unrest in the department. This combined with the extended period of demand on the service, caused many staff to raise concerns about the culture and their future in the department. The trust accepted the listening event has not been received well by the department.

A department culture survey was undertaken, and results provided in July 2019. The outputs of the survey were shared with the department and then populated into an action plan. Some staff told us they felt as the department worked at such high capacity, there was no time to develop the service. The team were very committed and had a positive attitude to achieving the best results for patients yet the pressure on time and resource was such that staff were experiencing burnout and they considered the pace to be unsustainable.

Staff took part in staff surveys, but they told us they felt nothing changed and no-one listened. They did not know what happened to their comments. Staff told us the trust did not appear to action feedback from staff about how to improve the department.

The trust had implemented 'Hero' awards for staff to recognise achievement. We saw several emergency department staff had won this award

Governance

A number of governance processes were not effective in developing the service. Staff at all levels were clear about their roles and accountabilities. Opportunities to meet were not consistent and learning from the performance of the service was not always maintained.

At our last inspection in 2017, we saw regular mortality and morbidity meetings were not taking place, with the last having been in August 2016. Mortality and morbidity related issues were not discussed in emergency department clinical governance meetings.

The trust told us there were quarterly mortality and morbidity meetings where the care of patients who had complications or unexpected outcomes was reviewed. Mortality and morbidity related issues were recorded briefly in emergency department clinical governance meetings.

Since the last inspection, improvements in governance hadn't become embedded. There was an agreed clinical governance structure and a clinical governance lead for the department, who attended into clinical meetings. However, several of these meetings had been cancelled because of pressures on the department.

The operational manager attended a change group in which they discussed systems and incidents such as missing notes. Both managers and clinicians attended this meeting. The change group fed into governance meetings. A further Urgent and Emergency care programme was drafted in November 2019 and the programme board reported to the integrated Governance Group. The plan was to meet the identified metrics by March 2020. We do not have any information to support that achievement.

Governance meetings were held but records did not identify clear outcomes and actions. The emergency department held monthly governance meetings, attended by consultant and middle grade doctors, the senior nurse and the trust's Associate Director of Nursing. Items discussed included incidents, complaints, performance metrics, the department's risk register and any new clinical guidance. The meetings produced an action plan, the action plan was not clear in its achievements and outcomes. For example, the emergency department action plan dated September 2019 showed not all actions had a due date, there were no outcomes and no audit trail of monitoring. For example, one action stated a review in weekly management meeting but not updated since September 2019.

We looked at clinical governance minutes which were available, but some months were missing with no reference to why the meeting had not been held. Minutes lacked enough detail and limited insight to provide the reader with enough information to understand what was discussed and agreed, for example a job interview date had been arranged and was recorded, but no detail of the job was noted.

Action logs were produced and reviewed at the next meeting. Minutes of meetings were distributed via email and key messages were delivered via daily staff handovers. The minutes seen did not provide an audit trail of discussion, challenge and outcomes. The actions identified were not all followed up and outcomes recorded. For example, we saw minutes for the clinical governance meeting in August 2019, with incomplete actions from August 2017. On the next set of minutes for September 2019, that item was missing with no evidence of whether had been completed or how outcomes were being managed.

A supportive framework document review had been completed. The trust described the document as “The supportive framework draws upon a variety of sources that review and analyse of qualitative and quantitative information, the areas that are reviewed: quality and safety including incidents, SIRIS, complaints and risk management; training and education; workforce including sickness, vacancies; culture, leadership and management. The aim of the supportive framework is to gain engagement clinically and operationally, to take time to understand the department and provide a programme of supportive measures”. A high-level oversight plan was completed, no updates of completion have been available.

Managers did not ensure staff attended team meetings or provide full notes when they could not attend. Regular nursing meetings were not held, and minutes were not available for staff to read. This meant staff did not have the opportunity to meet, share learning and receive group supervision and support. For example, regular band six and seven nurses’ meetings did not consistently take place. Between October 2018 and March 2020 only four meetings were recorded for band seven nurses. Band six nurses had one meeting between October 2018 and October 2019.

Management of risk, issues and performance

Leaders and teams did not consistently use systems to manage performance and issues in the department effectively. The system of risk register management was not consistently maintained.

The systems used to monitor risks were not well managed. The system of risk register management was not consistently maintained. We looked at risk register items and saw a high risk about the IT system had been reduced to medium without audit trail on risk register and no evidence of follow up. The risk had been downgraded in score. It had previously been scored at 15 on the risk register and was awaiting an emergency department response. There was no audit trail to explain the downgrade and no follow up to the actions identified. We raised this with the operations manager who was going to follow up why this risk had not been addressed.

We were aware from the risk register and the governance minutes of a further significant issue relating to the computer system in the emergency department. The risk register noted non-compliance by speciality doctors to use the emergency department IT system. The last entry in 2018 noted speciality doctors were writing paper notes and scanning them into the IT system. The risks were that scanned information may be missing on electronic documents and was recorded as a moderate risk. No further action was taken after 2018. The governance record notes a further risk of speciality doctors logging in under another clinician’s log ins. This meant records made on another doctor’s log and does not reflect the speciality doctors name and so is not an accurate

audit trail. This was in August 2019, no further action plan or audit trail to establish this risk had been addressed or reduced.

There was a department action plan, this included monitoring of ongoing performance and quality. The emergency department action plan was not structured or reviewed to provide an audit trail of actions. The action plan had been in operation since April 2019 and formed part of the department improvement group. The action plan did not provide a cohesive audit trail of aims and outcomes. There were very limited timescales for action, updates or explanations for action taking or not taking place. There was no identification of responsibility to own actions and bring back outcomes or results. There were no recorded changes as a result of the plan.

Some risks in the department were beyond the department staff control. The department had experienced significant pressure over a long period of time. A recent reduction in beds in the wider hospital had impacted on the ability to admit patients, who were then held in the emergency department. The hospitals bed occupancy was 91-94% with 18-22 escalation beds open. The performance figures reflected the trust had frequently been in a state of escalation over the past three years. The trusts board report for March 2020 noted “We have implemented a wide range of measures over the winter to make best use of our ED and assessment spaces, to increase our bed capacity and to maintain discharges, so that we can support people in the lowest clinical environment appropriate for their individual needs.” We saw the department continued to have periods of capacity pressure which impacted on the quality of patient experience.

There was some safety monitoring of the service for some aspects of the service, but some areas lacked safety oversight. For example, where patients were being boarded in minors this did not appear to be fully risk assessed or have a clear plan to review and mitigate risks. There was also an inability to clarify levels of compliance with advanced and immediate life support resuscitation training in a timely manner, which did not assure us of adequate oversight and assurance.

The trust were focussed on improving the 4-hour target, although targets were not being met the trust told us they were refining processes to achieve and sustain compliance. The trust had been supported by the Emergency Care Intensive Support Team who had been working with the trust in the last year. The trust also instigated an executive led workstream, the Urgent and Emergency Care Programme Board with four workstreams established and led within the Devon system leadership team.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed. The information systems had some issues the trust was addressing. The system was secure but not always used correctly.

Staff had access to clinical protocols and pathways via the intranet which supported evidence-based care and treatment by staff.

Staff had access to secure relevant patient information and an electronic information system which allowed them to view real time information about individual patients and the activity in the department. However, the systems had recognised issues and staff described when one record was opened another record could not be seen, causing problems accessing all information quickly.

Engagement

Leaders and staff engaged with patients but there were no clear systems to share information for service improvement. Some staff engagement had a negative effect.

The emergency department captured views and experiences of patients using feedback questionnaires. A carers support worker was in the department Monday to Friday to support and advise patient and carers.

Carers we spoke with did not know how to give suggestions for improvement to the hospital. For example, some carers said the department needed more wheelchairs at reception. At the time of our inspection, we saw there was only one wheelchair available for incoming patients and this was quite quickly taken. Those carers were unaware of how to feed back this information. Other carers said signage was poor about where to drop a patient off in an emergency. Carers were not sure if they were permitted to drop patients off in the ambulance bays. They told us they would not know how to share this concern.

Engagement with staff was not always effective or well led. A staff listening event had been undertaken, but the management of the outcomes had caused distress to staff and was currently being reviewed.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement but struggled because of capacity pressures to drive change.

The department team were very committed and had a positive attitude to achieving the best results for patients. Staff felt as the department worked at such high capacity, there was little time to develop the service with the greatest challenge being to manage the patients safely.

The paediatric team had recently won the trust's 'staff heroes award'. The team had a secure social messaging group where they all checked in with one another. There was a paediatric newsletter which went out to all staff. One of the band six nurses offered ad hoc support and training sessions.

The safeguarding team had just started weekly teaching sessions with the paediatric team, which consisted of a weekly drop in session for anyone who could attend. Staff said the safeguarding team were excellent and they gave the paediatric team feedback if they completed a good referral.

The trust had recently signed up to a Disability Confident Scheme which supported organisations to successfully recruit and retain disabled people and those with long term conditions.

Medical care (including older people's care)

Facts and data about this service

The Torbay and South Devon NHS foundation Trust revised its delivery model and delivery structure 11 months prior to this inspection. This was a move to become an integrated care organisation combining health and community services. It was created to encourage and support partnership working. The revised delivery model created five integrated service units (ISU). Torquay ISU, and Paignton and Brixham ISU, which sat within the Torbay system. The South Devon system included the Moor to Sea ISU, Coastal ISU and Newton Abbot ISU. There was also a separate service delivery unit focused on trust wide operations for the whole system across Torbay and South Devon. Medical care services were present in all five ISUs.

At Torbay Hospital, medical services include (but are not limited to) general medicine, respiratory medicine, cardiology, renal services, gastroenterology, elderly care, dementia services, dermatology services, stroke services and specialist cancer services.

The trust provides both inpatient facilities and outpatient clinics, with clinics at the main hospital sites and as part of wider services based in the community. During this inspection we only visited medical services at Torbay Hospital.

Medical services at Torbay Hospital included oncology. This is a non-surgical cancer service where patients with a hematological cancer or a solid tumor cancer diagnosis receive care. In addition, the Ricky Grant Day Unit is a hematology or oncology day unit providing Systemic Anti-Cancer Therapy (SACT) and associated treatments to patients living with a cancer diagnosis. This service provides outpatient clinics, radiotherapy treatment, specialist inpatient care on Turner Ward and transplants. All services are supported by the cancer nurse support team, the specialist palliative care team, the Cancer Support and Information Centre and living with & beyond cancer initiatives.

Cardiology services include an eight-bed coronary care unit and a six-bed chest pain unit. There are two dedicated cardiac catheterisation laboratories providing a percutaneous coronary intervention (PCI) service. A chest pain outreach service to the emergency department and assessment units are also provided seven days a week. Dunlop Ward has 14 cardiology beds, which are mainly for patients with heart failure and arrhythmia. Rehabilitation nurse specialists provide specialist support, nurse-led clinics and outreach services.

Care of the Elderly services are provided on Cheetham Hill Ward which specialises in care of older people.

There is a Stroke Unit (George Earle Ward), an acute Transient Ischemic Attack (TIA) service and outpatient management of TIA patients.

Midgley Ward is a 29-bed acute respiratory medical ward catering for a wide range of respiratory conditions, and non-invasive ventilation. An outreach team of nurses facilitate early discharge and support in the community for patients with respiratory conditions.

(Source: Routine Provider Information Request AC1 - Acute context tab)

During our announced inspection between 10 and 12 March 2020 we visited:

The Emergency Assessment Unit 4 (EAU4), Turner Ward, George Earle Ward, Cheetham Hill Ward, Ambulatory care, Dunlop ward, Ricky grant day unit, Midgley ward, Cardiac catheterisations

suite, Coronary Care Unit (CCU), Simpson Ward, Elizabeth Ward and Warrington Ward.

We also visited two surgical wards, Allerton and Cromie, where medical patients were also receiving care.

Our inspection team included two inspectors, a mental health inspector, and three specialist advisors. We spoke with 72 members of staff, including nurses, doctors, therapists, pharmacists, administration staff and housekeeping staff. We spoke with 15 patients and relatives. We looked at 35 sets of patients' records, which included medical, nursing and observation records.

The trust had 45,130 medical admissions from September 2018 to August 2019. Emergency admissions accounted for 20,485 (45.4%), 726 (1.6%) were elective, and the remaining 23,919 (53.0%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 19,775
- Gastroenterology – 10,543
- Clinical haematology – 3,571

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Staff did not consistently keep their training updated. Compliance with key training modules for nursing and medical staff was not meeting trust targets.

Mandatory training completion rates

Torbay Hospital

Nursing staff received mandatory training, but this was not always kept up to date for all modules. The trust had set a target of 85% for completion of mandatory training for all courses except for information governance, which had a trust target of 95%.

The overall compliance rate for mandatory training modules from December 2018 to November 2019 was 86% at Torbay Hospital for registered nursing staff in medicine. The service achieved compliance in five modules and failed to meet the trust target in four modules. No training modules scored below 75%.

Medical staff received mandatory training, but this was not always kept up to date for all modules. The overall compliance for mandatory training modules from December 2018 to November 2019 was 84% at Torbay Hospital for medical staff in medicine. The service achieved compliance in five modules and failed to reach the trust target in four modules.

One module failed to score above 75% as outlined below.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	Year to Date Compliance <75 %	Trust Target Met	Compliance change when compared to previous year
Infection prevention (Level 2)	101	71	70%	✗	↓

(Source: Routine Provider Information Request (RPIR) – Training tab)

The compliance rates for mandatory training across medical and registered nursing staff did not consistently meet the trust target. There were training shortfalls in infection prevention, information governance, moving and handling, fire safety and conflict resolution training modules. The infection prevention modules were considerably lower than trust target with completion rates of 70% for medical staff and 77% for registered nursing staff. There had been improvements in some modules. However, the modules where there were shortfalls were mostly the same as the modules that did not meet targets at our last inspection in 2017. This was a significant concern as, at our last inspection in 2017, we told the trust it should ensure mandatory training targets, including adult and child safeguarding were consistently met.

Staff told us when the hospital was busy it was difficult to find the time for training and training was often cancelled. This was also of concern as it was also something staff had highlighted for improvement at our last inspection.

Mandatory training was comprehensive and met the needs of patients and staff. Staff told us the quality and detail of the training was good and they received a full induction when they started work. Bank staff also told us they were confident in the induction process, they received a local level induction to the wards they were working on, as well as a corporate induction.

In addition to mandatory basic life support training completed by all staff, the trust had a training needs analysis, within their resuscitation guidelines, identifying the level of resuscitation required for different staff groups. It was mandatory for medical registrars and foundation year two doctors to complete advanced life support four yearly, medical registrars were compliant and this was a deanery requirement, there were eight outstanding foundation year two doctors who were due to complete this training. For foundation year one doctors it was mandatory for them to complete immediate life support.

In the event of a cardiac arrest wider support could be provided by the hospital. The clinical manager team bleep holders completed adult advanced life support and were 100% compliant. Resuscitation officers were also required to complete this training and were 87.5% compliant. Critical care outreach leads were 100% compliant with adult advanced life support.

Clinical staff did not all complete training on recognising and responding to patients with mental health needs, learning disabilities, and autism. Some managers and staff we spoke with about training for mental health talked about the Mental Capacity Act. Staff told us they could access bespoke mental health training. All staff received training on dementia and responding to these needs as part of their induction. In the last two years over 600 staff had received a range of dementia training.

It was unclear how well managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us most training was provided through an electronic record system which sent emails to them and their managers to inform them when training was due for renewal. Some managers told us staff did not always have time to complete training due to staffing levels being low and there being increased numbers of patients. Some managers reminded staff to complete training due, but not all staff felt this happened enough.

The education and training department had produced a training needs analysis for the trust and ISUs with specific focus on mandatory training. However, staff and managers we spoke with were not sure if there was any official training needs analysis completed. Mandatory training included 11 core mandatory training modules, and this information was captured on an electronic staff system. However, we were unable to identify if there was a process for gathering information together to assess where the service stood in relation to its required training for different staff groups outside of the 11 core mandatory training modules.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff knew how to apply safeguarding principles. However, staff did not consistently complete or keep up to date with training on how to recognise and report abuse.

Nursing and medical staff had access to training specific for their role on how to recognise and report abuse. However, completion rates for updating some training modules was below the trust target. Safeguarding adults level 3 is recommended in intercollegiate guidance document ‘Adult

safeguarding: Roles and Competencies for Health Care Staff'. The document and guidance was initially published by the Royal College of nursing in 2018. It advises registered staff who are engaging in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns, require safeguarding adults level 3 training. The guidance does not need to be fully implemented until August 2021. However, the data provided suggests the trust have considerable work to do to bring them in line with this guidance as only 20 nursing staff had been identified as eligible for training at level 3 and only 75% of these had completed the training. Medical staff were not yet required by the trust to complete this training. The staff required to complete Safeguarding level 3 training were the bleep holders.

There was a safeguarding lead for the trust, and most staff were able to identify who they were. However, there was potential for safeguarding concerns to be overlooked or missed due to staff not receiving the recommended level of training.

Safeguarding training completion rates

The trust set the following targets for the safeguarding courses for which medical, nursing and registered allied health professional staff were eligible.

- 90% for safeguarding level 1
- 80% for safeguarding level 2 and 3

The tables below include PREVENT training as a safeguarding course, which had a trust target of 85%. PREVENT works to stop individuals from getting involved or supporting terrorism or extremist activity.

All training performance at the trust is reported on a rolling month by month basis.

Nursing staff had access to some training specific for their role on how to recognise and report abuse, but this was not always at the recommended level and not all staff completed it.

The overall compliance rate for safeguarding training modules from December 2018 to November 2019 was 89% at Torbay Hospital for registered nursing staff in medicine. The service achieved compliance in three modules and failed to reach the trust target in three modules.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children (Level 1)	6	6	100%	✓	→
Safeguarding Adults (Level 1)	301	293	97%	✓	→
Basic Prevent Awareness	301	289	96%	✓	→
Safeguarding Adults (Level 2)	301	260	86%	✓	→
Safeguarding Children (Level 2)	295	230	78%	✗	→
Safeguarding Adults (Level 3)	20	15	75%	✗	→

Medical staff had access to some training specific for their role on how to recognise and report abuse, but this was not always at the recommended level and not all staff completed it.

The overall compliance rate for safeguarding training modules from December 2018 to November 2019 was 87% for medical staff in medicine. The service achieved compliance in three modules but failed to reach the trust target in three modules.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	102	94	92%	✓	↓
Basic Prevent Awareness	102	94	92%	✓	→
Safeguarding Adults (Level 2)	96	82	85%	✓	→
Safeguarding Children (Level 2)	88	71	81%	✓	→
Safeguarding Children (Level 1)	5	4	80%	✗	↓
Safeguarding Children (Level 3)	9	6	67%	✗	→

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Most staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff spoke positively about their safeguarding training and showed knowledge of different forms of abuse. A consultant we spoke with gave an example of an elderly patient whose discharge was planned carefully by a multidisciplinary team due to suspected financial abuse from their relative. The consultant told us about joint working with the safeguarding lead at the trust and with other external agencies to ensure the patient had the support they needed to protect them self from abuse in the future.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the procedure for reporting safeguarding concerns to the local authority. Although there was a follow up process identified within trust policy, not all staff were aware how this process worked. Staff were not sure why they would need to receive feedback from safeguarding investigations.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. However, there was an infection control risk where equipment was not always kept visibly clean and damaged flooring.

Ward areas were visibly clean and had suitable furnishings which were clean and mostly well-maintained. The housekeeping team were present on all units and wards we visited, and we saw good levels of cleanliness and hygiene. Cleaning records were up to date and demonstrated areas were cleaned regularly. A checklist was used by housekeeping staff, so all staff knew what needed to be cleaned and when.

The service performed well in audits for cleanliness. All wards completed cleaning audits, although the results were not consistently displayed at ward entrances or on the wards. However, audits showed consistently good performance for all wards. Hand hygiene audits were also not consistently displayed on all the wards and departments we visited. However, results for most areas were good, with consistent 100% compliance across the majority of wards. An infection prevention and control audit was completed each month and if there were any results less than 95% the audit would be repeated weekly to support improvement. It was unclear if any other actions were put alongside the re-audit process.

We observed good practice in response to infection control for isolation areas. There was additional cleaning and cleaning policy for these areas. During our inspection, the Emergency Assessment Unit 3 was temporarily quarantined on two occasions due to admission of patients with symptoms consistent with COVID-19 (novel coronavirus). The cleaning records we reviewed for the ward showed consistent and regular cleaning was completed and documented in line with trust policy. All wards we visited had side rooms, which enabled staff to treat and care for patients with confirmed or suspected infectious diseases. These rooms had clear signs on the doors or walls to restrict entry and had appropriate PPE available.

Staff followed infection control principles, including the use of personal protective equipment (PPE). We observed staff following Trust policy with the correct use of PPE and appropriate hand washing. Staff disposed of PPE appropriately in clinical waste bags. Patients and visitors were also reminded of the importance of hand washing and had guidance to follow.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. We saw commodes in sluice rooms which were labelled with ‘I am clean’ stickers to alert staff they should be suitable to be used. However, we found commodes stored in the sluice on Cheetham Hill Ward which were visibly dirty and had spider webs joining three commodes together.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well.

The environment on many wards was cluttered with mattresses being stored in corridors and storage trolleys containing intravenous fluids, needles and scissors being left unattended on wards without being locked. At our last inspection in 2017 we found the environment on many medical inpatient wards was sub-optimal with cluttered conditions. At this inspection we found there continued to be cluttered conditions on wards, with equipment being stored on corridors. The conditions resulted in there being risks due to trip hazards, items falling and patients or family member having access to potentially dangerous clinical equipment, such as needles and scissors.

There were risks relating to the significant wear and tear on the flooring on several wards. We spoke with staff on Simpson Ward, who told us the areas of taping covering the broken floor on the ward were risk assessed daily. If the tape was peeling this was logged as an urgent action for the estates team, who would respond within a few hours to re-tape the area. This was a significant concern as the flooring risk on the ward had been on the departmental risk register for a long while. We reviewed the departmental risk register that was provided as a part of the provider information request before our inspection. The risk had last been updated in November 2019. The taped flooring posed a significant infection control risk as it was not possible to clean effectively on sticky surfaces. It was also a trip hazard to staff, patients and visitors to the ward.

The wards we visited did not have enough storage space and there was equipment, such as chairs, stored in corridors. Equipment stored in corridors and storerooms was not covered to protect it from dust accumulating. Some stored items were placed directly on the floor, which compromised efficient cleaning of floor spaces in the sluice and storerooms.

We saw damage to furniture, walls and flooring on Midgley Ward that would pose a further infection control risk. This risk was not recorded on a departmental risk register, but had been escalated, in line with other estates issues, and reflected on the corporate risk register.

Patients could reach call bells and staff mostly responded quickly when called. Most patients we spoke with told us staff were attentive and available when they needed them. They all had access to their call bells and knew how to use them. We saw staff responding to call bells in a timely way. During a particularly busy time on Cheetham Hill Ward, one staff member took the time to give a brief explanation to the patient and to assure them they would be with them as soon as possible. However, some patients on Simpson Ward told us there could be a wait for staff to answer call bells and they did not always respond promptly when patients required assistance to use the toilet or commode. However, all patients knew how to use the call bells.

Staff did not consistently carry out daily safety checks of specialist equipment. There was a checklist on each ward we visited which prompted staff to perform daily safety checks, such as checking of emergency equipment. There were resuscitation trolleys on each ward which were easily accessible. However, we found daily checks of resuscitation trolleys were not consistently complete on some wards. We found gaps on Cheetham Hill Ward for two days in January and one day in February 2020. We also found gaps on the Cardiac Catheter Laboratory for two days in January 2020. A further trolley on the Chest Pain Unit (CPU) was found to have gaps for seven days in December 2019, which suggested there was no assurance checks were completed. This had not been resolved since our last inspection in 2017 when we told the trust it should ensure resuscitation trolleys and emergency equipment were checked across all medical areas in line with trust policies. We found all weekly checks we reviewed had been completed. These checks were to ensure the trolleys contained all relevant emergency equipment in line with national guidance (Resuscitation Council (UK). Emergency equipment was stored in tamper-evident trolleys which were stocked correctly when we checked.

The service had enough suitable equipment to help them to safely care for patients. Equipment store areas were well stocked, and staff had access to enough monitoring and assessing devices. There was equipment available to support patients to mobilise safely and access to specialist equipment for bariatric patients if needed.

We found most storerooms were clean and tidy. However, disposable items, such as urinals, bedpans and wash bowls were frequently stored in boxes on the floor. This could prevent thorough cleaning of the flooring and the contents could be easily compromised if the box were to become wet.

Staff did not always dispose of clinical waste safely. Staff used clinical waste bags and sharps bins to safely dispose of clinical waste on wards. However, we found sharps bins in the clean utility on Cheetham Hill Ward with no assembly details. The assembly details show how to put the container together, but also includes completion of a label identifying where it is being used, who put it together and the date it was put together. Any container not put together properly or without completed label may not be collected once used. We also found seven sharps bins on the floor in the dirty utility, two of which were not being used but had no lids and a further sharps bin which was in use/ assembled but had no assembly details recorded.

Substances Hazardous to Health were not stored securely in some wards. On Turner Ward we found tubs of disinfectant tablets kept in a cupboard, which was left open. This could pose a risk to patients if ingested. We raised this during our inspection and the trust sent messages out to all staff to remind them to keep disinfectant tablets locked. However, when we returned to the same area the following day, we found the cupboard still unlocked. We informed staff the door was open, and they locked it. It appeared the door was usually left unlocked as housekeeping staff did not all know the code to the door. We witnessed housekeeping staff having to ask and then be told the code by the ward sister after it had been locked.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff completed risk assessments for each patient on admission or arrival, using a recognised tool. Records we reviewed showed staff reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. The trust was using a version of the early warning score (EWS) tool to monitor patients who were being cared for on the wards and identify patients who had deteriorated. This tool is a numeric scoring system, using observation of patients' vital signs to identify deteriorating patients and prompt staff to take action. Staff knew how to escalate concerns about patient vital observations and stated they would always inform the doctors if they were concerned about a patient, regardless of the scoring system. Most records we reviewed showed staff used this tool well.

The trust was still using an older version of the early warning system, but staff were hopeful the National Early Warning Score (NEWS2) would be implemented by the end of March 2020. The trust advised the decision to delay the rollout of NEWS2 to some parts of the hospital was made by the information management group in 2019. They advised this was due to a critical safety issue with the software. NEWS2 was introduced in 2017 which means the trust had not embedded this tool in a timely way.

Sepsis

Sepsis is a life-threatening condition, where the body fights a severe infection that has spread through the bloodstream. Sepsis recognition and treatment is time-critical and requires prompt action.

Staff were trained in sepsis management so were able to monitor and respond appropriately to patients at risk of sepsis using sepsis tools. Staff had a good knowledge of sepsis which they could demonstrate to us through conversation and our review of records. Staff received training in sepsis awareness at induction and received additional training sessions. Staff were able to tell us about the signs of sepsis and what action they would take. A sepsis checklist was used in patient records.

Venous Thromboembolism

Risk assessments for venous thromboembolism (VTE) (formation of blood clots) were not always complete in line with the National Institute for Health and Care Excellence NG89 (2018). The guidance recommends all medical patients have a risk assessment as soon as possible following admission, or by the first consultant review and are re-assessed within 24 hours of admission. The trust's policy was for VTE assessments to be carried out within 24 hours of a patient's admission, although staff told us in practice these assessments were done more quickly. This was confirmed

by the patient records we reviewed. Most patients did have VTE assessments documented in their notes. However, in four records we reviewed we found staff had not complete or recorded re-assessment within 24 hours. In two additional records, we found that VTE assessment was recorded and reassessment was signed and dated by a relevant practitioner, but no time was recorded. This made it difficult to identify if the reassessment had been complete within the 24-hour period.

Falls

The medical care service managed falls by considering prevention and their initial response to a fall. The trust had a falls lead and falls team. The falls lead and team undertook case reviews on any falls identified as resulting in moderate harm and above. There were approximately 20-27 of these each year. Ward staff were invited to be present at the pressure ulcer and falls steering groups if there were any highlighted lapses of care.

The falls team was keen to implement NICE guidance to meet the CQUIN CCG7: Three high impact actions to prevent hospital falls. The team had ensured the provision of ultra-low beds, slipper socks for patients, falls alarms and 10 raiser chairs through charitable funds. The team said they were concerned it was difficult for staff to be released from the wards for training.

There was a falls steering group meeting held every other month. A newsletter was produced following the meeting. This was condensed to a one-page newsletter, with the current issues and was sent to each ward. Staff told us there was a patient volunteer who attended the falls steering group. They were heavily involved in gaining feedback from patients. Volunteers also participated in strength and balance classes and fracture prevention services and attended dementia steering groups. A band 6 physiotherapist was involved in the falls steering group and attended the meetings as a therapy representative. Staff looked to work within the acute and community settings by identifying patients at risk and referring on to community services if a falls assessment was needed for a patient at home.

We saw a poster detailing a quality improvement initiative on a ward where patients were provided with a different colour wrist band if they were at a higher risk of falls. However, therapists we spoke with were not aware of this project and nursing staff had told us it had not been continued as it was felt the pilot had not been successful.

Pressure Ulcers

Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is place under pressure. The service reported all pressure ulcers under the trust incident reporting system. Following the completion of the incident form, all grade three or four pressure ulcers were validated by the tissue viability team and a SSKin bundle implemented. Any pressure ulcers deemed as ‘avoidable’ or where there were lapses in care were reported externally, with a root cause analysis investigation completed. All investigations were overseen at the pressure ulcer steering group and from there reported to the trust quality improvement group.

There was a lead tissue viability nurse who was responsible for both community and acute patients, as well as the lower limb therapy service. The acute team was made up of one band 7 nurse, two full time and one part time band 6 nurses and an administrative assistant. The tissue viability team provided education to the wards on pressure ulcer damage and skin care, as well as collecting data and using this data to identify trends. Each safety brief on wards contained details of patients with pressure ulcers and we observed staff considering SSkin during handover meetings and during ward rounds. Cameras were available on wards to document pressure ulcer damage. Staff told us there was a policy for gaining medical photography consent from patients. The lead also told us of innovation being trialled with new equipment being provided to the wards.

The team were working closely with podiatry to support with foot ulcers caused by diabetes. There were 10 heel wedges being trialled on the wards to keep pressure load away from the foot.

The service had 24-hour access to mental health liaison and specialist mental health support, if staff were concerned about a patient's mental health. This service was from an externally provided psychiatric liaison team. Most patients who had been referred were seen within 24 hours. On the whole staff spoke positively about communications and joint working with the psychiatric liaison team. Any Mental Health Act documentation was accepted by the clinical site team but there was an expectation mental health colleagues would record applications for section under the Mental Health Act in the notes. The wards did not consider this to be their responsibility.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The psychiatric liaison team used a triage risk assessment form and completed a full assessment. However, there were sometimes difficulties accessing this risk assessment on the IT systems. The mitigation was for the psychiatric liaison team to write in the medical notes and provide a handover to staff, but there was a risk the information was not easily accessed if this was not done.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. A 'safety huddle' took place each day at shift change on all wards. The huddle was a meeting staff used to review patients. It followed a set processes and proforma to ensure all areas of safety risk were consistently covered.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. There were staff shortages and there was use of bank, agency to fill gaps in staffing levels. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. However, the service experienced staff shortages and rotas although rotas were covered, this was through a heavy reliance on bank and agency staff.

Staff spoke about their concerns with the current staffing levels. Some staff said the new integrated service units meant staff were spread too thin. They said there was limited time to carry out tasks to support professional development and maintain professional registrations, but they did feel supported by colleagues. On Turner Ward staff told us they did not always have enough nursing staff on the ward. They felt the situation was only going to worsen as workloads increased. The lack of staff meant they did not always feel the right standard of care was being given. Some staff told us the volume of work was a worry for them.

The table below shows a summary of the nurse staffing metrics in medicine compared to the trust's targets, where applicable:

	Medicine annual staffing metrics						
	November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	914	9%	10%	4.1%			
Registered nurses	312	15%	8%	4.0%	14,563 (7%)	13,365 (6%)	3,887 (2%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

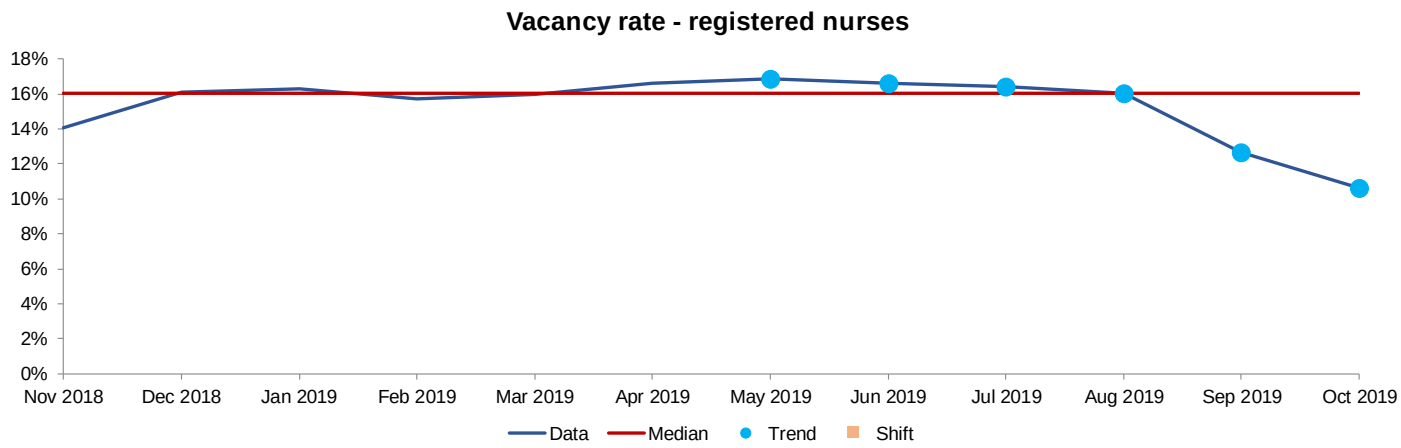
Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There were staff shortages, but managers and staff told us there was mostly a well-planned and appropriate mix of staff on shift. Staff told us managers were proactive in ensuring additional staffing was made available when required to support a patient with challenging behaviour or those who needed increased levels of care.

The ward managers could adjust staffing levels daily according to the needs of patients. However, this was often impacted by not being able to access additional staff. As a manager they were often caught up in their clinical role which did not allow adequate time for management.

The number of nurses and healthcare assistants did not always match the planned numbers. Although there were staffing vacancies, staff told us there were mostly the full complement of nursing and health care assistants on wards due to access and use of bank staff to cover shifts. All wards we visited during the inspection had either the planned number or more than the planned number which confirmed what staff told us.

Nurse staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

Vacancy rates



Monthly vacancy rates over the last 12 months for registered nurses show a downward trend from May 2019 to October 2019. This could be an indicator of improvement. Staff told us there had been lots of work ongoing to recruit to vacancies. Staff and Leaders told us there were challenges recruiting in the area due to its rural location. Leaders felt they were making progress while planning for the future workforce by holding open day events and encouraging students from local schools and universities to become involved at Torbay before they qualified.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

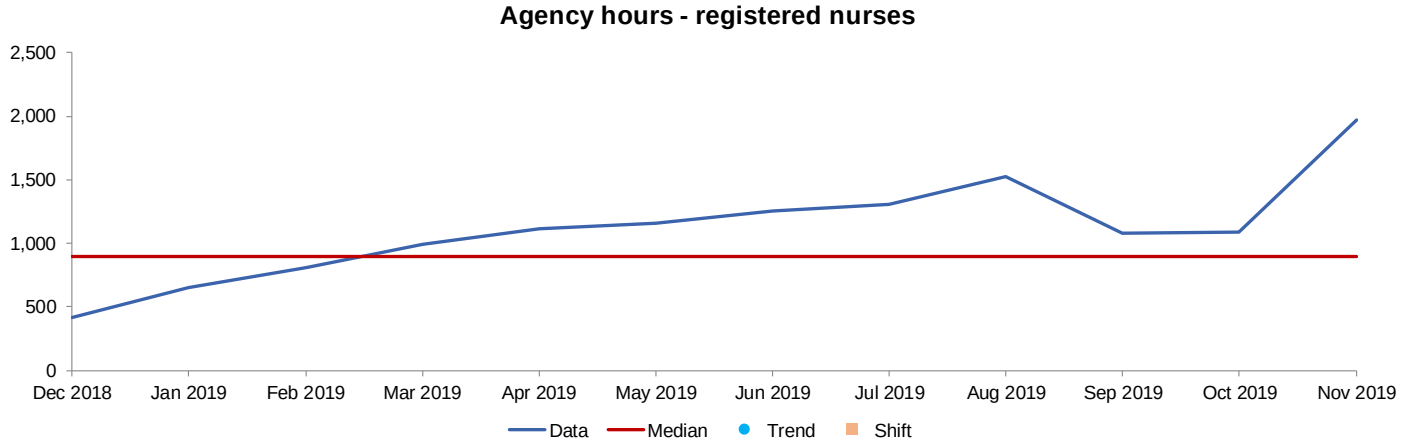
The service had low and/or reducing turnover rates. Staff spoke about a supportive environment which they did not want to leave.

Sickness rates

The service had low and/or reducing sickness rates.

Bank and agency staff usage

The service had increasing and fluctuating rates of bank and agency nurse usage. Managers made sure all bank and agency staff had a full induction and understood the service.



Monthly agency use over the last 12 months for registered nurses was not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The service experienced challenges recruiting due to its rural location. However, there were ongoing recruitment drives at local career fairs and leaders were taking every step to address this. Leaders hoped to have ongoing dialogue with students at local universities before they finished their courses and provided rotational roles to be attractive to potential new staff. Overseas recruitment had taken place with support for members of staff from within the trust.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, there were staff shortages and there was a heavy reliance on locum staff. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. However, leaders felt there were key risks were around the medical workforce, especially physiologists and cardiologists, oncology, neurology and stroke medical staff. The trust was particularly affected by the ability to recruit due the rural area.

The table below shows a summary of the medical staffing metrics in medicine compared to the trust's targets.

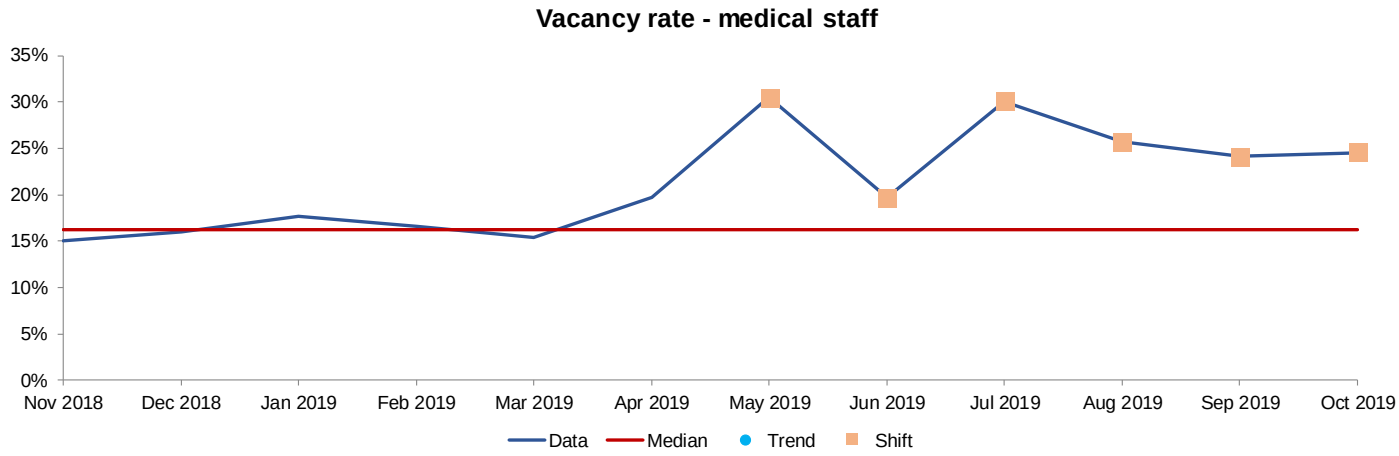
	Medicine annual staffing metrics November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	914	9%	10%	4.1%			
Medical staff	117	21%	13%	2.3%	8,701 (1%)	27,812 (3%)	3,769 (<1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Although the average establishment did not meet the planned establishment, when we reviewed medical staffing rotas, we found there were rarely gaps in medical cover. No indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use for medical staff.

Vacancy rates

The service had high vacancy rates for medical staff. Monthly vacancy rates over the last 12 months for medical staff showed an upward shift from May 2019 to October 2019 which could be an indicator of change. Staff told us they felt there were always enough medical staff available to meet the needs of the patients and the service. However, some medical staff told us they felt there was a lot of pressure on them due to the staffing numbers not being in line with the planned establishment.



(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

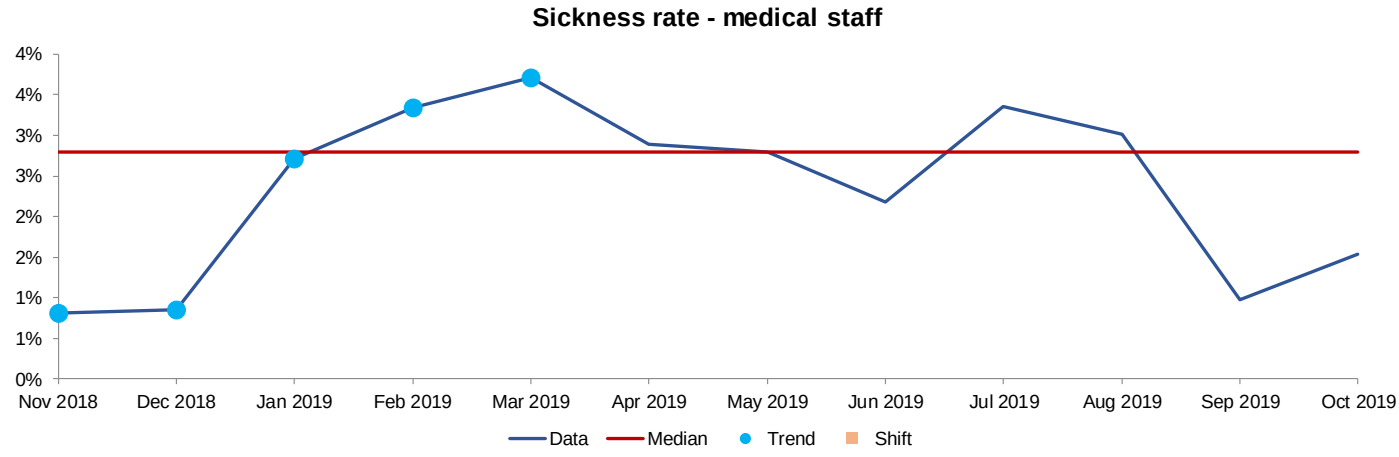
Turnover rates

The service had a moderate turnover rate for medical staff. Data provided showed levels were just over the trust target.

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

Sickness rates

The service had low and reducing sickness rates for medical staff.

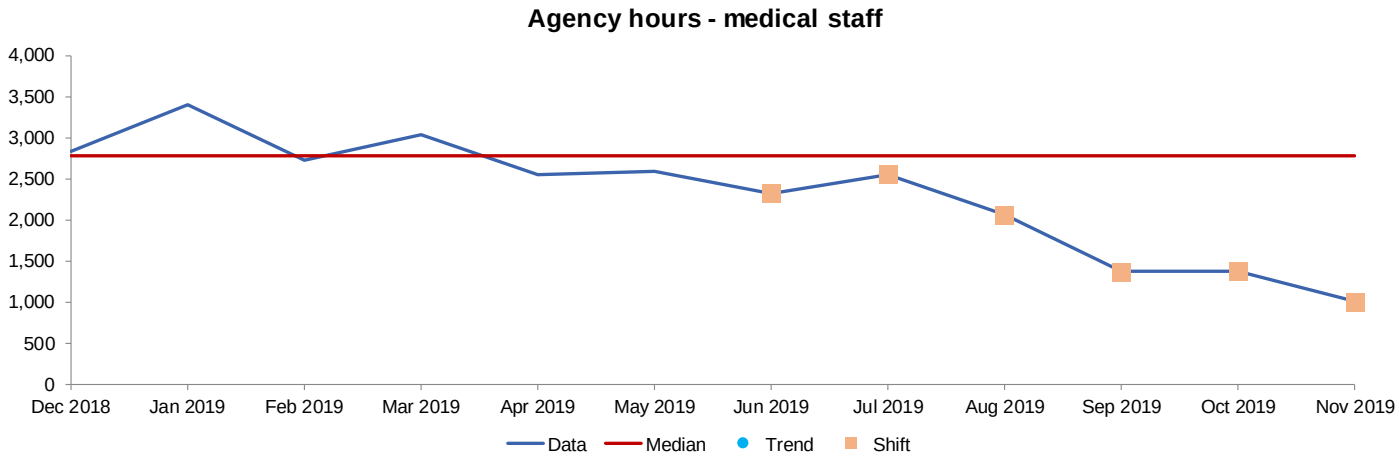


Monthly sickness rates over the last 12 months for medical staff show an upward trend from November 2018 to March 2019. However, sickness rates then reduced and appear to have continued to be below 3% since August 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The service had low and reducing rates of bank and locum staff.



(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

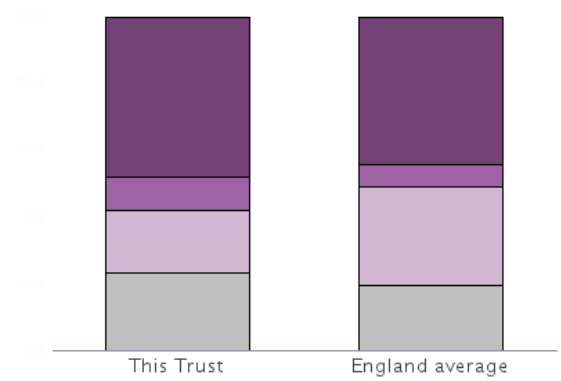
Monthly agency use over the last 12 months for medical staff showed a downward shift from June 2019 to November 2019 which could be an indicator of change. Managers could access locums when they needed additional medical staff. Consultants spoke of good access to locums, some of which were regularly used. Managers made sure locums had a full induction to the service before they started work. Mangers told us locum staff received the same mandatory training induction as other staff and also had a local induction to the area they were working in or the wards they were working on. Consultants reported ongoing vacancies and although work had been done to recruit to these positions, there had been long standing locum consultants in post within the service. Consultants said they did not feel this negatively impacted on the service and many staff spoke highly of the service and support provided by the consultant team.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Junior doctors told us they felt well supported by senior staff. They said they had access to support when they needed it.

In October 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 149 whole time equivalent staff working in medicine at Torbay and South Devon NHS Foundation Trust



	This Trust	England average
Consultant	48%	44%
Middle career^	10%	7%
Registrar group~	19%	30%
Junior*	23%	19%

^ 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

(Source: NHS Digital - Workforce Statistics - Medical (01/10/2019 - 31/10/2019)

The service always had a consultant on call during evenings and weekends. Medical consultant rotas were set up six months in advance. All staff told us they were able to access consultants when they needed to and were now able to access the consultant rota on the intranet.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date, but not always easily available to all staff providing care. However, we found examples where records were not stored securely.

Patient's notes were mostly comprehensive but staff could not always access them. Staff used a mixture of paper patient notes and an electronic patient recording system. This electronic system was a mobile telephone-sized device nurses carried around with them to update risk assessments and patient care plans. Staff told us these were not always hugely reliable as the battery life on them was limited. All patient records we reviewed were clear and legible, with staff signatures, initials and role clearly documented at the end of each entry.

When patients transferred to a new team, there were sometimes delays in staff accessing their records. Staff told us this mainly happened for patients who were admitted from the emergency department as they had to come with paper records. This was because the emergency department electronic system was not linked with the electronic system used in the wider hospital. Staff explained all unplanned admissions had to present through the emergency department pathway as there were no direct admission pathways available. When a patient left the emergency department a copy of the patient record should be printed and transfer with the patient. During the inspection we saw challenges of this system when the hospital's printing system was not working correctly and staff were unable to print for a period of time. Managers and staff told us this was not a frequent occurrence but had happened before.

At our last inspection in 2017 we identified patient records were not stored securely and the trust were told to take action to ensure the secure storage of confidential patient records in all areas. To increase the security the trust invested in lockable medical notes trolleys for all areas. During this inspection we found medical records were stored securely in locked cabinets on the wards with

key pad access for staff. Nursing notes and risk assessments were kept in folders on the wall outside of bays labelled private and confidential, and contained records which needed to be accessed quickly to include care plans, risk assessment, and nutritional and fluid charts.

However, some records were not stored securely and we identified unsecure confidential patient information. We found paper documents for intentional rounding (SSKIN) left attached to a clipboard and on a cupboard outside bay 9 on EAU4. The records had patient identifying information visible and could be seen by anyone walking past. Though the wards and departments now had lockable storage cupboards for patient records, we still found folders being stored in plastic storage compartments outside bays on most wards.

We also found records in an unlocked stationery cupboard on Turner Ward. The records included patient telephone records, annual leave requests, checklists and ward diaries, some of which dated back to 2008.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Records we reviewed on several wards showed there were gaps in the recording and monitoring of fridge temperatures. Staff did not record the ambient room temperature on any ward we visited, which was not in line with NICE guidance. Cumulatively this meant there was limited assurance medicines were stored at optimum conditions.

Staff did not always store and manage medicines and prescribing documents in line with the provider's policy. Medicines were mostly stored appropriately in locked cupboards. However, on Midgley Ward we found medicines in an unlocked fridge. On the same ward we found a patient's records where there were missed doses of medication and no recorded explanation.

We found a number of areas of concern in the cardiac Catheterisation laboratory which needed to be reviewed. Some prescribing arrangements which were being piloted meant medications were not being prescribed in line with the legal framework. Staff were providing clopidogrel for patients to take home without a prescription. We also found staff were using outpatient prescription pads to give larger packs of clopidogrel for patients to take home. These prescriptions were being given without being signed for by the dispenser or prescriber. This was not in accordance with national guidelines. We told the trust and chief pharmacist about these concerns and they acted promptly to stop the practice immediately and remove the outpatient prescription forms.

We reviewed the World Health Organisation checklist in the cardiac catheter suite and found there was a tick box to indicate whether a medication to take home had been ordered. This procedure did not comply with current legislation for prescribing and administration of medicines.

Prescription charts were completed appropriately and comprehensively, and we observed effective systems for drug rounds on wards. Staff reviewed patient's medicines regularly but did not always provide specific advice to patients and carers about their medicines. Staff we spoke with told us advice was not consistently given to patients when they were discharged, such as how to deal with side effects or adverse drug reactions. An example of this was in relation to the clopidogrel (a blood thinning medication) given to patients without prescription from the cardiac catheterisation laboratory. Staff told us they did not normally provide advice to patients with this medicine.

Staff did not consistently follow current national practice to check patients had the correct

medicines. We found clopidogrel was being given to patients when they went home from the cardiac catheter laboratory without prescription. This was not in line with national guidelines.

Decision making processes were established to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. However, we raised concerns with the trust regarding the use of lorazepam and haloperidol for a patient on Cheetham Hill ward. This was due to no legal framework being in place to authorise the use of these medicines for this patient. We raised this with the trust who responded appropriately.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff gave examples of the types of incidents they would report and told us how they would report these in line with trust policy.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us they were encouraged to report incidents and received feedback through ward meetings and emails from managers when they raised concerns.

There were systems to monitor safety alerts. Managers told us about alerts they had acted upon. However, we did find one instance on Ricky Grant Ward where we found super absorbent polymer powder granular sachets in an unlocked sluice. There had been a national patient safety alert in 2019 advising all of these sachets should be removed. We raised this with staff who recognised they should not have been there and disposed of them immediately. We also raised with the trust who could demonstrate their review of the safety alert and appropriate actions taken in response.

Never Events

The service had no never events on any wards. 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 2018 to November 2019, the trust reported no never events for medicine.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere. Staff were updated through staff bulletins, on the trust intranet and through emails. Learning was also discussed at ward meetings and staff told us they were encouraged to participate in discussions to aid their own learning and development.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2018 to November 2019. A breakdown of incidents by incident type are below.

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	5	50.0%
Treatment delay meeting SI criteria	1	10.0%
Pressure ulcer meeting SI criteria	1	10.0%
Diagnostic incident including delay meeting SI criteria	1	10.0%
Blood product/ transfusion incident meeting SI criteria	1	10.0%
Medication incident meeting SI criteria	1	10.0%
Total	**10**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

Staff reported serious incidents clearly and in line with trust policy. We requested root cause analysis (RCA) for the last three serious incidents, including two slips trips and falls and one pressure ulcer. The documents we reviewed were thorough and included clear action plans aimed at reducing the risk of similar incidents happening again. There was a record showing learning was shared with staff and there were plans for refresher training and prompts to be provided to staff.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff told us they were encouraged to evoke duty of candour in all appropriate situations. Staff were proud they were supported to be part of open and honest teams. The RCA's we reviewed showed clear consideration of duty of candour.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.

The service did collect safety thermometer data, but this was not clearly displayed at ward entrances and was not visible on wards for all to see. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

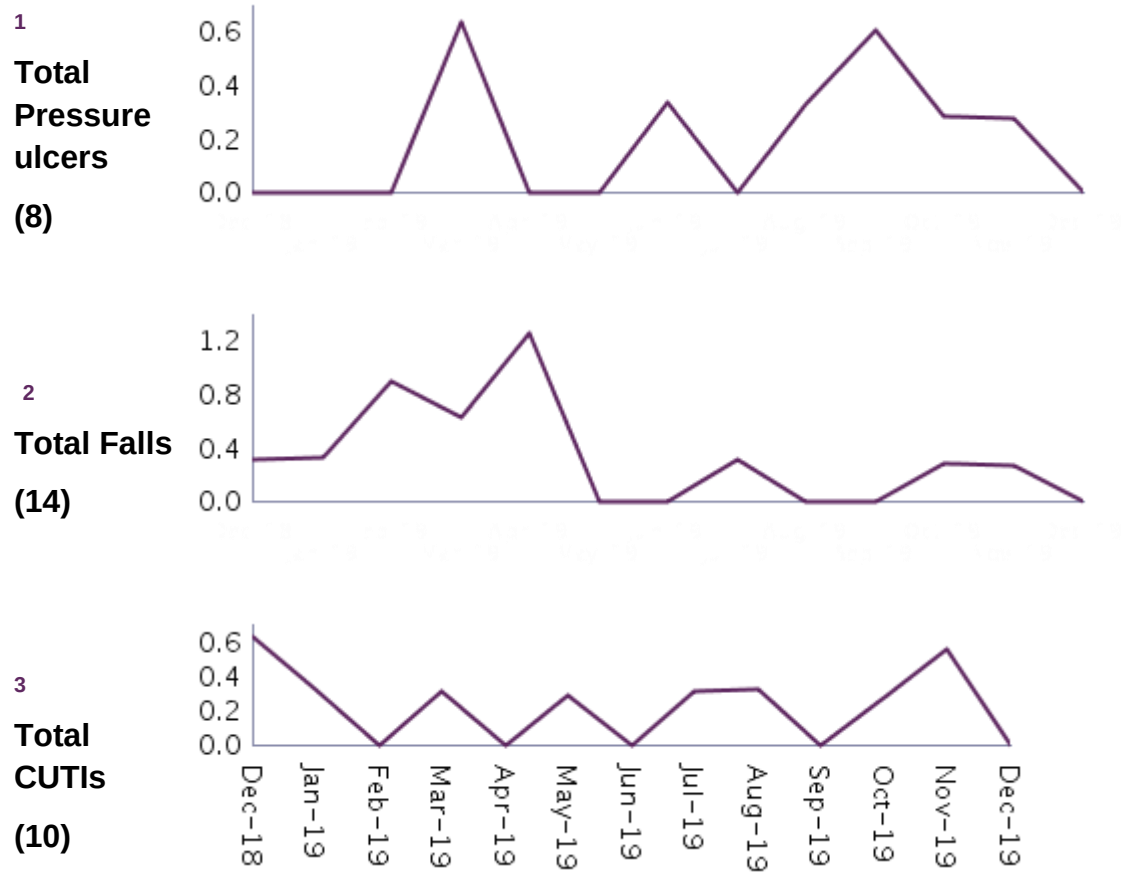
The safety thermometer data showed the service achieved harm-free care within the reporting period. Staff used the safety thermometer data to further improve services. The safety thermometer data was shared with staff on the staff intranet page and was used to inform focal areas for safety crosses on the wards when improvement was required. Safety cross is a tool used to visualise and identify safety problems. The focal areas are targeted at improving patient safety and reducing the risk of harm.

Managers told us safety cross information was a very useful way to support staff to focus on an

area requiring improvement. During our inspection managers told us there were current safety crosses involving controlled drugs checks and documentation audits. The focus of the safety crosses could come from issues raised by senior managers or those raised at a local ward level.

Data from the Patient Safety Thermometer showed the trust reported eight new pressure ulcers, 14 falls with harm and 10 new urinary tract infections in patients with a catheter from December 2018 to December 2019 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Torbay and South Devon NHS Foundation Trust



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed most guidance. However, staff did not consistently protect the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service had developed policies and guidelines in line with national policy. This included the National Institute for Health and Care Excellence (NICE) guidelines. Staff were able to access clinical guidelines and policies on the trust intranet.

Staff did not fully understand their responsibilities to patients subject to the Mental Health Act 1983 and Code of Practice. This hindered their ability to protect the right of patients subject to the Mental Health Act. Staff were unsure which legal framework they were practicing under. We observed a patient who was waiting to be admitted to Cheetham Hill Ward from EAU4. The patient had dementia and due to their diagnosis and concerns around their understanding of their situation, required a Mental Capacity Act (MCA) assessment. Some staff on the ward and staff facilitating the patient's move referred to the assessment as a mental health assessment and were unclear which legal framework they were working under.

There were clear processes to access the psychiatric liaison team and other support. The psychiatric liaison team had developed a joint triage form to support staff to identify issues and to make referrals to their team more effective. Most referrals made were seen within the 24-hour window. The wards could phone the psychiatric liaison team directly if needed, but may not always get hold of them, in which case the wards would seek support from the medical staff.

Records did not always include comprehensive risk assessments for patients with mental health needs. We observed a patient on Simpson Ward who was detained under section 3 of the Mental Health Act. The psychiatric liaison team described positive partnership working for the patient, whose care needs were being approached in a joined-up way. The records showed comprehensive risk assessments had been completed for medical and health needs but not for mental health needs. Separately, the daily records we reviewed included understanding and respectful language. However, triage notes used language such as "very demanding".

Guidance for staff was based on the patient's care plan, family guidance, hospital passport information and best practice guidance. However, the consent form was incomplete. Mental capacity to consent to care and treatment was considered on the consent form (recorded an MCA assessment had taken place), but the outcome or further details of this were not recorded. There was a further MCA assessment regarding medicines in the notes, which had evidence of the four-stage test and outcome. However, it was recorded there was a need to hold best interests meeting after discussion with the patient but no evidence of this meeting taking place, other than a recorded discussion by the psychiatric liaison team, telling the patient the outcome.

Ward staff were not always clear where a patient's section 132 rights, special opinion authorised doctor (SOAD) visits and outcomes, and section 17 paperwork would be recorded and stored. They said these were the responsibility of and were recorded by the psychiatric liaison team, but also told us that they were not always found in the same areas in patient notes.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed handover meetings on Cheetham Hill Ward

where staff considered the social situation of the patients and the support systems they had access to in the community, alongside their health needs. Discussions were initiated by the entire multidisciplinary team and we saw a holistic approach to patients care and support needs.

Staff did not always have access to up-to-date, accurate and comprehensive information on patient care and treatment. We observed transfers and discharges being delayed by a lack of IT system interface and printer malfunction. Staff did not all have access to the same electronic records system that they could all update. Some teams within the hospital used different IT systems and this was making it difficult for staff to communicate and connect. For example, the emergency department record system was not the same as the rest of the hospital. The psychiatric liaison team also recorded on another different electronic recording system. This meant there was potential for issues to be missed. However, the psychiatric liaison team were required to write in the patient's trust medical record, so information was available.

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. However, the recording of patient fluid and nutrition in care records could be improved.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed patients were provided with regular food and water, and additional nutritional supplements where required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed patient's fluid and nutrition charts where needed, although the completion of these could be improved. We reviewed records on George Earle Ward for patients with nutritional and fluid charts. Although these were mostly completed, there were no totals or signatures recorded on three documents. This meant the amounts of fluids and foods these patients had consumed was not recorded in their notes. This could increase their risk of malnutrition and dehydration. We also observed a set of notes on the same ward for a patient with a Percutaneous Endoscopic Gastrostomy feed (a feeding tube into the stomach). There were documented details of a flushing regime in the patient's notes.

Specialist support from staff, such as dietitians and speech and language therapists, was available for patients who needed it. Staff told us about collaborative working with ward staff and dieticians in order to achieve positive results for patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.

Staff assessed patient pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw a pain assessment tool was used to identify the severity of patient pain and pain relief was given when needed.

Patients received pain relief soon after requesting it. Patients told us pain relief was provided quickly when requested. We observed a positive response to a patient on Cheetham Hill ward who approached a staff member due to being in pain and feeling unwell. The staff member reassessed the patient's pain and symptoms and quickly provided more pain relief to the patient.

Staff prescribed, administered and recorded pain relief accurately. Records we reviewed showed pain relief had been documented clearly in patient notes. One staff member told us staff worked

together to check and double check all medicines, including pain relief, when administering them.

Patient outcomes

Staff monitored the effectiveness of care and treatment and used the findings to make improvements and achieve good outcomes for patients.

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Staff on most wards told us they had good working relationships with the discharge to assessment, rapid response and integrated care teams. Therapists felt they were a strong voice when it came to discharge planning. They were involved in the assessment for discharge plans and were present at multidisciplinary handovers and safer meetings. Therapists felt able to use their working knowledge of community teams to support the transition of patients between hospital and home.

Managers and staff used audit results to improve patient outcomes. Areas of improvement highlighted through audit were a focus of safety crosses on wards. The safety cross is a visual data collection tool that can be used to identify areas of improvement.

Managers shared and made sure staff understood information from the audits. Outcomes from audits were shared with staff and discussed at SAFER huddles (short multidisciplinary meetings held at predictable time and place and focussed on patients most at risk) and ward meetings. Any learning identified, or challenges highlighted in audits were also disseminated to staff through the staff bulletin, emails and on the staff intranet page.

The service made sure improvement was checked and monitored. Managers told us where audits highlighted areas for improvement, the information would be distributed to staff. They also told us the areas would then be re-audited.

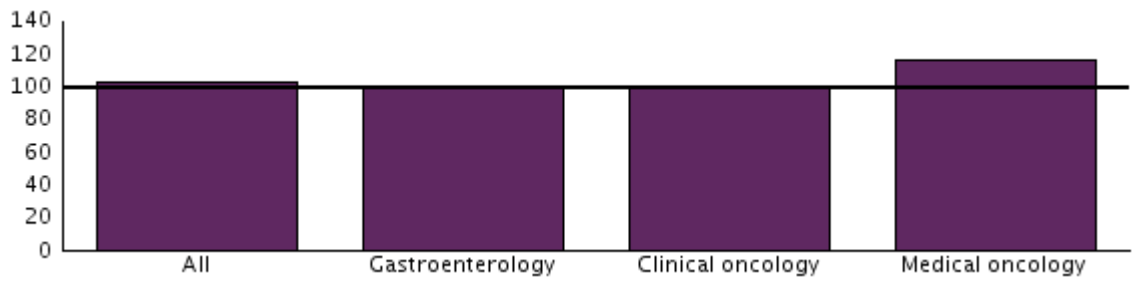
Relative risk of readmission

The service had a similar to expected risk of readmission for elective care than the England average. From September 2018 to August 2019, patients at Torbay Hospital had a similar to expected risk of readmission for elective admissions but a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology and clinical oncology had similar to expected risks of readmission for elective admissions compared to the England averages.

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions compared to the England average.

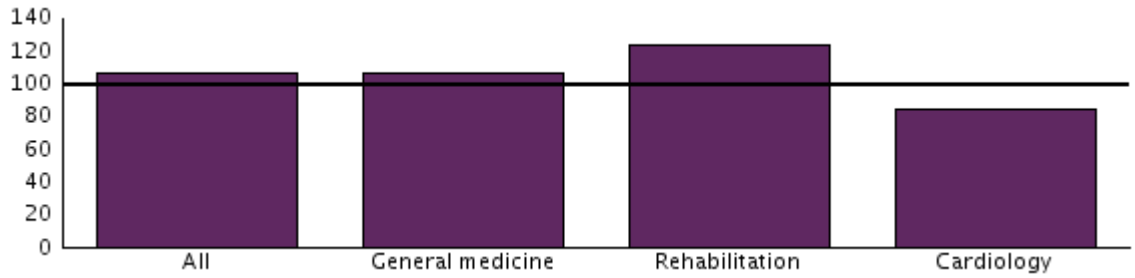
Elective Admissions - *Torbay Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in general medicine and rehabilitation had higher than expected risks of readmission for non-elective admissions compared to the England averages.
- Patients in cardiology had a lower than expected risk of readmission for non-elective admissions compared to the England average.

Non-Elective Admissions - *Torbay Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics (HES))

The service participated in some relevant national clinical audits. This included (but was not limited to) Sentinel Stroke National Audit Programme (SSNAP), Lung Cancer Audit, National Audit of Inpatient Falls and National Audit of Dementia. The trust had a clinical effectiveness group which analysed the data from audits.

Sentinel Stroke National Audit Programme (SSNAP)

The stroke pathway at Torbay hospital provides thrombolysis service 24 hours per day seven days each week. The service also had access to a medical registrar and the emergency department for support out of hours. The service included a 28-day stroke unit which had a 4.2 day average length of stay, which was positive.

Torbay Hospital took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade B in the most recent two audits, covering the period from April 2019 to September 2019.

Leaders told us there was flexible staff cover within the majority of the team but said the speech and language therapist service staffing impacted the service quite significantly. Speech and language therapy (SALT) was a small service within the trust which was managed separately to the stroke team. Leaders advised that there was no weekend SALT input which affects the SSNAP figures. There was an impact on swallow assessments being completed, and in response they advised that nurses had been trained to complete swallow assessments. However, nurses told us they would not initiate any feeding regime, which had an impact on patient treatment and care.

Overall Scores	**Jul 18 - Sep 18**	**Oct 18 - Dec 18**	**Jan 19 - Mar 19**	**Apr 19 - Jun 19**	**Jul 19 - Sept 19**
SSNAP level	**B**	**B**	**C↓**	**B↑**	**B**
Case ascertainment band	**A**	**A**	**A**	**A**	**A**
Audit compliance band	**A**	**A**	**A**	**A**	**A**
Combined total key indicator level	**B**	**B**	**C↓**	**B↑**	**B**

For patient-centred performance, Torbay Hospital achieved a score of C or better for all domains in the last two audits, with identical performance in each. Performance over the last five audits is shown below.

Patient centred performance	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sept 19
Domain 1: Scanning	B	A↑	B↓	A↑	A
Domain 2: Stroke unit	C↑	C	D↓	C↑	C
Domain 3: Thrombolysis	C↑	C	D↓	C↑	C
Domain 4: Specialist assessments	C↑	C	D↓	C↑	C
Domain 5: Occupational therapy	A	A	A	A	A
Domain 6: Physiotherapy	A	A	B↓	A↑	A
Domain 7: Speech and language therapy	C	D↓	D	C↑	C
Domain 8: Multi-disciplinary team working	B	C↓	B↑	B	B
Domain 9: Standards by discharge	B	B	B	B	B
Domain 10: Discharge processes	A	A	A	A	A
Patient-centred total key indicator level	B	B	C↓	B↑	B

For team-centred performance, Torbay Hospital achieved a score of C or better for nine out of 10 domains in the last two audits. In the latest, audit physiotherapy and standards by discharge scores improved from B to A.

Team centred performance	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sept 19
Domain 1: Scanning	B	A↑	B↓	A↑	A
Domain 2: Stroke unit	C↑	C	D↓	C↑	D↓
Domain 3: Thrombolysis	C↑	C	D↓	C↑	C
Domain 4: Specialist assessments	C↑	D↓	D	C↑	C
Domain 5: Occupational therapy	A	A	A	A	A
Domain 6: Physiotherapy	A	B↓	C↓	B↑	A↑
Domain 7: Speech and language therapy	D↑	E↓	E	D↑	C↑
Domain 8: Multi-disciplinary team working	B	C↓	B↑	B	B
Domain 9: Standards by discharge	B	B	B	B	A↑
Domain 10: Discharge processes	A	A	A	A	A
Team-centred total key indicator level	B↑	B	C↓	B↑	B

(Source: Royal College of Physicians London, SSNAP audit)

Lung Cancer Audit

The trust participated in the most recent Lung Cancer audit in 2019. In response to results the service had developed the service to improve performance and patient experience. Examples of actions taken include capturing patient feedback. The team carried out an audit of patient feedback in the waiting room and it was noted that good feedback was provided. The team now run a cancer support and information centre. This centre is run with two support workers and psychology support. It is designed to provide benefits advice, guidance and therapies to patients.

The table below summarises the trust's performance in the 2019 National Lung Cancer Audit. The Lung Cancer Audit demonstrated the audit measures were within expected range when compared to other hospitals. However, did not always meet the national standard.

Metrics *(Audit measures)*	**Hospital performance**	**Comparison to other hospitals**	**Met national standard?**
Crude proportion of patients seen by a cancer nurse specialist *Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment*	82.0%	N/A	Does not meet the audit standard of 90%
Case-mix adjusted one-year survival rate *Adjusted scores take into account the differences in the case-mix of patients treated*	36.2%	Within expected range	No current standard
Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery *Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen*	21.0%	Within expected range	Met (Audit standard based on NICE guideline 17%)
Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment *For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen*	62.0%	Within expected range	Did not meet (Audit standard based on NICE guideline 65%)

Metrics *(Audit measures)*	Hospital performance	Comparison to other hospitals	Met national standard?
Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy *SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen*	68.6%	Within expected range	Did not meet (Audit standard based on NICE guideline 70%)

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The service participated in the national audit of inpatient falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention. The service had responded to this audit through an action plan which included each ward recording number of falls as part of a safety thermometer check. For patients identified as at risk, assessments and action plans were now completed. We saw wards now provided non-slip socks to patients at risk of falls, which provided some grip to avoid slipping. Staff told us the socks also served to visually prompt and alert staff to patients who were at risk of falls.

The table below summarises Torbay Hospital's performance in the 2017 National Audit of Inpatient Falls.

Metrics *(Audit measures)*	Hospital performance	Audit Rating	Met national standard?
Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?	Yes	N/A	Met
Crude proportion of patients who had a vision assessment (if applicable) *Having a vision assessment is indicative of good practice in falls prevention*	6.7%	Red	Did not meet (Standard 100%)
Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) *Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention*	24.0%	Red	Did not meet (Standard 100%)

Metrics *(Audit measures)*	Hospital performance	Audit Rating	Met national standard?
Crude proportion of patients assessed for the presence or absence of delirium (if applicable) *Having an assessment for delirium is indicative of good practice in falls prevention*	25.0%	Red	Did not meet (Standard 100%)
Crude proportion of patients with a call bell in reach (if applicable) *Having a call bell in reach is an important environmental factor that may impact on the risk of falls*	80.7%	Green	Did not meet (Standard 100%)

(Source: National Audit of Inpatient Falls)

Chronic Obstructive Pulmonary Disease Audit

The trust participated in the 2019 Chronic Obstructive Pulmonary disease audit. The results showed that the service performed better that the national aggregate in some areas but worse than the national aggregate in others. Leaders told us action plans were being developed to improve performance, but this was a work in progress. The table below summarises Torbay Hospital's performance in the audit.

Metrics *(Audit measures)*	Hospital performance	Comparison to other hospitals	Met national standard?
Percentage of patients seen by a member of the respiratory team within 24hrs of admission? *Specialist input improves processes and outcomes for COPD patients*	38.8%	Worse than national aggregate	Did not meet
Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) *Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death*	95.9%	Worse than national aggregate	Did not meet
Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival *NIV is an evidence-based intervention that halves the mortality if applied*	40.0%	Better than national aggregate	Met

Metrics *(Audit measures)*	Hospital performance	Comparison to other hospitals	Met national standard?
early in the admission			
Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy *Smoking cessation is one of the few interventions that can alter the trajectory of COPD*	52.6%	Better than national aggregate	Did not meet
Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission *Completion of a discharge bundle improves readmission rates and integration of care*	12.9%	Worse than national aggregate	Did not meet
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file *A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt*	49.7%	Better than national aggregate	Did not meet

(Source: Chronic Obstructive Pulmonary Disease Audit)

National Audit of Dementia

The service has responded to the outcomes of this audit through action plans to improve services. Leaders told us the work had included the implementation of additional activities for patients on wards and development of activity boxes on wards. Staff told us families were also encouraged to use these resources and to join in with activities alongside their loved ones. The service has completed ongoing work alongside dementia awareness agencies in the community to promote the awareness of dementia among staff and the local population. Wards displayed the 'purple angel' logos. Purple angel is campaign to raise awareness, give hope to and empower people with dementia by giving out information on how shops, businesses and other services can support people who have these progressive diseases. The service had also introduced the use of the blue forget me knots in patient notes and above their beds to help ensure those with the condition are easily identifiable to staff and their care is planned accordingly. Specialist equipment has been made available for patients including different coloured trays and specialist crockery. The service had also done considerable work on their public website. They had created video guides for patients with and their carers about dementia and old age.

The service was also running a delirium pilot which was being led by community teams. Part of its focus was enabling patients to be discharged home within 24 hours with care.

The table below summarises Torbay Hospital's performance in the 2017 National Audit of

Dementia.

Metrics ***(Audit measures)***	**Hospital performance**	**Audit's Rating**	**Met national standard?**
Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good *(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)*	No data available	N/A	No current standard
Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?" *(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)*	70.8%	Worse	No current standard
Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium *(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary*)	45.5%	Similar	No current standard
Multi-disciplinary team involvement in discussion of discharge *(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)*	97.0%	Better	No current standard

(Source: National Audit of Dementia)

Competent staff

The service ensured staff were competent for their roles. However, managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were competency frameworks to support staff to evidence they were competent for their roles. We observed comprehensive examples of these, and staff gave examples of development opportunities they had access to. Several senior staff told us how they were supported to develop and take on additional duties in the process of promoting to more advanced roles. Health care assistants on several wards told us they were being supported to develop through the trust's development of the nursing associate role. At the time of this inspection the first nursing associate had recently started training on Midgley ward. The trust had also recently offered its first registered mental health nurse position.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us that every new member of staff received a comprehensive induction programme. Bank and agency staff also confirmed they received the same induction, alongside local level induction on the wards they were working on.

Leaders felt they offered good development opportunities for staff with leadership courses being offered to band 6 nursing staff. Leaders told us there were difficulties attracting staff to certain roles. For example, radiographers, respiratory and cardiac physiologists. They felt positively about 'home grown' staff and development of roles. For example, a non-medical consultant was part of the acute stroke pathway. Consultant roles were usually filled by those who had worked as registrars in the trust, which leaders felt was positive in terms of retention.

Appraisal rates

Appraisal compliance was not meeting trust targets. Managers did not always support staff to develop through yearly, constructive appraisals of their work. There was a risk staff would not all have the opportunity to discuss training needs with their line manager or be supported to develop their skills and knowledge as appraisals were not always complete in line with trust policy. Staff who had received their appraisals were positive about the process and felt well supported.

From December 2018 to November 2019, 71% of staff (excluding medical staff) within medical care received an appraisal, compared to a trust target of 90%. This compares to an appraisal rate of 73.8% in the previous financial year (April 2018 to March 2019).

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional professional scientific and technical staff	20	24	83.3%	90.0%	No
Administrative and clerical	92	118	78.0%	90.0%	No
Additional clinical services	127	177	71.8%	90.0%	No
Nursing registered	166	247	67.2%	90.0%	No
Estates and ancillary	2	3	66.7%	90.0%	No
Allied health professionals	29	44	65.9%	90.0%	No
Total	**436**	**613**	**71.1%**	**90.0%**	**No**

Appraisal data provided by the trust for this core service did not include medical staff and so it was unclear to what extent managers supported medical staff to develop through yearly constructive appraisals.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff said they were encouraged to attend team meetings and were told they should attend wherever possible. Staff received meeting minutes which happened regularly and were well attended by all staff.

Staff did not always have the time and opportunity to develop their skills and knowledge. A few staff told us they did not always have time to develop due to workload pressure on the ward. This was corroborated by some of the mandatory training refresher completion rates reported above.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Wards held SAFER huddles, these were regular daily meetings and the trust was hoping to implement an additional afternoon SAFER huddle in the near future. We observed ward handovers where there was a full complement of multidisciplinary team members present. Each staff member was involved in discussions about patient treatment and discharge pathways and it was clear all staff had respect for and considered each other's roles and professional opinions.

Staff worked across health care disciplines and with other agencies when required to care for patients. We observed good multi-disciplinary working on all wards. This included across health care professionals within the hospital but also included working with wider community services. For example, wards had developed networks and links with community teams and services. Staff told us about joined up working with the hospital and community therapy and social care teams. We also observed joined up working with voluntary sector organisations during this inspection. Staff told us this had improved discharge planning and encouraged more person focused ways of working. Although medical care teams showed good multidisciplinary working within itself, this did not seem to follow through to supporting and working alongside the emergency department.

Patients had their care pathways reviewed by the relevant consultants. All patient records we observed showed relevant consultants had reviewed care pathways. This was also the case for patients who were outliers (a medical outlier is a hospital inpatient who is classified as a medical patient but has at least one move to a non-medical ward during their hospital stay).

Wards could approach safeguarding lead, substance misuse links within the trust, or the psychiatric liaison team for any further assistance. Wards could access and bring in additional staff if needed. A care for older people ward was in the process of employing a registered mental health nurse to bring in additional mental health knowledge and experience. No wards had mental health champions. However, some wards had learning disability and dementia champions, who had access to ongoing training. The safeguarding team also supported education sessions around autism, DoLS and the Mental Capacity Act.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The psychiatric liaison team completed mental health assessments on wards and staff knew how to make referrals to them.

Seven-day services

Key services were available seven days a week to support timely patient care. However, some services were not available or more difficult to access out of hours or at weekends.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Consultants worked several uninterrupted days in each area each week to ensure continuity of care for patients. All staff told us they felt well supported by consultants. Staff said consultants were available and accessible all week, including evenings and weekends. They spoke positively about having access to the consultant rotas so they could identify who was available.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Physiotherapists provided a seven-day service. A senior staff member, band 6, band 5 and technicians were available seven days. Physiotherapists felt they were well staffed. However, there were three vacancies within occupational therapy. Staff said this meant they could not always prioritise continuity of care to patients as they were often moved to different areas within the hospital to provide support where there were gaps. Leaders told us a new role was being developed to establish what safe staffing levels were acceptable for therapy staff.

Therapy leaders told us they felt communication amongst themselves as a team was good. Staff told us the electronic recording system allowed for discharge plans, notes and plans to be written more easily and for a more joined up approach to patient care. Therapists also attended the flow meeting each day and staffing was coordinated amongst the team to ensure all medical units were staffed.

Speech and language therapy was available through a referral system on weekdays but not weekends. Staff spoke of this service positively but felt they were significantly short staffed. Staff told us this had some impact on the stroke services and impacted timely patient rehabilitation.

Dieticians were available and provided support on wards during weekdays, but support was not consistent at weekends. The impact of this was delayed assessments. Staff told us about additional input from dieticians on some wards but felt this was not always enough or at times when the wards needed it.

Onward referrals could also be made to community-based Drug and Alcohol services. There was a lifestyle team on site who could support with drug and alcohol screening. Staff could also make

referrals on to community domestic abuse services. These services were not available seven days each week which meant there could be delays in support.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards/units. On wards we found numerous leaflets which provided information about healthy eating, physical activity and support specifically for patients who had been diagnosed with cancer. There were also leaflets providing advice on healthy lifestyle, the chaplaincy service, 'safe and well visits', Medical Admissions and Avoidance Team (MAAT) and preventing pressure ulcers.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. We also found advice displayed in display cabinets on most wards. Staff told us these were there for the information of staff, patients and carers but were designed in a way to enable understanding and provide information for people with cognitive impairments and communication difficulties as well.

Patients had access to the cancer support and information centre located in the hospital. This centre provided pampering therapies, for example, skin care and make up sessions. The centre also supported patients to make advanced decisions about their care.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not consistently support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not consistently know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use agreed personalised measures that limit patients' liberty.

Staff did not consistently understand how and when to assess whether a patient had the capacity to make decisions about their care. The wards did have a proforma for recording mental capacity assessments and service leads were confident mental capacity assessments and best interest discussions were widely recorded. However, staff we spoke with had differing levels of understanding of the Mental Capacity Act and most nurses we spoke with said assessing mental capacity was the role of the doctors. We reviewed 10 patient records and found mental capacity assessments were not always complete when required and did not always include outcomes or best interest decisions when they were complete. All of the records we reviewed were incomplete. Managers acknowledged there were varying levels of understanding amongst staff.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not always make sure patients consented to treatment based on all the information available. For patients who could give informed consent, we observed good recording of this in-patient records. There was also evidence of advance decision-making discussions taking place for these patients. However, for patients who could not give consent, staff did not always understand their responsibilities regarding best interest decisions and taking into account patients' wishes. We reviewed a set of patient notes on Cheetham Hill ward, where the patient was described as 'wandering and climbing from bed'. The patient had a diagnosis of dementia and delirium but there was no mental capacity assessment or DoLS authorisation. A record completed by an occupational therapist stated 'best interest' to mobilise but no mental capacity assessment or best interest decision was documented and there was no rationale for this either. A further record three days later regarding personal care and medication showed no capacity to consent documented and no rationale provided. When we raised this issue with managers they said, as the

patient had ‘no intention of leaving’ they did not feel a DoLS was necessary. This demonstrated a lack of understanding about DoLS and suggested that staff were not familiar with or competent in applying the most recent guidance on its application.

Staff did not consistently or clearly record consent in patients’ records. Staff did not appear to understand why the DoLS authorisation was required or what the impact of a patient not consenting could be. We followed a patient journey from the emergency assessment unit (EAU4). When reviewing the patient notes staff found no record of mental capacity assessment or best interest decision documented for the patient, who the clinical site team were moving to a medical ward. The patient had a diagnosis of dementia and had been admitted due to showing behaviour that challenged at home. When we spoke with staff, they identified that the psychiatric liaison team had concluded that the mental health act was not the most appropriate legal framework for the patient. We then discussed whether there was a requirement for a mental capacity assessment and staff referred to this as mental health assessment. There was no recorded evidence of the patient’s consent documented in the records and there was no mental capacity assessment, best interest decision or DoLS authorisation. This was of concern as it suggested that the patient may have been unlawfully deprived of their liberty. There was evidence of input from the psychiatric liaison team who had concluded the patient did not meet the criteria for detention under the Mental Health Act. Although this was recorded, staff had difficulty locating the information and did not show clear and consistent understanding of the differences between the legal frameworks for Mental Capacity Act and Mental Health Act.

We also reviewed the universal care plan documentation used widely by the trust and found the fundamental questions were not presented in a logical order and were not in line with the fundamental principles of the Mental Capacity Act. The form gave prompts in the following order:

1. Does the individual have capacity?
2. If no, has a best interest decision been made?
3. Is a mental capacity assessment required?

The principles of the Mental Capacity Act include 1. Assume a person has capacity unless proven otherwise. The documentation seems to contradict this principle by asking first if the individual has capacity. This may have hindered staff from following a logical format, in line with the Mental Capacity Act guidance.

The next question asked if a best interest decision had been made. To have a best interest decision considered in the middle of this process may further confuse staff and also goes against principle two of the Mental Capacity Act: Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them.

A logical format is not encouraged as there is not a prompt to complete mental capacity assessment before completing best interest decision. There is also a breach of the individual’s human right under article 5: deprivation of liberty. This is because they may have been stopped from doing something they wanted to do; may have had to do something or have something done to them that they did not want; but they could make a decision on with some support or help. This suggested a lack of understanding from the higher levels of the trust as the documentation was confusing for staff to follow and did not follow key principles of legislation.

Mental Capacity Act and Deprivation of Liberty training completion

All staff had access to but did not always keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust reported Mental Capacity Act training, including deprivation of liberty standards, was delivered as part of the corporate and clinical induction for all

new staff. MCA and DoLS was also included in safeguarding adults level 2 and 3 training. The details of the training provided by the trust showed a comprehensive training session on key responsibilities of staff and their legal duties. A ward sister told us the training received on DoLS included a one-hour study session with the matron and on-line training on the trust intranet. Staff advised they would make contact with the safeguarding lead if there were any concerns but not all staff were able to identify who the safeguarding lead was.

Staff did not consistently understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. We reviewed a patient's records on Cheetham Hill ward, where there had been a reason to query if they had capacity to consent to their stay in hospital. The patient was diagnosed with vascular dementia. There was evidence of a Mental Capacity Act assessment taking place on a rapid mental capacity assessment document, but no rationale for any decision making was recorded. We observed there was no space for the recording of rationale to support the 4-stage test on the document. There was no reference to a best interest decision being made and we observed there were no prompts or space for evidencing of best interest checklist being utilised on the document either. We read the patient's family had consented to their stay, but this was not supported by evidence of lasting power of attorney. Staff we spoke with said they would often gain consent from patients' families if they could not consent for themselves. This suggested a lack of understanding of the Mental Capacity Act legal framework but also potential for patients' human rights to be breached and for there to be shortfalls in their care.

In the patient's notes also showed security was called twice as the patient was aggressive. However, no deprivation of liberty safeguards authorisation was requested and rationale for this was documented as being they have 'no intention of leaving the ward so not for DoLS at this time'. There was further documentation the individual may be a risk to self, staff and other patients. However, there was no consideration in their records this may indicate a need to look at mental health legislation. On one date it was recorded the individual needed lorazepam to be prescribed as there was a risk of harm to others. There was no consideration of the fact they may not be able to consent to sedation or if mental health legislation should be used. However, 19 days beforehand a mental capacity assessment was recorded. It concluded the individual could not consent to sedation. No rationale for mental capacity assessment outcome was documented as the assessment was completed on the rapid assessment tick box form. No best interest decision was documented.

Staff were not able to consistently or accurately describe policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff and managers on Dunlop ward, Cheetham Hill, Simpson ward and George Earle ward told us if there was any patient requiring a mental capacity assessment this was flagged to the doctor to complete an assessment. However, some nursing staff on Cheetham Hill ward said they would complete some mental capacity assessments themselves. This highlighted a lack of knowledge about mental capacity legislation as anyone can complete a mental capacity assessment. This was of concern as staff not having the knowledge or confidence to complete mental capacity assessments could mean patients could be being unlawfully deprived of their liberty for unnecessary periods of time. Managers also advised us once a week 'someone' checked on any deprivation of liberty safeguard authorisations required but the ward manager was unsure who this was.

Staff were not always able to identify who to get accurate advice from. However, staff could access support and advice from the psychiatric liaison team and safeguarding team. Staff could contact the on-site security team if a patient required physical restraint but would aim to de-escalate and only use restraint as a last resort. The on-site security team received additional

training in restraint which is why any more challenging patients may require support from them. When we asked managers and leaders about a mental health strategy, they felt there probably wasn't one. They were also uncertain if there was a clinical lead or board member champion responsible for mental health. However, the trust confirmed following this inspection that the trust seconds staff to Devon Partnership Trust, who oversee the strategy and planning for mental health services in Torbay hospital. The trust manages the Approved Mental Health Professionals and are responsible for the recruitment, development and training for this staff group.

Staff had access to mandatory conflict resolution training, but this was not always completed or refreshed in line with trust policy. There was a policy for managing challenging behaviour. This was used as guidance if a patient was needing additional support.

Managers did not monitor how well the service followed the Mental Capacity Act. Mental Capacity Act is an act of parliament designed to protect and empower people who may lack the mental capacity to make their own decisions. The Mental Health Act is legislation that covers the assessment, treatment and rights of people with a mental health disorder, it directly relates to people who require treatment for a mental health disorder and are a risk of harm to themselves or others. Many staff and managers said their rationale for not having DoLS was based around patients not actively attempting to leave. Staff knowledge of the legal framework of the Mental Capacity Act should facilitate them to ensure peoples' human rights are upheld and they are protected from unlawful deprivation of the liberty. If staff do not have this level of understanding, then they will not be able to meet the requirements of them under the Mental Capacity Act.

Not having the correct DoLS authorisation was a failure to adhere not only to mental capacity legislation but was also a breach of Article 5 of the Human Rights Act: right to liberty and Article 8 of the Human Rights Act: respect for your private and family life. Staff, managers and leaders did not appear to understand the significance of this for their patients who mostly met the Deprivation of Liberty safeguards acid test: many patients were subject to continuous control or supervision and were not free to leave if they chose to.

Staff did not implement Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. When reviewing patients' records, we found there were no DoLS authorisations for many patients on Cheetham Hill ward (care of the elderly). We identified six patients who met criteria for DoLS authorisations. As the authorisations had not been complete, these patients had been unlawfully deprived of their liberty for up to 23 days during their admissions. We fed this back to the trust during our inspection, they responded immediately by sending the trust safeguarding adults lead to the ward to review the patients.

Although the trust addressed our concerns by sending the safeguarding lead to review the patients, we had significant concerns regarding a lack of staff understanding of legal responsibilities under the Mental Capacity Act and subsequently deprivation of liberty safeguards. Specifically, the responsibility of hospital wards to ensure none of their patients are unlawfully deprived of their liberty.

Is the service caring?

Compassionate care

Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were mostly discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. However, not all members of staff introduced themselves when speaking to patients and entering their rooms. We also heard staff members referring to patients by their bed numbers rather than their names, on wards and within handover meetings. We were told bed numbers were used to maintain patient confidentiality and therefore staff were encouraged to avoid using patient names in public spaces, such as ward corridors. However, the matrons would review to ensure in non-public and private spaces patients would be identified by name as appropriate.

Patients said staff mostly treated them well and with kindness. Most patients we spoke with told us how caring and attentive the ward staff were. We were told “nothing was too much trouble” and “I feel completely safe here”. However, one patient told us some staff could be rude and they did not like their attitude towards them. We heard of one example where a patient had requested to use a commode, but they were asked to use a bed pan instead as it only required one member of staff. We were told although most nursing and healthcare assistants were “fantastic”, some of the doctors and consultants were abrupt and uncompassionate when speaking with patients.

Staff followed policy to keep patient care and treatment confidential. They supported patients and their relatives to access side rooms where sensitive conversations were needed and made every effort to provide privacy though use of curtains around beds. We observed all handover meetings and SAFER meeting were in confidential spaces away from cubicles and bays. Staff were careful to move away from patients’ beds if care and treatment discussion were required away from the patient.

Patients mostly gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. We spoke with the volunteer lead responsible for the patient experience network. Volunteers collected the patient experience information. This was a real time collection of data from patients on wards which nurses may have been too busy to collect. The feedback was audited, and the outcomes led to changes and improvements for the service. For example, one patient reported high room temperatures on the ward, and this was acted upon immediately.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

Staff mostly gave patients and those close to them help, emotional support and advice when they needed it. Patients knew how to seek help and said they felt listened to. We observed patients approaching staff for support and staff responding courteously, even when wards were very busy.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us if a patient was distressed the staff would look at any triggers (largely environmental) and look to move them if needed to a quieter area or side room. They would consider if the ward was appropriate for them and how staff could best support during challenging patterns of behaviour. Staff told us they would use the information to reduce a patient’s triggers. Wards had access to and used ‘pets as therapy’ and hand massage to soothe

distressed patients.

Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them. There was a carers support team who provided additional support to family members. There was access to parking permits and an advice clinic, run by a voluntary sector organisation, was held once per week on Cheetham Hill ward. We observed staff on Cheetham Hill ward, alongside members of the clinical site team, providing reassurance and support to a patient who had concerns about their discharge pathway. The patient and their relatives were given time to voice their concerns and these were listened to. The patient's family told us they had felt supported and reassured their concerns had been heard.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

Staff did not always support patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure patients and those close to them understood their care and treatment. However, due to concerns raised regarding application of the mental capacity act, this did not include patients who lacked capacity to make decision about their care and treatment.

Staff spoke with some patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff on the stroke wards utilising picture style communication cards to discuss care and treatment with patients and their families. These were also displayed outside the bays and were accessible and clearly presented for all to see and use. Most wards had a range of pictorial resources and other resources staff could use to support patients with communication difficulties. However, we did not see evidence of their use recorded in patient notes we reviewed. We also found that patients who had evidence of a disturbance in the functioning of the mind or brain were not always supported to make decisions about their care. They were not consistently supported to make best interest decisions and their rights were not always protected by legal frameworks as staff did not have sufficient understanding of deprivation of liberty safeguards the Mental Capacity Act or the Mental Health Act.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had comment forms people could complete to provide feedback about their experience. There was also a section available on the website where patients could give feedback. In addition to this, the service regularly collected live data from patients regarding their experience and audited this. The information formed the live patient feedback system which was used to drive change in the organisation and to improve patient experience. Patients knew how to seek help and said they felt listened to.

Staff supported patients to make both informed and advanced decisions about their care. We saw posters displayed on wards giving staff, patients and their families information about making advanced decisions about their care. Staff on Cheetham Hill ward were able to direct us to the poster when asked but did not all understand the purpose of advance decisions and were not able to tell us this information away from the poster. Leaders told us senior staff were confident in having conversations about advanced decisions and work was ongoing to enable other staff to build skills to trial having these discussions with patients as well.

The trust did not submit any friends and family test data. However, the service used a live patient feedback system that enabled them to get immediate feedback form patients and their families on

wards. The information was collected by a volunteer and then presented through the intranet system for all to see.

Is the service responsive?

Service delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. The service worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the needs of the local population. For example, the service had made changes to enable treatment of some patients on the same day. Leaders told us about treatments being completed as day patients such as anti-coagulants and intravenous medicines. The team had identified these patients were often safe to return home after their treatment was complete. As patients were not admitted, this reduced some of the pressure on inpatient beds.

Another department within the hospital was the emergency department, where people presented for urgent assessment and treatment. The trust was looking to reduce the numbers of people coming through the front door of the emergency department and was diverting patients as best they could. However, this was yet to be fully implemented and embedded within the wider hospital system and during our inspection we found all of the hospitals take were admitted via the emergency department. Leaders told us since the introduction of the integrated service units the emergency department was now seen much more as a part of the system. Matrons were challenging staff to discharge and there was a cultural shift. Leaders felt they had a good oversight of patients in the emergency department and knew where the capacity for admission was when this was needed.

Leaders told us patients were ‘sat out’ of wards, sometimes in day rooms, awaiting discharge to free beds. They said there was a technology project being piloted to monitor patients within these rooms to try and ensure safety. However, we did not see evidence of this on the wards during our inspection and found many day rooms were cluttered with equipment. The day rooms were mostly a safe environment for patients to wait in. They were not in the line of sight of the ward staff. However, being ready for discharge, there is potential that they wouldn’t need to be.

Managers monitored and took action to minimise missed appointments. We were told about virtual clinics and group sessions had been set up to brief patients before they received treatment.

The service mostly had suitable facilities to meet the needs of patients’ families. There were quiet rooms and day rooms on most wards where patients, their family members and visitors could have more private conversations. There was seating available on wards and there were services throughout the hospital where refreshments and food could be purchased. However, toilet facilities available for visitors on that floor of the hospital and visiting family members had to go down two levels to find suitable facilities.

We found signage throughout the hospital was clear and easy to follow. Patients and carers told us they were confident navigating the hospital and knew if they got lost the volunteer navigators were always around to help. This team were mostly based at the main entrance and we experienced how knowledgeable and friendly they were throughout our inspection.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Although the service reported no breaches in bays, there were some areas of concern. We observed some wards where staff tried to ensure men and women were

accommodated separately but this was a challenge, given the layout of the wards. The difficulties were relating to men having to walk past female bays in order to get to bathroom facilities. Staff told us how they would report a breach and how they could gain support from the ward manager or matron for this if needed.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems. The psychiatric liaison team services were available 24 hours a day, seven days a week. The team offered support to the emergency department and the hospital wards. The psychiatric liaison team was based on site but were commissioned for over 18s only.

The service had systems to help care for patients in need of additional support or specialist intervention. Leaders told us about staff supporting patients with communication difficulties. For example, we saw headphones and microphone sets being used on wards for people who were hard of hearing. There were also pictorial style communication cards on Turner ward to aid communication and staff showed us how they used them. If a patient had specific communication needs, the wards would also involve the speech and language therapy (SALT) team.

There was access to information videos and communication services through the trust internet page. There was a palliative care team and end of life care team who provided additional support to patients where needed. However, some staff told us this was not always available as quickly as they would have liked.

Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us records had a marker which could identify people who had a diagnosis of dementia or learning disability. Staff told us they completed learning disability passports to support patients with learning disabilities and difficulties.

Staff had taken some steps to support patients living with dementia by using 'This is me' documents (documents that help to support people with dementia, delirium or other communication difficulties when in unfamiliar places. The document captures information about the person that may help health and social care professionals to understand who the person really is, which can help them deliver care that is tailor to the persons preferences and needs). Managers told us these documents were also audited as part of falls audits. Staff showed us examples and explained how the document helped them understand things patients liked and disliked, along with information about their home life and past work experience.

Some wards were designed to meet the needs of patients living with dementia. There was work ongoing on Cheetham Hill ward to provide an environment and atmosphere supportive of patients living with dementia. There was access to vinyl records, a piano and specially designed cutlery. They also kept twiddle muffs and canula cuffs on the wards. These were knitted and designed to occupy a patient's hands as a distraction. Staff told us there were daily activities on most wards. However, we did not see or hear about many 'dementia friendly' initiatives or plans for other wards but did find a dementia friendly box with activities in on EAU4. Some wards had painted bays different colours and introduced systems to make it easier for patients to be identified and supported by staff. This also helps patients to orientate themselves.

The service had a dementia care strategy and was implementing new plans on Cheetham Hill

ward which was primarily for care of the elderly. The plans were titled the ‘Moving forward project’. The project included a lunch club every day (patients were encouraged to eat together in the day room). Staff would be encouraging patients to sit out of bed. Leaders told us they were working to introduce snacks and finger foods on wards for patients living with dementia. This was to support and encourage patients to eat regularly. Activities were provided on the ward, including bingo and exercise. There were vinyl records provided in the day room by league of friends and there was china tea sets available in the day room as well. The ward was also visited frequently by student hairdressers and patients were supported to have their hair done if they wanted to.

If a patient was distressed, ward staff would look at any triggers and look to move them if needed to a quieter area or side room. They would consider if the ward was appropriate for them and would consider how to deal with challenging patterns of behaviour and reduce triggers. Wards had used a ‘pets as therapy’ service and hand massage to soothe distressed patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service was compliant with the accessible information standards. They had information leaflets available in languages spoken by the patients and local community. There was access to translation and interpretation services, including sign language, easy read, braille and large print. All services were publicised well on the trust website and via leaflets we found throughout the hospital. Some additional leaflets we found publicised communication support cards offered by the trust. These cards enabled patients with support needs to have their requirements highlighted on their notes. They also enabled patients to receive information in a form that would support them to understand.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to tools to support communication. Staff told us about flash cards and headsets with microphones for patients who were hard of hearing. However, not all staff felt comfortable or confident using the tools available to support patients to communicate.

Peer support volunteers were involved with supporting long term conditions groups. For example, stroke survivors had set up a walking football team and there were exercise groups being supported.

Patients were given a choice of food and drink. Patients told us there was a choice of food and drink available each day, although several patients said the food was not always hot and did not have much flavour. One patient with special dietary needs told us staff went out of their way to make sure they had food that met their needs.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards. Although systems were established to support flow within the hospital, wards did not appear proactive when supporting the move of patients out of the emergency department and onto wards.

Managers and staff worked to make sure they started discharge planning as early as possible. However, this was not effective enough to facilitate flow through the hospital. The service had introduced systems designed to improve patient flow and facilitate timely discharge. Staff told us they were using these processes throughout the hospital. The main systems for this were morning SAFER (a practice tool to reduce delays to patients in adult inpatient wards) meetings and the Red2Green (developed by the trust to identify discharge pathways as soon as possible after patient admission and to support the consideration of discharge as soon as possible after a patient

arrives in a ward) tool. These tools were part of the trust's work to prevent and reduce delays in transfer of care. We saw them in use and found they were supported and reinforced by the recently developed clinical site team. The trust was working on developing an afternoon safer meeting. During this inspection safer meetings happened once per day in the morning. Wards received support from quality improvement leads when setting up the safer processes and posters had been developed.

Part of the role of the clinical site team was to manage bed availability and facilitate patient discharges and ward moves across the hospital. The team were new to the role but were an active part of the daily bed meetings. These meetings were the arena for a joined-up approach to gaining flow throughout the hospital. They were attended by bed managers, ward managers and consultants from across the hospital. They were also attended by the clinical site team. We attended bed meetings on three occasions during our inspection visit and found the meetings did identify potential beds that may become available or be available that day. The meetings were held four times daily. The service had introduced a process to enable all staff to work together to use the information about potential or actual bed availability to gain flow through the hospital. They used the terms Gold / Silver to make a clear differentiation between patients who were ready for discharge and those who may be ready soon. However, at the meetings we observed, we found beds identified in the morning meetings did not become available by the afternoon meetings. This suggested the systems and teams to facilitate the availability of these beds were not effective or responsive enough to drive the need for flow through the hospital.

The trust had a standard operating procedure for pre-emptive boarding on wards. Pre-emptive boarding is essentially the use of a 'full capacity protocol' where wards care for additional patients, over and above their usual capacity, until beds become available elsewhere. The Royal College of Emergency Medicine recommend this approach should be used to balance the risk to patients when emergency departments are crowded and there is no available space to assess patients. Staff spoken with told us they did not actively do this. However, the trust informed us the acute wards did accept patients from the emergency department and ran with increased capacity when they had clear plans for beds to become available later in the day, accommodating additional patients on the wards within the day room. To date the trust had not utilised additional bed spaces within day rooms due to the risks associated with monitoring this from ward bases. In addition, the clinical site team did not seem to pre-empt additional surges of activity. For example, when GP referrals would start to attend at the emergency department (ED) there did not seem to be any additional support from the team to encourage 'pull' from the wards to support the pressure on the emergency department. The result seemed to be a highly pressured emergency department which appeared to be holding an increasing level of risk, with limited support from the rest of the hospital.

Staff planned patient's discharge carefully, particularly for those with complex mental health and social care needs. We observed staff on Cheetham Hill ward coordinating a joined-up approach to a patient's discharge planning. There were discussions recorded with the psychiatric liaison team, social workers, domiciliary care providers, occupational therapy (who had also considered completing a home assessment in order to facilitate a successful discharge), physiotherapy and the rapid discharge team. There was consideration of complex health needs, mental health needs due to fluctuating capacity and dementia. There was also significant evidence of a holistic approach to discharge planning that included the patient's ability to access the community, their home situation and their wider social and support networks.

Managers monitored the number of delayed discharges. Delays were discussed during the bed meetings but also as part of daily SAFER huddles. Leaders told us medical champions fed into the flow group meetings. which took place in order to ensure medical priorities and concerns were

being discussed. The clinical site team also included an experienced member of the intermediate care team, which leaders felt improved identification of areas where delays were occurring. The trust was working on developing an afternoon SAFER meeting to improve this process. They were working with commissioners to address delays, but staff said most delays were due to capacity of community domiciliary care providers in the area. The hospital had implemented some improvement plans developed by the Integrated Service Unit to support ward staff to take an organisation and system view of patient flow. Wards had implemented Red2Green, Gold and Silver early discharge identification, safer board rounds, a managing expectations policy and weekly review of long length of stay led by Matrons, to name a few. However, there was still work to do before these systems were fully embedded and not all staff we spoke with understood their purpose.

The service also had an ambulatory care unit to support the movement of patients from the emergency department into the hospital system for assessment or treatment. Ambulatory care units provide assessment and treatment to patients who present at emergency departments and need urgent review by a hospital specialist but may not require admission. The team within the ambulatory care unit were experienced, positive and proactive and provided support wherever they could to the emergency department. They worked together to support patients and made sure the environment was supportive of patients who may have to wait to be assessed or treated. There were clear signs throughout the unit and posters explaining what patients could expect whilst there. A self-service drinks station was easily accessible in the waiting area and there were signs advising that food could be made available if required. The patient waiting area had information leaflets for patients and patient feedback was clearly displayed for all to see. However, the ambulatory care team felt admissions to the unit were not always appropriate despite them raising concerns before patients were moved into the unit. They spoke of wanting to provide support and relieve the pressures on the emergency department, but felt the unit was often used inappropriately for escalation. Staff were concerned that there was little respect for them as a team. They felt pressured to triage from the emergency department in order to prevent and offset breaches to emergency department national standards. Staff gave examples of stroke patients being transferred to the ward who had not been through the appropriate stroke pathways. Staff also told us about the attempted admissions of patients who required piped oxygen. Although the cubicles in the department did have cylinder oxygen available, they did not have piped oxygen installed. This was concerning as the trust's admission criteria for ambulatory care detailed that patients must not require piped oxygen.

Managers worked to minimise the number of medical patients on non-medical wards. Medical patients who were outliers on other wards were discussed every day at bed meetings. The outlier patients we reviewed had not experienced repeat moves. Staff told us there were escalation areas used such as Warrington ward which were used as part of the trusts winter pressures plan as an escalation ward. At the time of our inspection, these were being used regularly due to increased numbers of patients in the hospital. The Medical Admission Avoidance Team had also been set up with microbiologist input who provided advice on antibiotic treatment within the community to reduce the need for patients to be admitted. There was no discharge lounge for patients who were waiting to be collected from the hospital by transport, friends or family members. This meant these patients had to wait on the wards which could have been impacting access to bed for patients entering the hospital. The trust had tried, on a number of occasions over the last five years, the use of a discharge lounge, but had found this had not worked with too few numbers of people who met the criteria for the discharge lounge to make it viable. A discharge lounge was considered regularly and formally as part of every winter plan.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. At a bed meeting we attended on 10 March 2020 the hospital had 12 medical outliers. We followed up two of these medical outlier patients. When we reviewed their records, we found patients classed at medical outliers had comprehensive records, were reviewed in a timely way by consultants and were placed appropriately for specialities their care was linked with.

Average length of stay

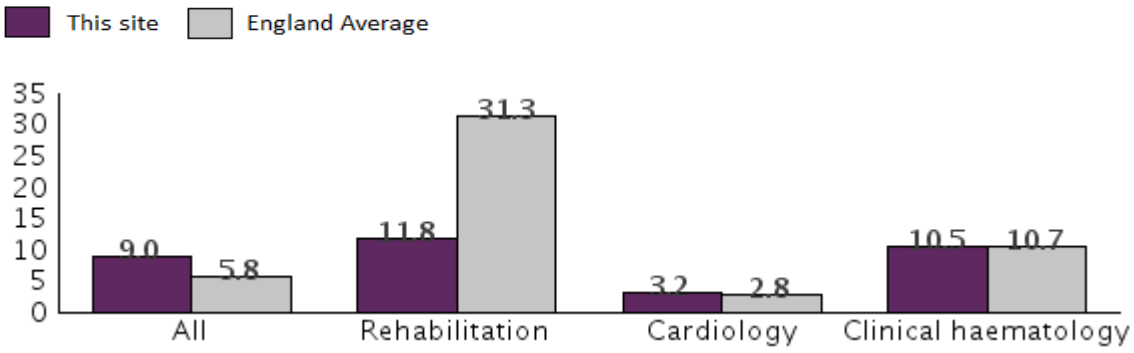
Managers and staff worked to make sure patients did not stay longer than they needed to, but this did not always happen. This was supported by the data the trust provided for medical non-elective patients. However, length of stay (LoS) was higher overall for elective patients. Leaders advised this was largely due to community care services having limited capacity to facilitate timely discharges.

From October 2018 to September 2019 the average length of stay for medical elective patients at Torbay Hospital was 9.0 days, which is higher than England average of 5.8 days. However, the trust position for elective medical LoS is influenced by the inclusion of rehabilitation as rehabilitation has a longer average LoS than other specialties. Transfers from the acute site to Newton Abbot Hospital for rehabilitation were counted as ward transfers not discharges. Even though the trust's LoS for rehabilitation is lower than the national average, other acute non-integrated care organisations would not include these as transfers between wards as patients would be more likely to be discharged to another rehabilitation provider. Therefore, the trust's medical average LoS is inflated compared to the benchmarked LoS.

The chart below shows the average length of stay for the top three specialties at Torbay Hospital:

- The average length of stay for elective patients in rehabilitation is lower than the England average.
- Average lengths of stay for elective patients in cardiology and clinical haematology are similar to the England averages.

Elective Average Length of Stay - Torbay Hospital



Note: Top three specialties for specific site based on count of activity.

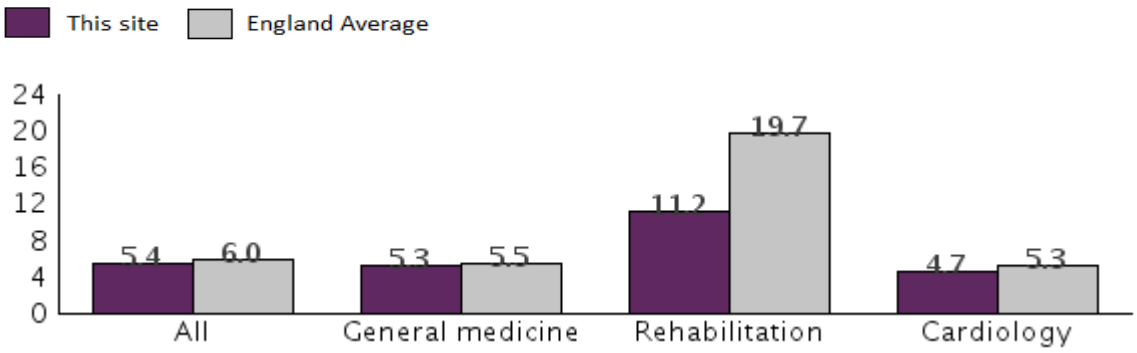
For medical non-elective patients, the average length of stay was 5.4 days, which is lower than England average of 6.0 days.

Average length of stay for non-elective specialties:

- The average length of stay for non-elective patients in general medicine is similar to the England average.
- Average lengths of stay for non-elective patients in rehabilitation and cardiology are lower than

the England averages.

Non-Elective Average Length of Stay - Torbay Hospital



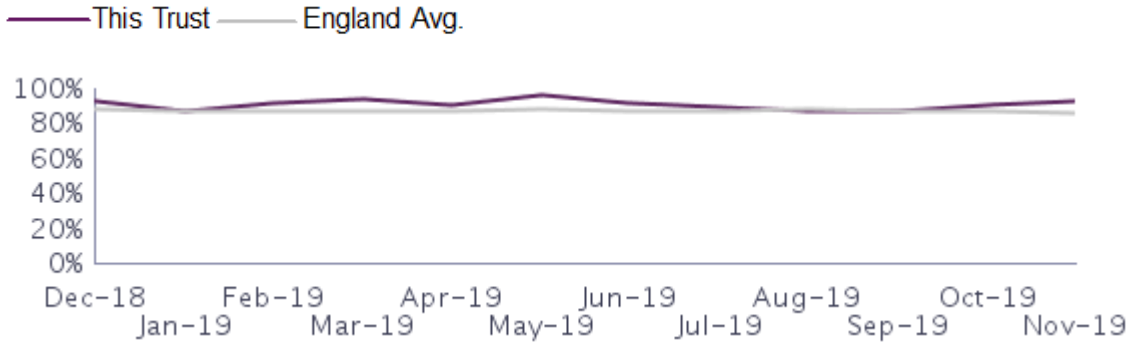
Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with national standards.

Referral to treatment (percentage within 18 weeks) - admitted performance

From December 2018 to November 2019 the trust's referral to treatment time (RTT) for admitted pathways for medicine was generally similar to or slightly higher than the England average.



(Source: NHS England)

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

Seven specialties were above the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Dermatology	100.0%	79.9%
General medicine	100.0%	96.2%
Neurology	100.0%	88.7%
Thoracic medicine	100.0%	93.5%
Rheumatology	99.3%	94.1%
Gastroenterology	92.4%	92.0%
Cardiology	82.5%	79.9%

No specialties were below the England average for admitted RTT (percentage within 18 weeks). This was a positive and improving picture for the service.

(Source: NHS England)

Patients moving wards per admission

Staff worked to limit patients moving between wards at night. However, there were instances where this had happened. The highest number of moves at night was from the acute medical unit, this is an admissions unit and therefore we would expect higher numbers. Managers said they made sure moves between wards were kept to a minimum. However, data for patients moving wards per admission was not submitted to CQC.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

Staff worked to limit patients moving between wards at night. However, there were instances where this had happened. The highest number of moves at night was from the acute medical unit, this is an admissions unit and therefore we would expect higher numbers.

From December 2018 to November 2019, there were 1,004 patients moving wards at night within medicine. A breakdown of moves by ward is below:

Ward name	**Number of moves at night**	**Percentage of total**
Acute medical unit	712	70.9%
Torbay coronary care beds	57	5.7%
Midgley	49	4.9%
Cheetham Hill	38	3.8%
Torbay chest pain unit	36	3.6%
Dunlop	32	3.2%
Simpson	32	3.2%
George Earle	24	2.4%
Warrington	17	1.7%
Turner	6	0.6%
Elizabeth	1	0.1%
Total	**1,004**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Most patients we spoke with said they felt supported and able to raise concerns or make complaints if they needed to. Some patients spoke about positive experiences coming out of complaints they had raised. Most patients were aware of the patient advice and liaison service (PALS) and knew about feedback

processes available on the ward and on the trust website.

The service clearly displayed information about how to raise a concern in patient areas. There were posters displayed on most wards and throughout the hospital directing people to the PALS service and providing contact numbers. There were also leaflets on most wards providing information to patients on how to raise a complaint. Staff we observed were proactive and supportive to patients who wished to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff told us about the complaints policy and felt confident to support patients to access the complaints process. Allied health professionals told us they were encouraged to be involved in the complaints process and contributed to responses if necessary. Learning was then shared amongst others during team meetings.

The service included patients in the investigation of their complaint. Managers told us they led the response to complaints. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The trust had a complaints policy they followed for all complaints received. All complaints received an acknowledgment of the complaint in writing, which was then followed up within six weeks once investigations had been completed. Managers told us if investigations were not going to be complete within the trust identified timeframe, the complainant would receive a further letter identifying this, keeping them informed of what action was being taken and letting them know a revised timeframe for when they could expect to hear from the manager again. Managers told us they were supported to send the letters by administration staff but any other direct contact with the complainant would be undertaken by managers.

Summary of complaints

From December 2018 to November 2019 the trust received 35 complaints in relation to medical care (12% of total complaints received by the trust). The trust took an average of 51.5 days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be answered within 30 days. A breakdown of complaints by type is shown below:

Type of complaint	**Number of complaints**	**Percentage of total**
Treatment	22	62.9%
Care	7	20.0%
Discharge	3	8.6%
Assessment	1	2.9%
Appointment	1	2.9%
Diagnosis	1	2.9%
Total	**35**	**100.0%**

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

Number of compliments made to the trust

From December 2018 to November 2019 there were 82 compliments about medicine at Torbay Hospital, 18% of the total compliments made about the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership team for each ISU was detailed as part of the ISU personnel delivery structure. The medical care leadership teams were organised within this structure. There were elements of medical care services within all five ISUs. The leadership for each ISU included an associate director, associate medical director, associate director of nursing. Each specialty or division within each ISU also had a Ward manager, nurse lead, specialty lead and service manager.

Leaders were proactive and gave consideration to the quality and sustainability challenges faced by the service and specific wards. Leaders told us trust board members were very approachable and accessible both formally and informally. Most staff were able to identify their leaders. Many staff were able to give explanations of the structure of integrated service units and told us there was a scheme of delegation if leaders were away from work or unwell. Leaders told us there was good visibility of the trust board, especially the trust chair.

Therapy staff told us they felt supported as there was an interim professional practice lead, who was a physiotherapist, and one therapist at executive level. However, therapy staff and leaders told us there had not been an occupational therapy manager for three years. This had been a concern for some occupational therapists as they worried their voice was not being heard. However, the trust informed us there had been an interim occupational therapist lead to provide leadership, which did not align with what staff were telling us during our inspection.

Vision and Strategy

There was no formalised, written vision or strategy specifically for medical specialisms.

The trust, as a whole, had a vision and strategy for what it wanted to achieve. The strategy included four key objectives which leaders within medical care were able to articulate. The trust's vision was "Our vision is a community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes. When we need care we have choice about how our needs are met, only having to tell our story once". It was focused on sustainability of services and aligned to local plans within the wider health economy. However, there was no formalised or written vision or strategy for ISUs or specialities within them.

Leaders and staff were all knowledgeable about the trust values. We observed these being discussed and highlighted during some ward meetings and during discussions between management staff on wards.

Leaders told us about shared decision-making processes with the clinical commissioning groups. An example was provided where a joint decision was made to offer hip and knee replacements to day patients and had been identified as a sustainable way to reduce the need for inpatient beds. They advised certain other treatments were also being completed as day patients such as anti-coagulants and intravenous medications as they had also identified these patients were often safe to return home after their treatment was complete.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff consistently spoke of a supportive service and supportive managers on wards. They described a pressured service but were confident their views were listened to. Staff felt their practice and views were respected and valued by the leadership teams. This was represented in the high levels of engagement with the staff survey, which had increased participation since the previous year. Staff were aware of the service's whistleblowing policy and leaders told us they had an open-door policy and encouraged all staff to be supportive to each other.

Staff felt able to challenge leaders and raise concerns if necessary. For example, therapy staff told us they were able to suggest new ways of working within a no blame culture. Staff felt the trust was forward thinking and 'dynamic'. Staff were kept informed of changes through emails, bulletins, safety briefings and newsletters. However, staff told us they found it difficult to find time to read these with their workload.

The trust had implemented a staff heroes award to celebrate and recognise the good work different teams were doing. There had been several teams and team members nominated for the awards across medical care recently. Staff felt positive about its introduction and were glad to be able to celebrate each other's successes. Leaders told us they were proud of the entire team, not just the staff on wards and gave an example of engineers who walked three miles in the snow to service machines. All staff told us they felt able to identify areas for improvement and to share ideas which leaders gave them the freedom to develop.

The trust had a freedom to speak up (FTSU) guardian. The medical care leadership team also said they had received good support from the FTSU guardian and were positive about the FTSU process. Leaders felt that staff were very aware of who the FTSU guardian was and how to access them. This was confirmed by staff who were positive about the position, could identify the guardian and new where how to get in contact with them if they needed to.

Governance

Leaders operated governance processes throughout the service and with partner organisations, but these were not always effective. Staff were not always clear about their roles and accountabilities.

The Torbay and South Devon NHS foundation Trust had revised its delivery model and delivery structure 11 months prior to this inspection. This was a move to become an integrated care organisation combining health and community services. It was created to encourage and support partnership working. The revised delivery model created five integrated service units (ISU). Torquay ISU and Paignton and Brixham ISU, which sat within the Torbay system. The South Devon system included the Moor to Sea ISU, Coastal ISU and Newton Abbot ISU. There was also a separate service delivery unit focused on trust wide operations for the whole system across Torbay and South Devon.

The implementation of the ISUs required a redesign of the governance structure. This included a re-structure of senior teams and review of service provision with greater outreach with primary care and community services. The trust was four years in to a ten year plan. The ISUs now carried the governance structure. Each ISU held their own governance meetings which were represented by each speciality or service within that ISU. Leaders told us that the expectation was for at least

one person to be present to represent each service or speciality. There were also monthly assurance and transformation meetings (ATM) where all ISUs came together to review service delivery. The ATM informed the integrated governance group which subsequently informed the board. Leaders told us the ATM was an opportunity to understand the pressures that were presenting to other areas. There was an overlap half way through the meeting where ISUs had the opportunity to discuss concerns or difficulties.

The separate services or specialities within each ISU also held monthly business meetings where any concerns were discussed. The medical division had continued with their weekly consultant meetings as the team had identified that they needed a channel to feedback information to each other. Implementation of best practice was discussed locally at governance meetings, with areas of concern discussed with trust management at monthly performance review meetings.

Medical Care services were present within all five integrated service units. Although the new structure had been in place for almost a year, there was no formal plan for a review of this structure. However, leaders told us changes had been made when issues were raised and felt the process and governance structure were under constant review. For example, cardiology pathways had been split between what some felt were too many integrated service units, so this was changed. Managers felt positive about the recent change to the integrated service units and felt it was the best governance system they had ever had.

Staff feedback suggested there may be a disconnect between the department and the board level. Matrons held weekly meetings with ward managers. Following this the ward managers were responsible for sharing messages with staff in newsletters, safety briefs and monthly ward meetings. However, we raised concerns during our inspection in relation to disinfectant tablets being kept in storage areas that were not locked in line with trust policy. Despite leaders sending out a trust wide bulletin to remind staff to lock these areas, we observed areas where action had not been taken in a timely manner by the local leadership teams. This was concerning as it suggested the required level of governance and oversight was not there. Particularly in relation to responsiveness, efficiency and effectiveness.

The new meetings did not always support good governance. For example, the acute medical consultants continued to arrange their own meetings as they felt they still needed to come together as a group which the new service units did not allow for easily. However, specialities held monthly business meetings, where there was opportunity to come together and explore any concerns before and alongside quality assurance and risk assurance meetings. The acute medical departments were now represented within five of the integrated service units.

Ward managers said they fed back concerns at quality improvement group and risk assurance group meetings. Action logs from these meetings were created as part of the minutes and outstanding risks or concerns were fed back at integrated service unit meetings. There were regular governance meetings. However, we reviewed the last three mortality and morbidity meeting minutes and found them to be lacking in detail and of limited quality.

Policies were not always reviewed as detailed in the trust governance process. Leaders told us all policies should be reviewed by the care and clinical policies group and each policy should be reviewed every three years. However, we reviewed 12 policies and found three were out of review date. These were the falls prevention policy (review was due 21 October 2018), pressure ulcer prevention policy (review was due 31 July 2018) and wound management policy (review was due 31 May 2018).

Staff were not always clear about their roles and accountabilities. They were not always aware of their legal responsibilities regarding consent, mental capacity and deprivation of liberty

safeguards. Although training was comprehensive and available, staff did not always apply the legal frameworks correctly. Leaders did not have clear oversight of how staff were applying the legislation in practice. This did not evidence good governance and management of these processes.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated risks but did not effectively take action to reduce their impact. However, they had plans to cope with unexpected events and staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were systems to identify learning from incidents, complaints and safeguarding alerts. The service had a departmental risk register which included a clear risk review process. Risks were categorised by type and then scored to identify potential consequences of the risk. They were also considered in relation to the likeliness of the risk occurring. The figures produced were then used to identify an overall risk score for that risk. The risk scores ranged from one to 25. Anything up to a score of nine was managed by the ward managers. Anything above this was managed by senior leadership teams.

We reviewed the medical services risk register and found some inconsistencies with the major concerns of staff and leaders and what was recorded on the risk register. Some staff told us there was nothing on their 'worry lists'. This was of concern as it did not seem in line with risks that were on the departmental risk register. Some staff were not clear what items were on the departmental risk register.

Leaders felt a key risk was around the nursing and medical workforce staffing levels which was present on the risk register. However, the trust was particularly affected by the ability to recruit due the rural area which was not specified on risk register entries regarding workforce. There were ongoing recruitment drives at local career fairs with a more proactive stance being taken the last year especially. Leaders hoped to have ongoing dialogues with students at local universities before they finished their courses and provided rotational roles in order to be attractive to potential new staff. There had also been successful overseas recruitment and support was being successfully provided for these members of staff from within the trust.

Managers also identified the limitation of the older estate as a risk. This was also discussed in relation to a risk on the departmental risk register regarding the flooring on Simpson ward. Although we observed the risk remained on the ward, the last entry on the risk register was documented as 16 July 2019. There was a review date documented as 29 November 2019 but there was no entry to show that this review had taken place. This had been escalated to the corporate risk register as part of a wider estates risk, but did not remain updated at a local level to be assured staff were made aware of actions being taken.

We found it unclear which sections of the risk register any action plans and their follow up notes were being recorded in. Where action plans were followed up and recorded, they did not consistently identify the actions that had been taken and what was still outstanding and requiring further review.

There was a major incident plan for the trust and the trust were working within their winter plan.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance. Data or notifications were consistently submitted to external organisations as required. However, staff did not always

have the time they needed to access audit results, so were not always able to use them to improve the service. The information systems were not all integrated and secure.

Performance data was collected through audit and easily accessible via performance dashboards and the intranet system. They said this was reviewed regularly and issues were addressed by re-auditing and through focussing on performance issues through safety crosses.

Not all services within the hospital worked and recorded information on the same system. This caused difficulties as patient information and notes were not always easily accessible to all. For example, the emergency department and the psychiatric liaison team used different systems to the rest of the hospital. There was a risk patient information could not be accessed in a timely way to ensure appropriate assessment and treatment.

During our inspection the hospital experienced significant disruption to their IT systems, including to the printers across the site. Staff said this was not a regular occurrence but did happen from time to time. We observed a significant impact on all of the hospital services and teams during our inspection as they were unable to print discharge summaries and prescriptions. As the emergency department used a different system to the rest of the hospital, patients being admitted did not always have handover information during the technological challenge. This was because the emergency department used a different electronic system to the rest of the hospital and patient information had to be printed and sent with patients when they were admitted to a ward. The clinical site team received several calls regarding the difficulties while we were there, and we saw the challenges and frustrations staff were voicing and experiencing. However, the trust leadership and technology teams worked together across the site to resolve the issues as quickly as possible to prevent there being ongoing disruption to the services. They communicated with wards to update what was being done and offered support or other ways of working where wards were having difficulties.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff were proud of the system they worked within and said they were encouraged to bring ideas to improve the trust's collaboration with community teams and partner organisations. Staff spoke favourably of the integrated service unit governance structure. They said this had improved their ability to engage with and understand the wider health and social care systems. They also told us this had encouraged a more holistic approach to people's care within the hospital but also when considering their discharge pathways.

The service engaged staff when considering restructure, planning and managing of the service. Staff were kept up to date through emails, newsletters and regular bulletins. They were asked for their views and we involved in any changes in process and appropriacy. Staff told us they were encouraged to discuss ideas and their thoughts on changes at team meetings. They felt that they were listened to and valued throughout all levels of the organisation. Executive directors also talked to staff about feedback they gave when consulted on change and plans. There were examples of action being taken in response to staff feedback such as the introduction of handheld electrical devices that enabled staff to access electronic records proactively on wards.

The service had been working closely with local schools to encourage youth volunteers to get involved with opportunities within the hospital. These initiatives were focused on offering new

experiences to local youth community, spreading healthy living messages and engaging a potential future workforce.

The trust held large public events in their 'TREK' learning buildings to provide additional advice, education and support to the public, patients and their families. The next event was scheduled for May 2020. Managers told us dementia was the focus of the event, which they were being supported to run by voluntary organisations, local universities and the Alzheimer's society.

The service had begun working towards a joined-up approach with neighbouring NHS trusts. Leaders advised this was early days, but they were working towards some joint appointments and collaborative working. The service had also been working with providers in the voluntary sector to provide support systems for the wider population and young people who have not thrived in mainstream educational settings. They had also been working with community teams to promote health and wellbeing centres.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff were passionate about their roles and had good ideas on how to improve the service. All staff we spoke with told us they felt able to identify areas for improvement and to share ideas, which leaders gave them the freedom to develop. For example, staff spoke of support they had been given to make contributions to Schwartz rounds and to give their ideas for the topics covered (Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients). Staff also told us about the support provided to enable a 'wellbeing' hour on a care of the elderly ward. The idea had grown to provide upskill training to allied health professionals on the ward so they could provide nursing cover whilst they had a protected training hour once each month.

The trust was involved in and encouraged research. Leaders told us of links with oncology, neurology, cardiology and rheumatology research trials which they were involved in alongside universities and other surrounding hospital trusts. Enthusiastic oncology consultants supported involvement in research trials. There was a band 7 research lead radiographer who worked three days on the unit and two days on research which meant there were good links.

There was use of telemedicine to reduce the need for patient contact and meet demand in new ways. For example, leaders told us about a new monitoring system which was being considered for use in the day rooms on wards. It was a system similar to a falls detector that measured changes in joint angles and could alert staff if a patient may have fallen. Allied health professionals were also involved in a pilot to support discharge including the use of technology to reduce the need for face-to-face welfare checks. They felt this was innovative. Staff told us of an example where a person was not able to return home as their phone line was not working. The trust was able to provide a quick installation of the new technology which assisted the person to be discharged. This package included sensors which could be used to monitor a person discretely at home. For example, when a kettle had been boiled or a door had been opened. Relatives could have an application on their phone where they would be able to monitor these sensors to support their loved one.

Surgery

Facts and data about this service

Torbay Hospital has 10 main operating theatres, seven of which cover general surgery and the remaining three cover more complex procedures. Each theatre has a surgical speciality allocated to it, as well as a core of specialist theatre practitioners (nurse or operating department practitioner), to carry out the surgical procedures.

There are five wards with a total of 120 inpatient beds at this site.

Ward name	Specialty	Number of beds
Ainslie	Trauma and orthopaedics	26
Allerton	Colorectal surgery and gastroenterology	29
Cromie	Upper gastroenterology, urology and colorectal beds	26
Ella Rowcroft	Elective orthopaedic surgery	14
Forrest	Ear nose and throat, maxillofacial surgery, ophthalmology and specialist surgery.	25

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

The trust had 20,465 surgical admissions from July 2018 to June 2019. Emergency admissions accounted for 7,975 (39%), 10,365 (51%) were day case, and the remaining 2,125 (10%) were elective.

(Source: Hospital Episode Statistics)

The trust provided the following information about its surgical services.

Elective and emergency surgery are led and managed within the coastal integrated service unit (Coastal ISU). Elective and non-elective surgery supported at Torbay Hospital includes:

- breast surgery
- colorectal surgery
- ear nose and throat
- gastroenterology
- maxillofacial surgery
- orthodontics
- ophthalmology
- trauma and orthopaedics
- upper gastrointestinal surgery
- urology
- vascular surgery

Screening is provided by breast, endoscopy and vascular teams.

Day surgery at Torbay Hospital includes emergency procedures and the site has a dedicated unit

to support this. There are enhanced recovery pathways for colorectal and orthopaedic surgery. The endoscopy unit is a national training unit and has a bowel cancer screening and bowel scope.

There are five inpatient wards caring for patients undergoing surgery, two of which specialise in orthopaedic surgery. Ella Rowcroft ward is for patients undergoing elective surgery (and contains two high dependency beds). Ainslie ward covers orthopaedic trauma.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

Is the service safe?

Mandatory Training

Staff did not consistently keep their training updated. Compliance with key training modules for nursing and medical staff was not always meeting trust targets.

Mandatory training completion rates

Nursing staff were close to achieving the trust's target for their mandatory training modules, but medical staff were falling behind. Staff told us this was due to the heavy workload causing training to be cancelled. Staff told us they had adjusted training scheduling to avoid winter periods of high pressure and had plans to become compliant when possible.

The trust set a target of 85% for staff to be updating mandatory training for all courses except for information governance, which had a trust target of 95%. There was no evidence provided of how the department planned to improve this trajectory.

The compliance for mandatory training modules from December 2018 to November 2019 was 87% for nursing staff in surgery at Torbay Hospital. Of the training modules provided, four achieved compliance and four failed to reach the trust target. No training modules scored below 75%.

Not enough medical staff were up-to-date with their mandatory training.

The compliance for mandatory training modules from December 2018 to November 2019 was 84% at Torbay Hospital for medical staff in surgery, against the trust's target of 85%. Of the training modules provided, four achieved compliance and four failed to reach the trust target.

One module failed to score above 75% as outlined below.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance <75 %	Trust Target Met	Compliance change when compared to previous year
Infection prevention (Level 2)	215	149	69%	✗	↓

The mandatory training when delivered was comprehensive and met the needs of patients and staff. There was an annual mandatory study day which provided staff with refresher training in a range of mandatory subjects, including safeguarding adults and children, fire safety and infection control. Staff told us the quality of the training was good and suitable for their needs.

In addition to mandatory basic life support training which all staff completed, the trust had a training needs analysis identifying required level of resuscitation training for different staff roles. For anaesthetic registrars it was mandatory for them to complete advanced life support resuscitation training for adults and paediatric. The trust were unable to provide compliance figures with this training. It was recommended for registered staff in theatres to complete adult and paediatric immediate life support, the trust did not provide compliance against this. For theatre recovery staff it was mandatory for adult immediate life support (15 out of 24 compliant) and recommended paediatric immediate life support (14 out of 24 compliant). For theatre shift co-ordinators it was mandatory to complete advanced life support for adults where six staff members

had completed this training and paediatrics where compliance was not reported.

Trust wide support was also available in the event of a cardiac arrest. The clinical manager team bleep holders completed adult advanced life support and were 100% compliant. Resuscitation officers were also required to complete this training and were 87.5% compliant. Critical care outreach leads were 100% compliant with adult advanced life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Senior managers told us ward and theatre managers held a register of staff which showed who had completed the training, were booked to complete and which staff had not completed training modules. Ward and theatre managers told us that if staff had mandatory training courses pending, they would remind them regularly in person or electronically of the need to complete this until it was done.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it, and staff were mostly up to date with their safeguarding training.

Safeguarding training completion rates

The trust set the following targets for the safeguarding courses for which medical, nursing and qualified allied health professional staff were eligible.

- 90% for safeguarding levels 1
- 80% for safeguarding level 2 and 3

The tables below include PREVENT training as a safeguarding course, which had a trust target of 85%. PREVENT works to stop individuals from getting involved or supporting terrorism or extremist activity.

Most nursing and medical staff had access to training specific for their role on how to recognise and report abuse.

The compliance for safeguarding training modules from December 2018 to November 2019 was 92% for nursing staff in surgery at Torbay Hospital. Of the training modules provided three achieved compliance and two failed to reach the trust target.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	234	231	99%	✓	→
Basic Prevent Awareness	234	227	97%	✓	→
Safeguarding Adults (Level 2)	234	207	88%	✓	→
Safeguarding Children (Level 2)	234	194	83%	✓	→
Safeguarding Adults (Level 3)	9	6	67%	✗	↑

The compliance for safeguarding training modules from December 2018 to November 2019 was 88% at Torbay Hospital for medical staff in surgery. Of the training modules provided three achieved compliance and two failed to meet the target.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	215	200	93%	✓	→
Basic Prevent Awareness	215	195	91%	✓	→
Safeguarding Adults (Level 2)	215	186	87%	✓	→
Safeguarding Children (Level 2)	207	177	86%	✓	↑
Safeguarding Children (Level 3)	8	2	25%	✗	↓

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding adults level 3 is recommended in intercollegiate guidance document 'Adult safeguarding: Roles and Competencies for Health Care Staff'. The document and guidance was initially published by the Royal College of nursing in 2018. It states that registered staff who are engaging in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns, require safeguarding adults level 3 training. Data provided by the trust showed a small number of staff were eligible for training at level 3.

There was a safeguarding lead for the trust, and most staff were able to identify who they were.

Staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff we spoke with were confident to raise concerns to their managers about disrespectful, discriminatory or abusive behaviour or attitudes.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with on wards could tell us what they would do if they had any concerns about a patient's welfare. Staff described how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

Staff mostly controlled infection risk well, but there were areas in need of maintenance. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection.

We saw records of weekly and monthly cleaning schedules for wards and theatres, which were consistently completed in all areas we visited. Cleaning staff were allocated wards and theatres each day and they followed a set cleaning programme. Medical equipment and devices were cleaned by nursing staff. Cleaning staff we spoke with told us they felt included as part of the wider ward teams and were updated about any infection control risks.

We found some of the premises in need of maintenance. For example, a number of areas were cluttered due to a lack of storage space. This prevented effective cleaning. Some walls and door frames had chipped paint and flaking plaster which gave rise to risk of the spread of infection. There was also a lack of trolley and cupboard space in the new anaesthetic rooms. A steel instrument trolley was used for a range of sterile products, such as syringes, patient sheets, as well as staff bags and rucksacks. This prevented effective cleaning and stock rotation.

Staff in the operating theatres said they were satisfied with the standard of cleaning. The hospital

undertook monthly audits of the standards of cleanliness on wards and in theatres. We saw cleaning logs in theatres and anaesthetic rooms were signed daily.

Staff worked effectively to prevent, identify and treat surgical site infections. The trauma and orthopaedics teams engaged with Public Health England. The latest report, based upon data for patients admitted during September to November 2019, showed no surgical site infections. The internal audit team had been analysing surgical site infection rates following the publication of the report and found that infection rates remained below the national average.

The wards we visited looked visibly clean. Infection prevention and control audits were completed regularly in wards. Environmental/cleaning audits were carried out and demonstrated all areas were cleaned regularly. Reports showed an improvement with hand hygiene audit performance on surgical wards. Examples of audits in wards included; hand hygiene, checking of corridors and waiting areas, and bed cleaning. Mostly, the wards had suitable furnishings which were clean and well-maintained. However, we found the day room on Forrest ward had torn seats which presented an infection control risk.

There were side rooms on wards where infectious patients could be isolated, and staff were clear in describing the infection control procedures used.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were hand wash basins and hand gel dispensers at the entrance of each wards and theatres. We saw staff washing their hands and observing standard infection control precautions. Staff wore protective clothing when required and observed the 'bare below the elbow' policy to optimise hand washing techniques. We saw staff cleaned equipment after patient contact, and we saw labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities and premises meant there were some risks to patients. We found some wards were not equipped for their designed use. There were some risks to the spread of fire from poor health and safety practices in relation to fire doors.

The design of some of the environment did not follow national guidance. Senior managers told us that theatres and ward estates were on the risk register. We noted the following issues relating to estates were on the risk register: lack of recovery space for procedure rooms; temperature fluctuations on wards due to poorly fitting windows; and intermittent flooding of sewage from sinks and toilets on Forrest ward. This was due to an inadequate infrastructure of pipe work in the building. Staff had been reminded not to put inappropriate items into the macerator and toilets to avoid blockages.

On Forrest ward, a patient pointed out a window which could not be fully closed. They told us that during the night staff had attempted to block the gap with a towel. The patient told us the noise of the wind whistling through the gaps in the windows disturbed their sleep. We also found on Ainslie ward a call bell fitting was hanging from the ceiling with a hole behind it. It appeared that a surgical glove had been used to fill the hole.

We saw on Ainslie ward that beds were close together, which could pose a risk to cross infection. We discussed this with the ward sister who told us this was an issue, and if staff had to use a hoist, it was very tight. They told us there was no suitable-size space for bariatric patients, and if they were caring for a bariatric patient, they could not use the bed space next to them. However, there were dedicated side-rooms on Cromie ward for bariatric patients, with purpose built overhead tracking facilities. If a patient on Ainslie ward required this level of support, they would

be transferred to Cromie ward.

Surgical equipment including resuscitation equipment was available and checked in line with professional guidance. Resuscitation trolleys were placed within wards and units, so they were accessible and visible. Trolleys were locked with a breakable seal. This demonstrated the trolley had not been opened or equipment used or tampered with since it was last used or checked. Daily checks were required for resuscitation trolleys, and equipment including defibrillators on each ward, theatres and other surgical areas. We found that daily checks of resuscitation trolleys were consistently complete on all wards. These checks were to ensure the trolleys contained all relevant emergency equipment in line with national guidance (Resuscitation Council (UK)).

There were some risks to the spread of fire from poor health and safety practices in relation to fire doors. We noted that some fire doors were propped open on all wards we attended and in theatres.

The trust had a medical devices replacement programme. Medical devices were managed by the medical devices support services and recorded on a management system. Devices were supported and maintained from in-house specialist teams and other external providers. Service level agreements were arranged for the in-house specialist teams. External support providers had contracts with levels of cover. These ranged in length from three months to five years depending on the servicing requirements.

The arrangement for managing, storing and disposing of waste and clinical specimens mostly kept people safe. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste. However, we saw some sharps bins (rigid bins used for the disposal of needles, syringes and other sharp objects) were not being used following the manufacturers guidance and were not shut when not being used to reduce risk of accidents or were overfilled. We raised this with staff during the inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them effectively. The service had recently implemented the latest version of the National Early Warning Score (NEWS2). This was a system to alert staff to a patient deteriorating when certain clinical ‘triggers’ were reached. At the time of the inspection not all staff were using NEWS2, but those who were using the new tool had received training and could tell us how it was used. Other staff were still using the previous system which remained effective and were awaiting training for the new system.

Instructions for staff on what to do if they suspected or knew a patient to be suffering from sepsis were set out in observational charts. Senior staff were confident staff were aware of how to escalate patients suspected or known to have sepsis.

The sepsis audit showed an improved response with a faster time to administer antibiotics. The trust had monthly ‘saving lives’ antimicrobial stewardship audits for wards. Results of audits with action plans were shared with the Coastal ISU clinical director, matrons, and ward managers. From July to September 2019, audit scores were above (better than) the trust’s target of 85%. These audits were set against the trust’s antimicrobial guidelines, available to all prescribers on a free app.

The trust also undertook audits of antimicrobial resistance urinary tract infections (UTI) and antibiotic prophylaxis for elective colorectal surgery. This was to deliver safer patient care,

increase effective antibiotic use, which was expected to improve both patient mortality and length of stay. The latest audit showed 100% compliance against targets, and we saw that antimicrobial stewardship was well embedded.

The trust took part in the ‘saving lives initiative’, which was designed to reduce hospital acquired infections. Costal ISU undertook monthly audits in wards and the theatres environments. We saw the results of these audits, and where wards fell below the expected standards, we saw that team discussions took place to re-educate staff and highlight good practice. There had been a lack of consistency in the results in theatres, with difficulty in uploading the handwashing data. The infection control team had been informed. We saw an action plan had been completed in regard to this.

Staff completed risk assessments for each patient on admission. Operating lists were arranged, where possible, to reflect the assessed complexity and risk of the patients and procedures being undertaken. Safety briefings took place in theatres where any staffing issues, the order of operating lists and the individual risks of each patient were discussed and confirmed.

The World Health Organisation's (WHO) surgical safety checklist was developed with the aim of reducing errors and adverse events and increasing teamwork and communication in surgery. In 2010, the National Patient Safety Agency (NPSA) introduced the ‘five steps to safer surgery’. This was based on the WHO checklist and involved briefing, sign-in, timeout, sign-out and debriefing, and advocated by the NPSA for all patients in England and Wales undergoing surgical procedures.

On this inspection, we observed the surgical safety checklists were mostly performed as required. Staff were attentive during the surgical safety checklist process. We observed a sign in, time out and sign out with patient participation during a local anaesthetic procedure. This was in line with the five steps to safer surgery. Staff audited compliance against the five steps every month. In 2019, the day surgery theatre achieved compliance between 98% and 100% every month. The inpatient theatres achieved the same standards with the exception of May 2019, where compliance dropped to 94%. Further investigation by the trust found this related to sign out documentation not being signed, but this did not relate to any particular individual or theatre.

We attended a team brief in theatres. In accordance with ‘national safety standards for invasive procedures’ (NatSIPPs) recommendations, all the team participated and were given the opportunity to speak up. The team debrief checklist recorded any actions following the procedure undertaken. The team also recorded staff satisfaction of each team brief. The results of compliance with the surgical safety checklist was displayed on the quality board in theatres.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff had access to a psychiatrist liaison if needed to support a patient. The psychiatric liaison service aimed aim to respond within 24 hours and ward staff told us that they usually responded in good time.

There were effective handovers and shift changes to ensure staff could manage risks to patients. Staff shared key information to keep patients safe when handing over their care to others. We attended safety briefings and safety huddles on wards and in theatres. Shift changes and handovers included all necessary key information to keep patients safe. Ward handovers in the morning and evening were comprehensive, and patient information was shared.

Nurse staffing

The service mostly had enough nursing and support staff with the right qualifications, skills, training and experience to provide the right care and treatment. Managers reviewed and sought to adjust staffing levels and skill mix, and gave bank and agency staff a full induction. However, there were periods of understaffing or a skill mix of nursing staff not in line with national guidance.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, senior managers explained recruitment had become an increasing challenge. Daily nurse staffing within the trust was monitored and reviewed at each control meeting in order to get the right staff in the right place at the right time. This was confirmed through senior oversight by a matron associate director of nursing against a standard operating procedure for safe staffing.

Staff were moved in line with patient need and dependency measured and ratio of agency to substantive staff. Matrons did a daily ward round to check staff levels, and redeployed nursing staff to other areas where possible when staffing levels were lower than required. Nursing staff we spoke with told us they understood that this was done to keep patients safe. Staffing issues were discussed at weekly divisional matron meetings. Any additional requests for agency were escalated for review and assessment by an executive leader.

The table below shows a summary of the nursing staffing metrics in surgery at Torbay Hospital compared to the trust's targets, where applicable:

	Surgery annual staffing metrics November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	767	5%	15%	4.6%			
Qualified nurses	222	5%	9%	4.9%	7,510 (5%)	5,349 (3%)	2,087 (1%)

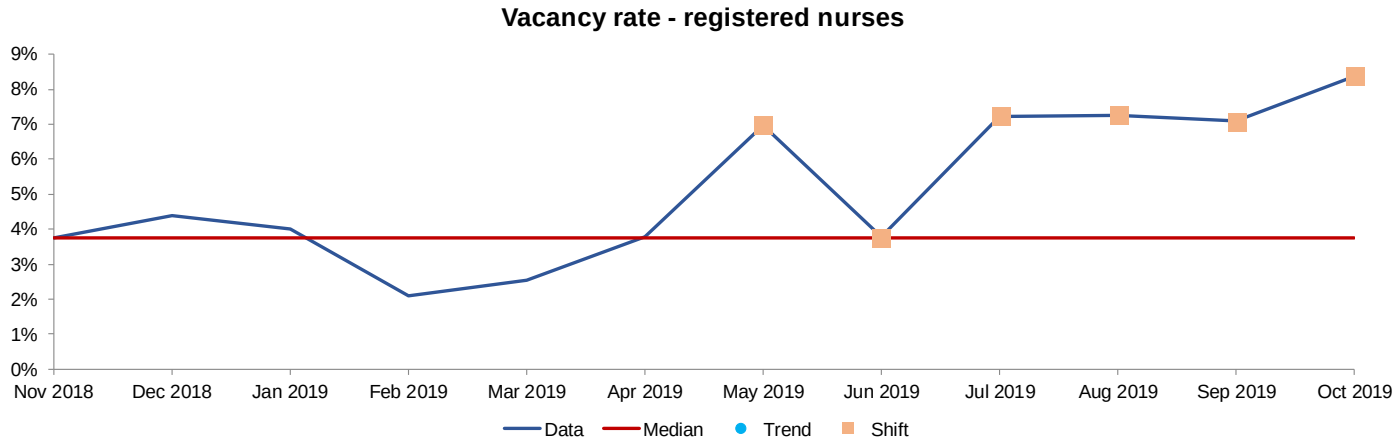
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.

During the inspection we met a number of ward staff who had joined the trusts as health care assistants, or cleaners, and were now registered nurses.

Vacancy rates

The service had increasing vacancy rates.



Monthly vacancy rates over the last 12 months for registered nurses show an upward shift from May 2019 to October 2019. Staff and managers told us there were challenges recruiting in the area due to its rural location. Senior managers told us registered nurses reaching or coming up to retirement was an increasing problem and recruiting staff into vacant posts was problematic. There were also larger hospitals in the area able to offer more varied roles.

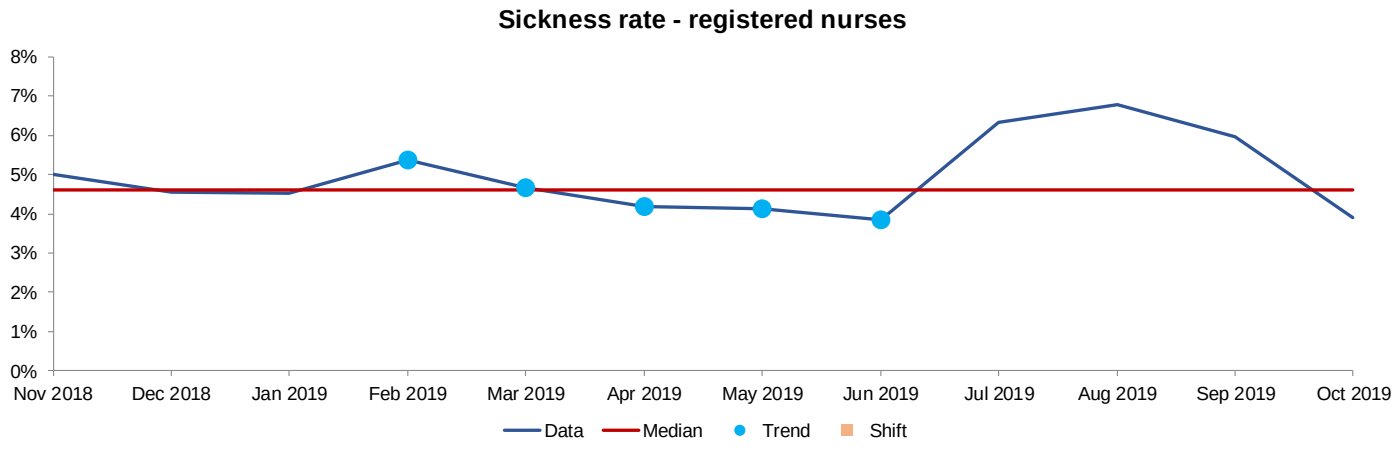
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The service had low and/or reducing turnover rates. Registered nurses and health care assistants we spoke with told us that they had received fantastic support by their managers.

Sickness rates

The service had low and/or reducing sickness rates.

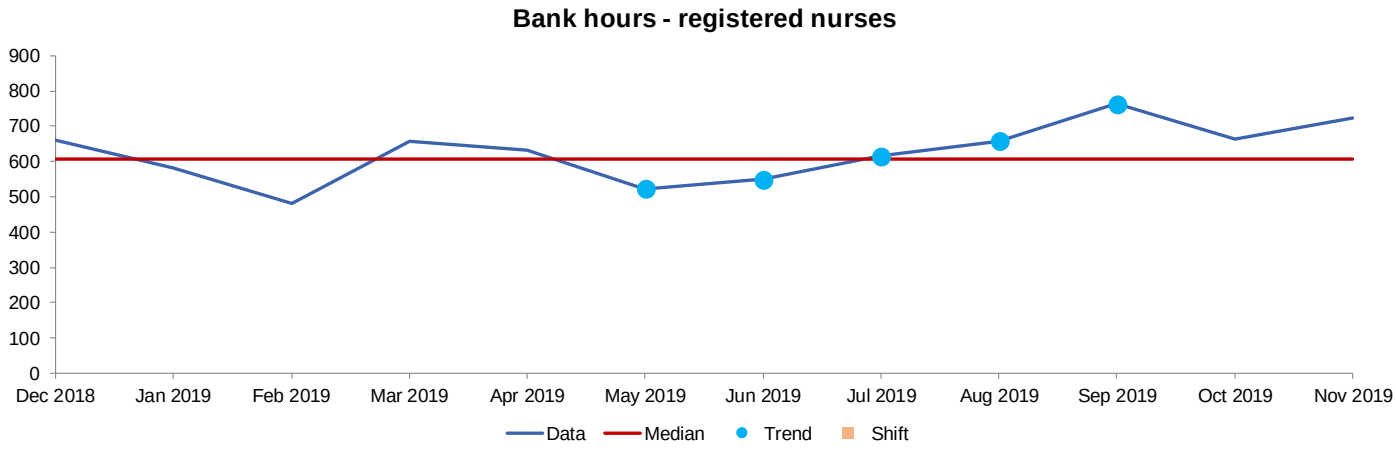


Monthly sickness rates over the last 12 months for registered nurses show a downward trend from February 2019 to June 2019. However, it then increased in a peak over the summer of 2019 before dropping back more into the trend pattern by October 2019. Short term sickness for Coastal ISU had been identified as an issue and reported to the board through the safe staffing and nursing work programme update. Senior staff were in the process of designing a recruitment and retention strategy and workforce redesign.

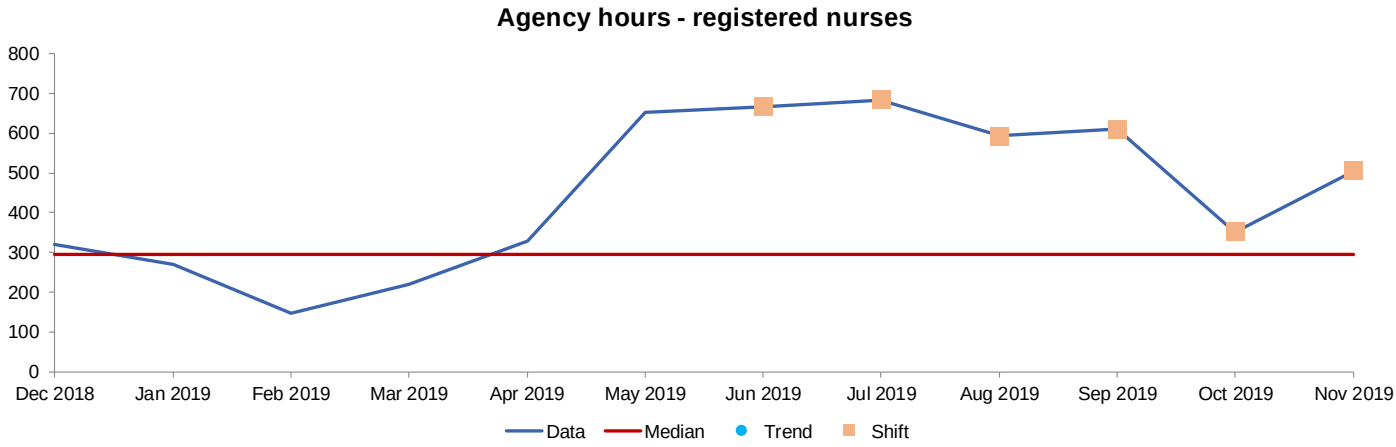
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The service had increasing use of bank and agency nurses.



Monthly bank use over the last 12 months for registered nurses show an upward trend from May 2019 to September 2019.



Monthly agency use over the last 12 months for registered nurses show a downward shift from June 2019 to November 2019.

(Source: Routine Provider Information Request (RPIR) – Bank and agency tab)

Managers told us they made sure all bank and agency staff had a full induction and understood the service in accordance with trust policy.

Medical staffing

Although there were vacancies, the service ensured it had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service ensured it had enough medical staff to keep patients safe. The service always had a consultant on call during evenings and weekends. However, senior managers spoke about vacancies in consultant level medical staff, and the difficulties faced in recruiting to these roles. There were vacancies in specialities including anaesthesia, and upper and lower gastroenterology.

Senior managers explained there were multiple reasons for challenges in recruiting to consultant-

level vacancies. This included the trust's location between larger hospitals in the area with which they were traditionally competing for potential recruits. They told us that while current consultant staffing levels assured patient safety, they were aware of the need to invest in the consultant workforce to ensure a sustainable future. We were advised that the consultant anaesthetist posts were on hold until a theatre productive project had been completed. The integrated service unit needed to demonstrate they were maximising theatre efficiency to the board. We were also told by senior managers that at the point of care, they were happy patients were safe. However, the vacant posts meant some patients had to wait longer to be seen, and this was a concern.

Torbay Hospital

The table below shows a summary of the medical staffing metrics in surgery at Torbay Hospital compared to the trust's targets, where applicable:

	Surgery annual staffing metrics November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	767	5%	15%	4.6%			
Medical staff	172	0%	32%	1.4%	4,716 (<1%)	6,817 (1%)	911 (<1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within surgery at Torbay Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use or agency use.

Vacancy rates

The service had low and/or reducing vacancy rates for medical staff.

Turnover rates

The service had low and/or reducing turnover rates for medical staff.

Sickness rates

The service had low and/or reducing sickness rates for medical staff.

Bank and locum staff usage

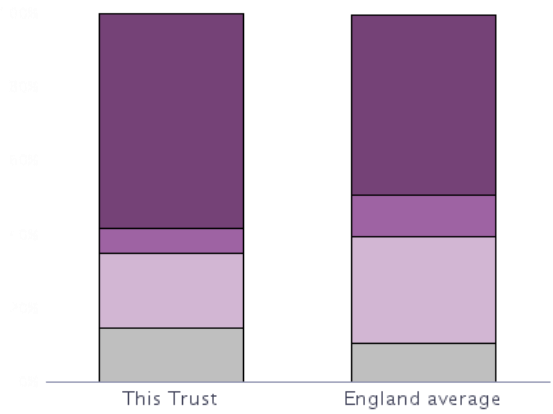
The service had low and/or reducing rates of bank and locum staff.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In October 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was also higher.

Staffing skill mix for the whole time equivalent staff working at Torbay and South Devon NHS Foundation Trust



	This Trust	England average
Consultant	58%	49%
Middle career^	7%	11%
Registrar Group~	20%	29%
Junior*	15%	11%

^ 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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Most records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Patient records we reviewed were legible, complete, signed and dated. All records included an audit trail of decisions made and treatment. They included diagnoses and management plans. Seven-day personalised care planning was recorded in the records we reviewed, including falls, mobility, nutrition, and pain management.

We reviewed eight sets of medical records. Staff used a mixture of paper patient notes and an electronic patient recording system. Hand-held devices were used by nursing staff to update patient's risk assessments and care plans.

Staff also audited their own nursing records. In March 2020, the trust had introduced a new process of auditing five sets of records, the new process was more thorough and performed every day and in addition to monthly safety thermometer audits. It provided on the spot feedback to staff.

There were systems such as the 'forget-me-not' flower next to a patient's name on the board that quickly identified when a patient was living with a diagnosis of dementia. This was to ensure the care of those with the condition was planned and managed safely.

All information about patients' mental health and wellbeing were stored in paper. We reviewed four care records when assessing mental health provision in the surgery service. We found it was unclear from the care record whether patients had the capacity to consent to be in hospital or if a Deprivation of Liberty Safeguards (DoLS) authorisation was required. In one case the patient's

care record indicated a DoLS authorisation had been applied for, but there was no link to the submitted paperwork, so we were unable to review the referral. Although we found a document for recording decisions taken in the best interest of a patient who was not able to provide valid informed consent.

Records were stored securely. We found lockable cupboards were used on the wards to store patients' medical records confidentially. Observation records were kept by patient beds.

We observed computer screens being locked when not in use, and access was password-protected to prevent unauthorised access.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The trust's patient drug chart was well designed to ensure the safe administration of medicines. The medicine administration chart had different colour-tagged pages to indicate the categories of medicines prescribed.

Pharmacy staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. The clinical pharmacist attended the wards regularly. Time sensitive medicines, such as those for Parkinson's patients and medicines requiring specific monitoring were put against the patient's information in the nurses' handheld device. However, as there was no alarm or alert able to be set against the patient as a reminder that medicines were due, some wards highlighted these specific requirements in the hand-over spreadsheet. This minimised the risk of medicines being given to patients late.

Staff stored and managed all medicines and prescribing documents in line with the trust's policy. The medicines and medicine trolleys were stored in locked utility rooms with below 25-degree room temperature. Medicines fridge temperatures were logged daily. We checked log sheets and observed minimum and maximum temperatures were within expected ranges.

Stocks in medicines cupboards were regularly checked by pharmacy technicians and expired or unused stocks were removed and returned to pharmacy. During the inspection we checked controlled drug cupboard stocks. The sample checked of products balance was correct and were in date. However, we found an oxycodone liquid and morphine oral solution with no 'opened on' date sticker on the bottle. This was a trust-wide issue that was shared with the chief pharmacist and clinical pharmacy lead.

On Forrest ward we found a morphine sulphate suspension which had expired in February 2020. This was removed from the controlled drug cupboard immediately when we brought this to the attention of staff.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff showed us reference books such as the BNF (British National Formulary), and the intravenous antibiotics reference folder in the treatment room. We also saw information on the trust's intranet which was accessible for all clinicians and the online antimicrobial app which was used to provide prescribing guidance.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and they told us they felt fully supported.

All staff knew what incidents to report and how to report them. Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with understood their responsibilities to raise concerns, record safety incidents, and near misses and were encouraged to report them. They also told us they would have no hesitation in reporting incidents and were clear on how they would report them. Most staff told us they received feedback on incidents they had reported. Safety briefs were used to disseminate wider learning from the investigation of incidents. We attended one safety briefing after the morning handover and observed incidents and learning were discussed.

Lessons were learned and communicated widely to support improvement in other areas where relevant, as well as services that were directly affected. Opportunities to learn from external safety events and patient safety alerts were also identified. Improvements to safety were made and the resulting changes were monitored. Senior managers we spoke with told us action plans following incidents were followed through to ensure learning was embedded. The trust provided us with a list of reported incidents relating to surgery. We saw that actions were taken in respect to all incidents identified as causing moderate harm. This included patients who had developed pressure ulcers, and actions taken included providing pressure relieving equipment.

Never Events

The surgery service had no never events in the 12-month period we have reported.

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 2018 to November 2019, there were no reported never events for surgery at the Torbay site.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust, which including learning about never events that happened elsewhere. Each ward had a folder containing shared learning around divisional governance. This complemented learning shared through emails, and divisional and speciality level governance reports.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2018 to November 2019. A breakdown of incidents by incident type are below.

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	3	33.3%
Pressure ulcer meeting SI criteria	3	33.3%
Diagnostic incident including delay meeting SI criteria	1	11.1%
Surgical/invasive procedure incident meeting SI criteria	1	11.1%
HCAI/Infection control incident meeting SI criteria	1	11.1%
Total	**9**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

We saw investigation reports and action plans for recent serious incidents and there were plans to review these to gain assurance actions had been completed.

Staff understood the 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. Staff we asked were able to explain this duty and their responsibilities were outlined in policies. The trust's incident reporting system also prompted staff about the duty of candour.

All incidents were reviewed on a daily basis for relevance and significance by the patient safety manager, incident database manager and by the integrated service delivery unit coordinators. All incidents recorded moderate or above were reviewed and investigated. If they met the criteria for causing moderate harm or above, they were reviewed at the weekly incident huddle. This included the medical director and deputy director of nursing with the process being led by the patient safety and experience lead. This group also reviewed and decided upon actions including being put forward for local review or the serious adverse events group review. Any incidents which invoked the duty of candour required the relevant manager, matron, doctor or specific person to contact the patient and/or family and follow up with a letter.

Staff met to discuss the feedback from incidents and look at improvements to patient care. Feedback was also provided more informally by senior staff. Learning was shared across specialities and service lines through information sharing provided by the trust's governance team.

Managers investigated incidents thoroughly and there was evidence that changes had been made as a result of feedback. There was an ongoing programme of human factors training that was provided to theatre staff in response to incidents and never events. Human factors are those things that affect an individual's or team's performance. Human factors training seeks to help individuals or teams understand the things that support or hinder the way people work, thereby improving patient safety. This training had now been extended to all other trust staff. The course promoted effective, professional behaviour, and to recognise personal fallibilities, to watch out for yourself and for others. There was a non-technical team skills course, and there were 12 or more courses run a year to support team working and skills. For example, staff had reported that the safety checklist in theatres had been imposed without good teamwork. The course allowed staff to discuss the issues they had and to contribute to a more successful implementation.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer was used to record the prevalence of patient harms (such as pressure ulcers, falls and urinary tract infections) and to provide immediate information and analysis for

frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination. Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of the suggested data collection date.

Safety thermometer data was displayed on wards for staff and patients to see. There were noticeboards near the entrances of the wards displaying information about patient avoidable harms. This included hospital acquired infections, the number of falls and pressure ulcers developed in the care of the ward. The noticeboards also included information on ward cleanliness, compliance with nutrition screening and call bell response times.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, some pre-assessments for patients waiting for surgery were out-of-date by the time the surgery was undertaken.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust had an in-house database to manage National Institute for Health and Care Excellence (NICE) guidelines holding information for all NICE guidance. At the end of each month, new or updated NICE guidance was downloaded, registered on the database, and distributed to relevant departments. New and updated guidance were sent to the clinical lead within Coastal ISU. Responses and assessments were logged, and the level of implementation was also recorded. Where guidance was not fully implemented, an action plan was requested to ensure that implementation was achieved. We found that both in wards and theatres relevant and current evidence-based guidance, standards, and best practice legislation was identified and was used. Staff could discuss with us recent NICE guidelines and how they impacted on the treatment and care delivered.

Sepsis pathways were followed to ensure patient safety. Sepsis is a serious, potentially life-threatening complication of an infection. There was a sepsis screening bundle in use which included neutropenic guidelines. The document prompted staff to consider, identify and manage sepsis. The service used a sepsis pathway to screen patients and escalate if treatment or review was required. As part of the admission proforma, information about sepsis was included to alert staff to follow the correct pathway. Sepsis audits were undertaken to ensure effective sepsis practice was maintained.

Venous thromboembolism (VTE) assessments were not being completed within 24 hours of admission. Medical staff were required to assess each patient on admission, for risk of developing a deep vein thrombosis and to prescribe preventative medicines and compression stockings. This was in accordance with national guidance from the Department of Health and from the National Institute for Health and Care Excellence (NICE) guidance (NICE) CG92 (2010). A VTE assessment was completed for each patient going to surgery, and TED stockings were given to most patients unless not suitable. However, the guidance also states all patients should be re-assessed within 24 hours of admission or whenever the clinical situation changed. Board papers stated VTE assessments were being completed but were not inputted on to the electronic system by medical staff.

At handover meetings, staff routinely referred to the psychological and emotional needs of

patients, their relatives and carers. Staff attended a ward round in the morning to discuss the patients on the ward. Staff could then identify any patients with mental health needs. Patients with dementia had a 'forget-me-not' flower symbol next to their names on the inpatient board, and next to their bed. This meant staff could identify quickly a patient with dementia in a dignified way for them.

Preoperative assessment unit was not always effective due to it being sometimes undertaken too early. The hospital had a nurse-led clinic which assessed patients for planned and day surgery. The nurses linked with GPs to ensure patients were prepared for surgery, for example, by requesting medication was adjusted where required, as well as getting patients ready for coming into hospital. However, the hospital guidance required preoperative assessments to be valid for no more than six months prior to the patient's surgery. However, staff reported that many patients came despite their operation likely to be more than six months after their pre-assessment. This meant that patients had to come back into hospital for a further preassessment prior to their surgery.

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 patients' religious, cultural and other needs.

Staff fully and accurately completed patient's fluid and nutrition charts where needed. Records we reviewed were completed as required. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Records we reviewed were complete and scores were calculated correctly which helped to identify patients at risk.

Staff encouraged patients to safely eat and drink. Support from staff such as dietitians and speech and language therapists were available for patients who needed it. We saw evidence in patient notes of input from speech and language therapists about patients' swallowing ability and the suitability of food and drink. Patients had drinks on their tables within reach. Some had cups with lids, others open cups and mugs to meet the individual patient's needs. When giving meals and drinks to people staff ensured the beds were raised so the person was sitting up, which reduced the risk of choking. Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Dietitians were available on wards five days a week.

When staff were preparing meals from the trolley, they talked about where patients had requested changes. Staff were heard to discuss one patient who had not been eating well. The staff preparing the meal discussed trying the patient with a smaller portion size, as a large portion may be putting the person off of eating.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods if surgery was delayed. Staff told us patients waiting to have surgery were not left without food or drink for long periods, and this was confirmed by patients we spoke with.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs. An observational tool was used to measure pain in patients who had difficulties communicating, including those living with dementia.

Patients received pain relief soon after requesting it. Patients we asked told us their pain was well controlled, including at night. One patient told us the pain team had been very responsive to their concerns about taking morphine, and that their “communication had been fantastic”. Another patient told us that staff “always ask me about my pain levels”. Another patient told us that they had been told about the different types of pain relief available.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this when reviewing prescription records.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Information about people’s care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care.

There was participation (that included all relevant staff) in local and national clinical audits. The extended to other monitoring activities such as reviews of services, benchmarking and peer review and approved service accreditation schemes. Accurate and up-to-date information about effectiveness of treatment was shared internally and externally and was understood by staff. It was used to improve care and treatment and patients’ outcomes, Managers shared and made sure staff understood information from the audits.

The day surgery team had won prizes at the International Association of Ambulatory Surgery (IAAS) Congress. First prize was awarded to the day surgery emergency team and second to the day case hip replacement service for presenting projects based on their work which had transformed patients’ lives, improved their experience in hospital, reduced waiting lists, improved the efficiency of trust clinical processes, and reduced costs. Emergency day surgery had saved 400 hours of emergency inpatient theatre time over two years, and 94% patients were discharged the same day as surgery.

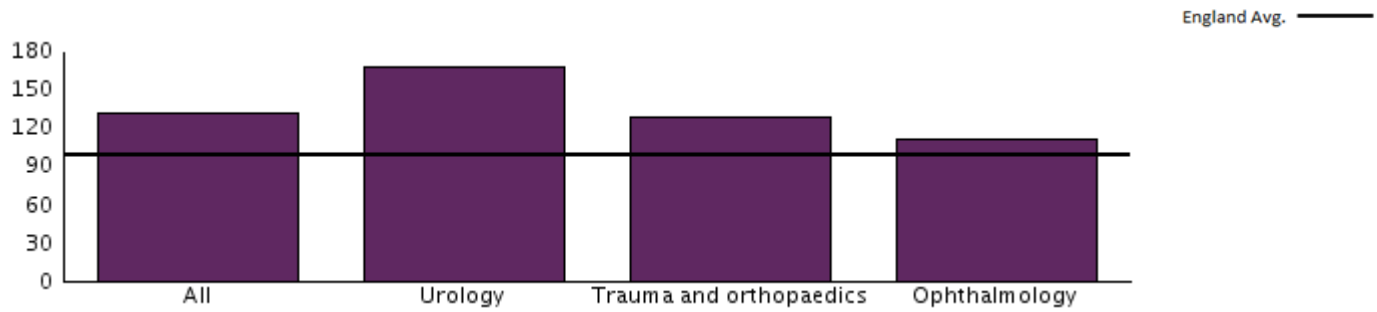
Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Local audits were owned by specialties. They used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

Relative risk of readmission

From September 2018 to August 2019, all patients at Torbay Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Colorectal surgery, upper gastrointestinal surgery and trauma and orthopaedics patients at Torbay Hospital had higher than expected risks of readmission for non-elective admissions when compared to the England averages.

Elective Admissions - Torbay Hospital

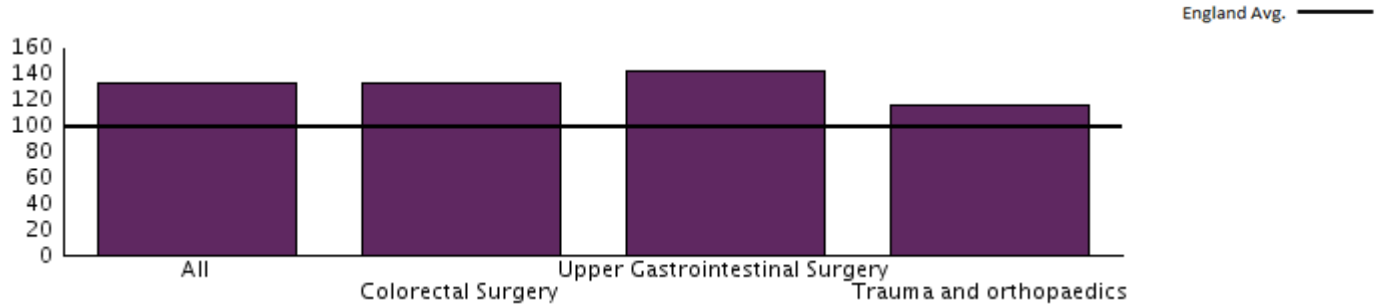


Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

All patients at Torbay Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Colorectal surgery, upper gastrointestinal surgery and trauma and orthopaedics patients at Torbay Hospital had higher than expected risks of readmission for non-elective admissions when compared to the England averages.

Non-Elective Admissions - Torbay Hospital



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

(Source: Hospital Episode Statistics)

National Emergency Laparotomy Audit

The table below summarises Torbay Hospital's performance in the 2018 National Emergency Laparotomy Audit (NELA). The audit reports on the extent to which key performance measures were met and grades performance as red (less than 55% of patients achieving the standard), amber (between 55% and 85% of patients achieving the standard) and green (more than 85% of patients achieved the standard.

We saw results of the NELA audit discussed at clinical audit meetings and actions and learning points identified to improve the service. Performance had improved over time. We saw completion of records was highlighted as an action, with anaesthetists encouraged to support surgeons to do this while in theatre.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Case ascertainment *(Proportion of eligible cases included in the audit)*	100%	Green	Met (National Standard 85%)
Crude proportion of cases with pre-operative documentation of risk of death *(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)*	71%	Amber	Did not meet (National Standard 85%)
Crude proportion of cases with access to theatres within clinically appropriate time frames *(Proportion of patients who were operated on within recommended times)*	91%	Green	Met (National Standard 85%)
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre *(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)*	78%	Amber	Did not meet (National Standard 85%)
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to surgery post-operatively *(Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)*	88%	Green	Met (National Standard 85%)
Risk-adjusted 30-day mortality rate *(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)*	11%	Within expected range	No current standard

(Source: National Emergency Laparotomy Audit)

National Joint Registry

We saw results of the national joint registry audit discussed at clinical audit meetings and actions and learning points identified to improve the service. We saw that results had been scrutinised at individual consultant level.

The table below summarises Torbay Hospital's performance in the 2018 National Joint Registry (NJR).

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Hips, knees, ankles and elbows			
Case ascertainment (hips, knees, ankles and elbows) *(Proportion of eligible cases within the trust that were submitted to the audit)*	100.0%	As expected	Met (Standard 95%)
Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) *(Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)*	72.8%	Red (Less than 80% of patients consented)	Did not meet (Standard 100%)
Hips			
Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) *(Proportion of patients who need their hip replacement 're-doing')*	1.0	Within expected range	No current standard
Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) *(Proportion of patients who die within 90 days of their operation)*	1.4	Within expected range	No current standard
Knees			
Risk-adjusted 5 year revision ratio (for knees excluding tumours) *(Proportion of patients who need their knee replacement 're-doing')*	1.4	Within expected range	No current standard
Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) *(Proportion of patients who die within 90 days of their operation)*	1.3	Within expected range	No current standard

(Source: National Joint Registry)

National Hip Fracture Database

The table below summarises Torbay Hospital's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Case ascertainment *(Proportion of eligible cases included in the audit)*	93.3%	Worse	Did not meet (Standard 100%)
Crude proportion of patients having surgery on the day or day after admission *(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)*	78.4%	Similar	Did not meet (Standard 85%)
Crude peri-operative medical assessment rate *(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)*	95.6%	Similar	Did not meet (Standard 100%)
Crude proportion of patients documented as not developing a pressure ulcer *(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's admission; this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient)*	97.0%	Similar	Did not meet (Standard 100%)
Crude overall hospital length of stay *(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)*	14.7 days	Better	No current standard
Risk-adjusted 30-day mortality rate *(Adjusted scores take into account the differences in the case-mix of patients treated)*	7.3%	Within expected range	No current standard

(Source: National Hip Fracture Database)

Audit results showed that surgery was managed in accordance with NICE guidelines for CC24 hip fracture, QS49 and surgical site infection. In the 2018 Hip Fracture Audit, Torbay Hospital performed better than the England average in seven out of nine relevant measures. These included patients being admitted to orthopaedic care within four hours (18%) compared to a national average of 46%), and patients having surgery on the day or the day after admission 67%

compared to a national average of 72%).

We saw that the latest results from the latest national hip fracture database audit were discussed at the anaesthetic clinical audit meeting. We saw both good performance and underperformance was discussed, and action plans agreed.

Bowel Cancer Audit

The table below summarises Torbay and South Devon NHS Foundation Trust's performance in the 2018 National Bowel Cancer Audit.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Case ascertainment *(Proportion of eligible cases included in the audit)*	112.4%	Good (over 80%)	No current standard
Risk-adjusted post-operative length of stay >5 days after major resection *(A prolonged length of stay can pose risks to patients)*	57.1%	Better than national aggregate	No current standard
Risk-adjusted 90-day post-operative mortality rate *(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)*	6.1%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate *(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)*	20.1%	Within expected range	No current standard
Risk-adjusted 30-day unplanned readmission rate *(A potential risk for early/inappropriate discharge is the need for unplanned readmission)*	8.2%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection *(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)*	53.0%	Within expected range	No current standard

(Source: National Bowel Cancer Audit)

National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach).

The table below summarises Torbay and South Devon NHS Foundation Trust's performance in the 2018 National Oesophago-Gastric Cancer Audit.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Trust-level metrics *(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	81 to 90%	Better than national aggregate	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission *(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)*	19.0%	15-20%	No current standard
Risk adjusted 90-day post-operative mortality rate *(Proportion of patients who die within 90 days of their operation)*	Not eligible	Not eligible	Not eligible
Cancer Alliance level metrics *(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.*			
Crude proportion of patients treated with curative intent in the Cancer Alliance *(Proportion of patients receiving treatment intended to cure their cancer)*	33.3%	Significantly lower than the national aggregate	No current standard

(Source: National Oesophago-Gastric Cancer Audit)

National Prostate Cancer Audit

The table below summarises Torbay and South Devon NHS Foundation Trust's performance in the 2019 HQIP National Prostate Cancer Audit.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Men with complete information to determine disease status *(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)*	95.7%	N/A	Not met (Standard 100%)
Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy *(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)*	Not eligible	Not eligible	Not eligible
Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy *(Complications following surgery may reflect the quality of surgical care)*	Not eligible	Not eligible	Not eligible
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy *(External beam radiotherapy uses high-energy beams to destroy cancer cells)*	8.3%	Within expected range	No current standard

(Source: HQIP National Prostate Cancer Audit)

National Vascular Registry

The table below summarises Torbay and South Devon NHS Foundation Trust's performance in the 2018 National Vascular Registry.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Abdominal Aortic Aneurysm Surgery *(Surgical procedure performed on an enlarged major blood vessel in the abdomen)*			
Case ascertainment (AAA) *(Proportion of eligible cases included in the audit)*	100.0%	Better than audit aspirational standard	Met (Standard 90%)
Risk-adjusted post-operative in-hospital mortality rate *(Proportion of patients who die in hospital after having had an operation)*	1.2%	Within expected range	No current standard
Carotid endarterectomy *(Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)*			
Case ascertainment (CE) *(Proportion of eligible cases included in the audit)*	100.0%	Better than audit aspirational standard	Met (Standard 90%)
Crude median time from symptom to surgery *(Average amount of time patients wait to have surgery after the onset of their symptoms)*	8 days	Better than audit standard	Met (Standard 14 days)
Risk adjusted 30 day mortality and stroke rate *(Proportion of patients who die or have a stroke within 30 days of their operation)*	0.0%	Within expected range	No current standard

(Source: National Vascular Registry)

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises Torbay and South Devon NHS Foundation Trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Trust-level metrics *(Measures of hospital performance in the treatment of cataracts)*			
Case ascertainment (*Proportion of eligible cases included in the audit)*	71.3%	Not eligible	No current standard
Risk-adjusted posterior capsule rupture rate (*Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill)*	1.0%	Within expected range	No current standard
Risk adjusted visual acuity loss (*The most important outcome following cataract surgery is the clarity of vision)*	No data available	Not eligible	No current standard

(Source: National Ophthalmology Database Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Hip replacements
- Knee replacements

In the below table, scores for adjusted average health gain at Torbay and South Devon NHS Foundation Trust in 2018/19 have been compared with scores for all trusts in England. **Metrics *(Audit measures)***	**Adjusted average health gain**	**Comparison to other trusts***
Hip replacement (Primary)		
EQ VAS[1]	15.3	About the Same
EQ – 5D index[2]	0.5	About the Same
Oxford hip score[3]	24.6	Better
Knee replacement (Primary)		
EQ VAS[1]	9.0	About the Same
EQ – 5D index[2]	0.3	About the Same
Oxford knee score[4]	19.7	Better

*Much better – Trust is above the upper 99.8% control limit

Better – Trust is above the upper 95% control limit

About the same – Trust is not significantly different from England as a whole

Worse – Trust is below the lower 95% control limit

Much worse – Trust is below the lower 99.8% control limit

1. The **Visual analogue scale (EQ VAS)** asks patients to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".
2. **The EQ-5D-5L questionnaire** comprises five domain questions which ask about specific issues. These are: mobility, self-care, usual activities, pain and discomfort anxiety or depression. The EQ-5D-5L uses five levels of responsiveness to measure problems, ranging from ‘no problem’ to ‘disabling/extreme’.
3. **The Oxford Hip Score (OHS)** is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living. A simple scoring and summing system provides an overall scale for assessing the outcome of hip interventions.
4. **The Oxford Knee Score (OKS)** is a Patient Reported Outcome questionnaire that was developed to specifically assess the patient's perspective of outcome following

total knee arthroplasty. The OKS consists of twelve questions covering function and pain associated with the knee.

(Source: Patient reported outcome measures (PROMS))

Competent staff

Managers ensured staff were fully competent for their roles. Managers mostly appraised all staff's work performance on time or held supervision meetings with them to provide support and development.

Staff were experienced, qualified and mostly had the right skills and knowledge to meet the needs of patients. Different specialities had a set of competencies which all nurses were required to complete and have signed off to demonstrate they had the required skills and knowledge the needed for their role. We reviewed examples of competency frameworks, these were well completed.

We found that healthcare assistants (HCAs) were used to fill vacant registered nursing roles. We saw that where this occurred, managers would overstaff the wards with HCAs, to compensate for the lower numbers of registered nurses. Nevertheless, HCAs were not able to complete tasks undertaken by registered nurses. We found there was a 'grow your own' culture within the ISU. We identified many members of staff who had been encouraged and supported for promotion. Trainee nurses worked together under the supervision of a registered nurse, to improve their competence and skills, including engaging with consultants. Staff we spoke with were very positive about the support they had on wards.

Training could not always be attended as planned due to increased demands on wards. For example, we were told trainee nurses who required training for giving intravenous medication had their training cancelled a number of times because of escalation issues across the trust, when the trust was under high levels of operational pressure. When this happened, all training sessions were cancelled, and staff were returned to wards.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us that every new member of staff received a comprehensive induction programme. Bank and agency staff also confirmed they received the same induction, alongside local level induction on the wards they were working on. This was confirmed by both permanent staff and bank staff we spoke with on the inspection. They told us they were well prepared for work on wards or in theatres.

Medical staff were supported to develop through regular, constructive clinical supervision of their work. Junior doctors told us their supervision was good, and they told us consultants were approachable.

Appraisal rates

From December 2018 to November 2019, 78.5% of staff within the surgery department at the trust received an appraisal compared to a trust target of 90%. This compared to an appraisal rate of 80.9% in the previous financial year (April 2018 to March 2019).

Managers and staff told us pressures of work, especially over the winter, meant that appraisal meetings were booked but then cancelled. All staff we spoke with told us they felt they could speak to their manager if they had any concerns or have a conversation about training. In addition, a weekly huddle took place for early escalation of issues and support. However, this was not always done in a way in which conversations could be documented.

Appraisal data provided by the trust for this core service did not include medical staff, although all

medical staff have to have an annual appraisal to be revalidated, to allow them to continue to hold a doctor's license to practice.

From December 2018 to November 2019 78.6% of staff within the surgery department at Torbay Hospital received an appraisal compared to a trust target of 90%. This compares to an appraisal rate of 81.1% in the previous financial year (April 2018 to March 2019).

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Nursing and midwifery registered	156	191	81.7%	90.0%	No
Estates and ancillary	8	10	80.0%	90.0%	No
Administrative and clerical	92	117	78.6%	90.0%	No
Additional clinical services	110	142	77.5%	90.0%	No
Additional professional scientific and technical staff	42	58	72.4%	90.0%	No
Allied health professionals	6	9	66.7%	90.0%	No
Total	**414**	**527**	**78.6%**	**90.0%**	**No**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. When patients received care from a range of different staff, teams or services, it was well coordinated. We saw all relevant staff, teams and services were involved in assessing, planning and delivering patient care and treatment.

Staff worked collaboratively to understand and meet the range and complexity of patients' needs. We observed daily patient safety meetings on two wards where a range of different needs for patients were brought and discussed. We also observed ward handovers where there was a full complement of multidisciplinary team members present. Each staff member was involved in discussions about patients' treatment and discharge pathways and it was clear that all staff had respect for and gave consideration to each other's roles and professional opinions.

The trust used national guidance known as 'red and green bed days' (NHS Improvement) to ensure all patients received value adding care to progress recovery towards discharge. Planning for effective transfer of care, with the patient and their carers and all multidisciplinary team members was started on admission or at the preassessment appointment. However, we spoke with four patients who were not aware of when they should be discharged and had not had conversations with staff about what their needs were once discharged.

The trust had a 'discharge from hospital' policy. This stated that the complex discharge team would support complex discharges where there were multiple on-going health and social care needs that require detailed assessment, planning and delivery by a multi-professional team and multiagency working. If required, advocacy including independent mental capacity assessor (IMCA) services should be involved in providing advice and information on behalf of the patient. For patients returning to a care home, this also included ensuring they were suitably equipped and had capacity to meet the patient's known and anticipated health and social needs.

Seven-day services

Key services were available seven days a week to support timely patient care. However, not all patients were seen within the required 14 hours by a consultant.

The trust had identified three workgroups to improve quality in relation to seven-day hospital services. These included a 'wards group' and 'home first group'.

Assessment of all emergency patients by a consultant within 14 hours of admission was monitored for general surgery patients. Between April and September 2019, 69% of patients were seen by a consultant physician on the ward round within 14 hours of referral, to decide which is the best pathway for the patient. We saw progress had been made in the assessment of all emergency patients by a consultant within 14 hours of admission since 2016. The target of 90% had not been achieved but progress was in line with that achieved by other trusts in England.

Staff we spoke with told us they could call for support from doctors and most disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Physiotherapists provided a seven-day service. A senior staff member, nurses at band 6 and band 5 grade, and technicians were available seven days a week. Speech and language therapists were available through a referral system on weekdays but not weekends.

Pharmacy services were available either in the department, accessible by telephone or on call. There was an on-call pharmacist available by telephone outside of core hours.

Psychiatric support was available seven days a week.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support for patients on the wards. On each ward we found numerous leaflets promoting healthy lifestyles and signposted patients to sources of information and support, for example in relation to substance and alcohol abuse and smoking. There were information leaflets available in reception waiting areas and on noticeboards on wards.

Staff told us they assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Patients were offered advice and support in the pre-assessment unit on smoking cessation and dietary advice. At the time of the inspection, six exercise bikes were available for patients to use to aid weight loss, as part of a research programme.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support some patients to make informed decisions about their care and treatment. Some staff did not know enough about how to support patients who lacked mental capacity to make their own decisions or were experiencing mental ill health. However, staff followed national guidance to gain patients' consent.

Not all staff fully understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We reviewed four sets of patient records and talked with staff. There was a lack of understanding in relation to DoLS and Mental Capacity Act within patient notes reviewed. On Ainslie ward, there was some confusion as to which patients were under an authorisation or awaiting a DoLS assessment, and ward staff could not clearly identify which patients were subject to an authorisation.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff clearly recorded consent in the patients' records. Staff used consent forms designed to obtain consent from patients prior to treatment and surgery. The consent forms we reviewed held information about risks and benefits of the proposed treatment to enable patients to make informed decisions about consent.

Mental Capacity Act and Deprivation of Liberty training completion

All staff had access to but did not always keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust reported that Mental Capacity Act training including Deprivation of Liberty Safeguards was delivered as part of the corporate and clinical induction for all new staff.

Is the service caring?

Compassionate care

Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We spoke with nine patients and five carers on wards and there was mainly positive feedback about the nursing and medical staff and the treatment they had received.

Patients said that staff treated them with respect and dignity. One patient said staff "are wonderful, very obliging, nothing too much trouble for them." Another said, "they respect my privacy." One carer said they "rang the ward a number of times while [the patient] was being operated on, and I felt nothing was too much trouble when they talked to me. I rang them three times and was not made to feel I was bothering them. We both feel fully involved in what has happened." One patient told us they had been "exceptionally well cared for. All the understanding and sympathy the staff show. I was going to the toilet five times a night [due to their condition] and the staff were always too kind to me."

However, another patient told us staff were not always on hand when they needed them and had not been given their breakfast which they needed to have with their medication. We spoke with staff about this, and were shown a hand-written note left by staff, but it was not clear why the patient had not been offered any breakfast.

Patients mostly said staff treated them well and with kindness. We saw staff pull curtains around patient's bed for privacy. We saw jovial, warm and well received conversations between patients and staff. Staff took time to explain to the patient why they had to stand up to take their dressing off. While providing care the staff member talked about other topics with the patient. For example, they talked with one patient about a possession which was personal to the patient and where it come from and what it was about. This showed an interest in the patient as a person, finding out about their interests.

Feedback from people who used the service, those who were close to them and stakeholders was mostly positive about the way staff treated people. People were mostly treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. People felt supported and say staff cared about them.

Staff we spoke with told us about the importance of providing kind and compassionate care to the best of their ability. Patients mostly confirmed this and told us, “The care has been very good, we are just waiting now to see what happens next, we can’t fault the care”, and, “staff are doing their absolute upmost for us. The service over the years has been brilliant. They are kind and caring and do everything they can. Staff are excellent and I feel respected.” However, one patient had noted that staff appeared to be using mobile phones all the time, and they felt that they had to wait to ask questions because staff were distracted. We noted that staff used hand held devices to record patient observations, but that this was not always explained to patients, who therefore assumed staff were using mobile phones.

The trust had introduced a real time feedback project called the ‘patient experience collaborative’. The ‘working with us’ panel of volunteers and the patient experience group obtained feedback from patients in inpatient settings and in ‘real-time’ The aim was to make it easier for patients to provide feedback and for their concerns to be addressed as quickly as possible to improve their experience before they left the ward. Patients were interviewed on the day and feedback given on the day as well, rather than waiting for feedback to go through the usual channels. This enabled staff to put things right.

For example, staff had improved how medicines were explained to patients, after feedback from Ainslie ward. The trust had made a medications poster which encouraged patients to ask about their medicines. This learning has now been shared with other wards. Other outcomes and improvements included soft closing doors for patient comfort at night (as it reduced loud noises), a "reducing noise at night" poster was produced to raise awareness of this issue. Sleep well packs (including ear plugs, eye masks and tips on how to improve sleep) had been ordered for many of the inpatient wards and teams were regularly encouraged to reduce avoidable noise at night.

Staff responded in a compassionate, timely and caring way to people experiencing physical pain, discomfort or emotional distress. Most patients told us their pain had been well managed and had been reviewed every day by the pharmacist or doctor.

From our observations, staff made sure people’s privacy and dignity was respected. For example, we saw nurses closing curtains around patients when delivering personal care and treatment. All patients we spoke with were positive about the way staff maintained their privacy and dignity. Patients had access to chaperones if required and information about how to access a chaperone was displayed clearly in treatment rooms. The service had a chaperone policy and staff were aware of their responsibilities.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs. There were times when some patients did not feel well-supported or cared for. Staff did not always make sure patients and those close to them understood their care and treatment.

People who use services, carers and family members were mostly involved and encouraged to be partners in their care and in making decisions and received any support they needed.

We saw staff spend time talking to people, or those close to them. We saw several examples of the support and help provided to patients by nursing and medical staff. Staff were polite and introduced themselves by name and by role. Patients could reach call bells and staff usually responded quickly when called. During our inspection we saw call bells were placed within reach of patients and staff mostly responded promptly to call bells. However, we noted on Forrest ward,

during the ward round in the morning call bells were ringing and staff were not available to respond promptly. On two occasions we pointed this out to ward staff who then responded to patients. Feedback we received from patients on our inspection mostly supported our observations.

We observed a healthcare assistant getting blankets when patients asked for them. They spoke with patients to check they were comfortable. When a patient said they felt cold, after getting them a blanket, the staff talked to them about checking their temperature. They explained they wanted to do this to check they were okay as it was not cold in the ward.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The chaplaincy service at the trust consisted of free church, Anglican and Roman Catholic chaplains. They were supported by a team of trained volunteers who visited clinical areas. The chaplains were also able to contact other faith/ belief leaders for support where needed. Members of staff of the Muslim faith were able to offer support for other staff and patients when requested. There was a chapel on the Torbay Hospital site open at all times, including a separate prayer room for those who preferred a space without Christian symbols. Holy Communion was available in the chapel (and at the bedside for those unable to attend chapel services).

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients who received life-changing diagnoses were given appropriate emotional support, including access to further support services. For example, nurses could signpost patients to support services, including cancer support services.

On Forrest ward we spoke with two patients who did not have access to their hearing aids or glasses. The first patient had been on the ward for six days. They told us that they did not have their hearing aids in the hospital, and nor could they find their glasses. When we spoke about this to nursing staff, we were told the patient's glasses were with the patient, and that the patient did not want their hearing aids. However, we could not confirm this in the patient's notes. The ward sister confirmed there was no documentation in the patient's file about how staff should take into consideration the patient's lack of hearing, or that the patient may not be able to see without his glasses.

We then spoke with a second patient on Forrest ward. They told us that they had been operated on in the morning and then transferred to the ward. The bag with the patient's clothing, glasses and hearing aids arrived on the ward eight hours later. During that time the patient told us they could not hear or see anything. They told us, "the staff have been wonderful, but I felt stranded on the ward without my glasses".

We spoke to audiologists who worked within the hospital who told us they were able to support patients staying in hospital if they required hearing aids, but it was apparent this was not understood by all staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure patients and those close to them understood their care and treatment. One patient told us they had been given a choice about the care plan and had felt they had been given enough information to make an informed decision about the right procedure for them. However, staff did not always speak with patients, families and carers in a way they could understand. One carer felt that they were not fully informed and had been given conflicting

information. Another told us that they saw different members of staff and we were told they felt everyone was telling them something different. One patient told us the doctors would attend in a group and introduce themselves. However, they told us the doctors would then talk among themselves and the patient did not feel involved in their own care.

Otherwise, we observed most staff talked with patients, families and carers in a way they could understand. Most of the patients we spoke with felt well informed as to their diagnosis and care plans. They felt the management of their care and treatment had been discussed with them as much as possible.

The trust scored highly in the patient friends and family test with 98% of patients reporting they were likely or extremely likely to recommend the service overall. These questions were supplemented by the patient engagement network interviews which provided real time feedback on experience. The real time patient survey undertaken by the 'working with us' panel showed 96% of patients surveyed would be highly likely or likely to recommend wards to their families and friends and 95% said they were treated with respect and dignity.

Is the service responsive?

Service delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service worked with stakeholders to understand whether and how the service could meet the needs of the local population. Leaders told us about treatments that were being completed as day cases. This reduced some of the pressure on inpatient beds. However, the wards did not effectively work together to take patients from the emergency department. The emergency department was the point of entry to the hospital for all unplanned admissions.

The hospital served an elderly population. There were arrangements to ensure the needs of elderly patients were met. The orthogeriatricians, who were normally responsible for reviewing all fracture neck of femur patients, also reviewed any elderly trauma patients.

Staff could access emergency mental health support 24 hours a day, seven days a week for support for patients with mental health problems, learning disabilities and dementia. Staff had access to advice and support from the psychiatry team if a patient decided to either discharge themselves or refuse treatment.

The service had systems to support patients in need of additional support or specialist intervention. If a patient had specific communication needs, the wards would also involve the speech and language therapy (SALT) team. Staff we spoke with told us the SALT team were very responsive to requests to help and support patients on wards.

There was access to information videos and communication services through the trust internet page. There was a palliative care team and end of life care team who provided additional support to patients where needed.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. We saw senior staff were involved when patients missed appointments or did not respond to correspondence. In one case, a senior manager visited the home of a patient who was on the 52 week breach list to check whether they still required and would be attending their appointment.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients with equality and diversity needs access services on an equal basis. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us that records had a marker which could identify patients who had a diagnosis of dementia or learning disability.

Staff had taken some steps to support patients living with dementia by using a 'This is me' booklet Staff supported patients or their carers to fill out the booklet on their admission which staff then used for information about the patient' s preferences around, for example, eating, drinking and personal hygiene. Patients also stated things that made them happy or upset, the way they preferred to communicate and useful information about their life so far.

Wards were generally designed to meet the needs of patients living with dementia. Signage for toilets and showers on some wards were 'dementia friendly' with large colourful pictures, although this was not yet used throughout the hospital. Wards had dementia link nurses to act as a resource for other staff to ask for support and information and help deliver safe and effective care and treatment.

Patients had access to information leaflets available in most languages recognised as spoken in the local community. Staff had access to an interpretation service 24 hours a day.

Wards had access using the trust intranet to a folder of resources to support care for people with learning disabilities. This contained links to national material and practical help such as a range of symbols, signs and speech to enable people to communicate.

The trust had a policy to support carers. Provisions included, for example, family members and carers of people with dementia able to stay overnight if needed.

Transgender patients were supported in being cared for in a ward area based on the gender they identified as at the point of admission.

Nurses on the wards kept patients well-informed of timings and delays to going to theatre. Patients we spoke with were happy with the way nurses kept them updated. However, patients we spoke with were not always informed about when they would be going home or what support they would need at home.

Staff involved patients who used services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment. In trauma and orthopaedics an online decision aid had been created for patients having hip or knee surgery. It was designed to help patients and health professionals make decisions together about a course of care.

The trust had a liaison nurse to support people with a learning disability when they had an outpatient, elective or emergency inpatient admission.

Access and flow

People did not always access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Bed management meetings took place every weekday to identity where there were staff shortages, patients who were on wards or areas not intended for their clinical procedure (known as outliers), and how these could be managed. We attended bed meetings on three occasions during our inspection visit and found that staff identified potential beds that were expected to become available that day. The service had introduced a process to enable all staff to work together to use the information about potential or actual bed availability to improve patient flow through the hospital. They used the terms ‘gold’ and ‘silver’ to differentiate between patients who were ready for discharge and those who may be ready soon. However, at the meetings we observed, we found that beds identified in the morning meetings did not become available by the afternoon meetings.

The efficiency of the operating theatres had been reduced. Primarily this had been because of the closure of two operating theatres due to a failure of the air handling unit. However, theatre staff recognised changes could be made to improve efficiency. A theatres improvement project had been introduced two months prior to the inspection. This included looking at cancellations of surgery on the day it was due to take place. One of the themes identified was the patient not being fit on the day of surgery. The project team introduced a pre-operative triage form, where a check was made with the patient about a week before the planned surgery to check medication, and they knew they were due to attend for their surgery. Decisions about cancelling surgery on the day were now escalated to a senior manager. The impact of these changes had not been calculated by the time of inspection, but staff reported that theatre efficiency felt better.

Average length of stay

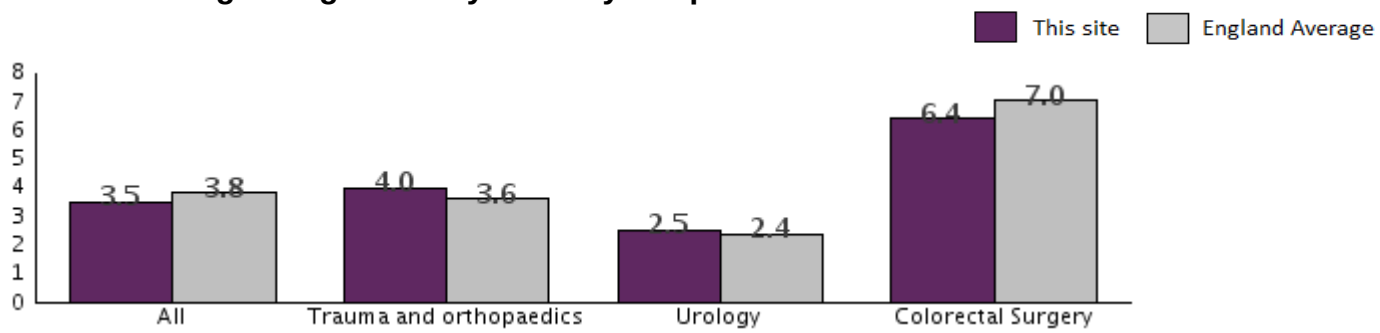
On average, most patients’ length of stay was below (better than) the England average. Some patients receiving elective or planned surgery were staying longer than average, but most were discharged in good time. No non-elective or emergency patients were staying longer than the England average. This is an indicator of good recovery times and the hospital taking steps to free capacity for other patients.

Torbay Hospital - elective patients

From October 2018 to September 2019 the average length of stay for patients having elective surgery at Torbay Hospital was 3.5 days, the average for England was 3.8 days.

- From October 2018 to September 2019 the average length of stay for patients having elective trauma and orthopaedic surgery at Torbay Hospital was 4.0 days. The average for England was 3.6 days.
- From October 2018 to September 2019 the average length of stay for patients having elective urology at Torbay Hospital was 2.5 days. The average for England was 2.4 days.
- From October 2018 to September 2019 the average length of stay for patients having elective colorectal surgery at Torbay Hospital was 6.4 days. The average for England was 7.0 days.

Elective Average Length of Stay - Torbay Hospital



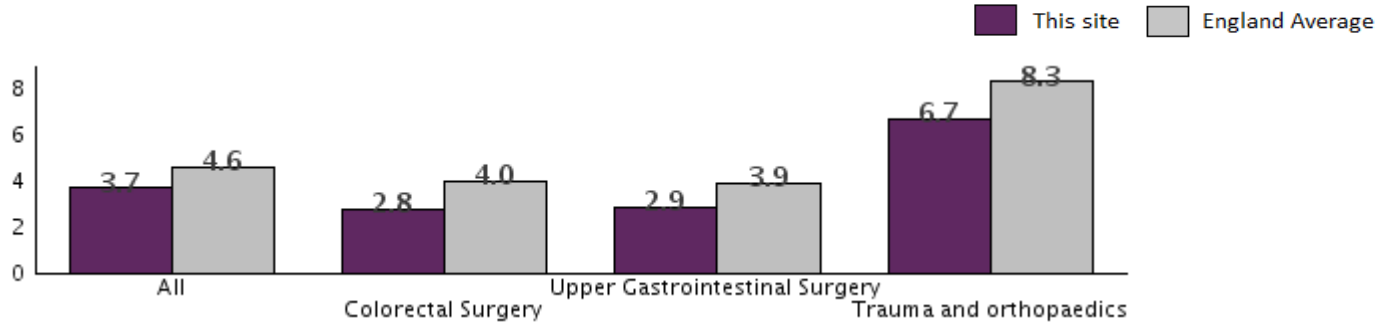
Note: Top three specialties for specific site based on count of activity.

Torbay Hospital - non-elective patients

The average length of stay for patients having non-elective surgery at Torbay Hospital was 3.7 days. The average for England was 4.6 days.

- The average length of stay for patients having non-elective colorectal surgery at Torbay Hospital was 2.8 days. The average for England was 4.0 days.
- The average length of stay for patients having non-elective upper gastrointestinal surgery at Torbay Hospital was 2.9 days. The average for England was 3.9 days.
- The average length of stay for patients having non-elective trauma and orthopaedic surgery at Torbay Hospital was 6.7 days. The average for England was 8.3 days.

Non-Elective Average Length of Stay - Torbay Hospital



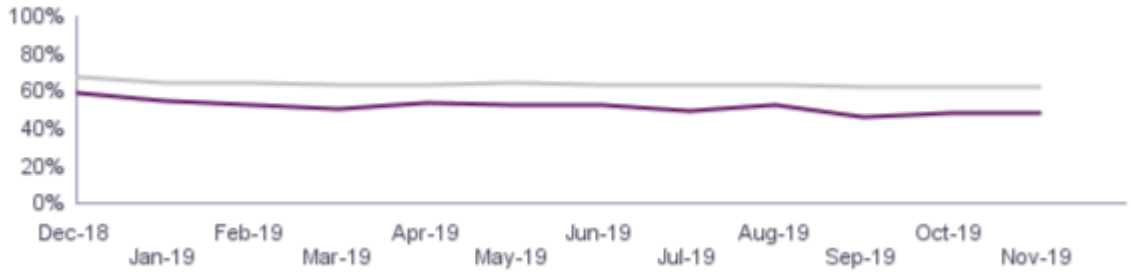
Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

Managers monitored waiting times. However, patients could not always access services when needed to receive treatment within agreed timeframes and national targets. Reduced activity and insufficient theatre capacity had resulted in underperformance in admitted patient pathways. Patients had breached 52 week waits and there was a risk that there would still be patients breaching this target by April 2020, although the trust had set a target of no patients breaching by this date.

From December 2018 to November 2019, the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. It was not clear how the service planned to improve this situation.



(Source: NHS England)

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

The standard national for referral to treatment was 92% and no specialty grouping achieved this. The trust's operational plan had a target of 82%, which was also not being achieved.

Two specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Ear, nose and throat (ENT)	70.0%	59.5%
Oral surgery	57.1%	53.1%

Four specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	73.5%	73.7%
Plastic surgery	68.0%	78.3%
Trauma and orthopaedics	47.9%	57.4%
Ophthalmology	36.6%	60.2%

At December 2019, 20.6% of patients were waiting more than 18 weeks for their operation.

There had been progress to treat patients waiting over 52 weeks for their operation using the two new laminar flow operating theatres which opened in the summer of 2019.

An additional investment was made to support a plan to see all patients waiting more than 52 weeks by March 2020. Senior managers told us that it was unlikely that there would be no patients waiting longer than 52 weeks by that date, as there was a cohort of 15 to 20 patients who may choose to wait over 52 weeks.

Following closure of two operating theatres due to the failure of the air handling unit, there was an impact on patients and waiting times, with a number of patients waiting over 52 weeks for their operations, and some patients were being sent to other locations for their surgery. The theatres were closed for 11 months. However, new theatres opened in the summer 2019.

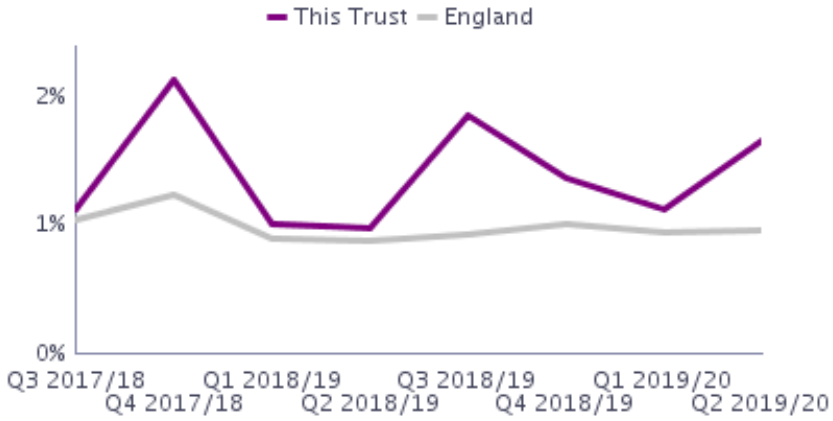
Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital, or on the day of their operation. If a patient had not been treated within 28 days of a last-minute cancellation, then this was recorded as a breach of the NHS constitutional standard and the patient should be offered treatment at the time and hospital of their choice.

There had been a successful reduction in the number of patients who were cancelled at the last minute. Managers worked to keep the number of cancelled operations to a minimum. The surgical performance on the integrated performance dashboard included 'on the day'

cancellations for patients having elective surgery. This showed the target had not been achieved in any month from January to November 2019. However, in December 2019, the trust reported the number of operations cancelled on the day of surgery for hospital reasons had decreased to 19. This represented 0.6% of all elective procedures undertaken. There had been a focus on prioritising patients who had waited a long time for their surgery.

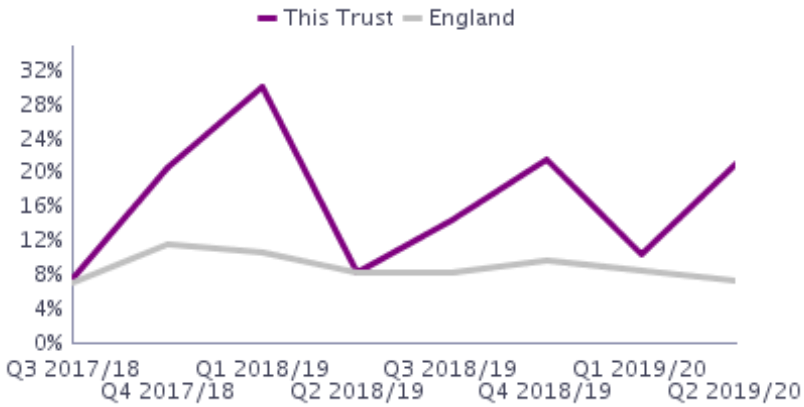
Cancelled operations as a percentage of elective admissions - Torbay and South Devon NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust was slightly higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

When patients had their operation cancelled at the last minute, the trust did not always make sure it was rearranged as soon as possible and within national targets and guidance. Data showed that some cancelled patients were not always not treated within 28 days. This was consistently above (worse than) the England average.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Torbay and South Devon NHS Foundation Trust



(Source: NHS England)

Managers planned for patient moves between wards/services to be kept to a minimum, but this was not always achieved. It was higher on some wards than others.

Patient moving wards per admission

From December 2018 to November 2019, 30% of all patients on Ainslie ward moved wards during their admission. On Forrest ward 10% of patients were moved during their admission.

(Source: Routine Provider Information Request (RPIR) – Ward moves)

Patient moving wards at night

From December 2018 to November 2019, there were 295 patients moving wards at night within surgery. A breakdown of moves by ward is below:

Ward name	Number of bed moves at night	Percentage of total
Ainslie	98	33.2%
Forrest	89	30.2%
Allerton	49	16.6%
Cromie	49	16.6%
Ella Rowcroft	10	3.4%
Total	**295**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The majority of complaints were responded to in a timely way in line with trust policy.

Staff we spoke with explained they got more positive feedback than complaints. Senior nurses shared feedback from patients and learning from complaints at safety briefing meetings that were held every morning.

Information about making complaints was available in all surgical areas we visited. Patients, relatives and carers knew how to complain or raise concerns. We saw leaflets on wards, and patients we spoke with told us they knew how to make a complaint or raise concerns. Patients told us they felt comfortable and confident to speak up. Staff they always tried to resolve complaints directly. If a patient wanted to make a complaint they would speak to the nurse in charge, or they were directed to the patient complaints service.

Staff spoken with were aware of learning from recent complaints. We were given an example of a complaint that had been upheld about fluid charts not being completed. Procedures were updated and we saw that daily fluid checks were undertaken, and staff told us these were also audited to confirm they had been fully completed.

We were told managers shared both positive and negative feedback from patients with staff. Managers told us complainants were provided with information about advocacy services to assist them to provide their feedback where required. The patient feedback and engagement team would contact advocacy services on behalf of enquirers if required.

We reviewed two complaints received regarding surgery. We saw that the response letters answered the patients' concerns. The first complaint had been responded to within six weeks and had advised the complainant of what to do if they were not happy with the response. The second complaints had taken eight weeks to provide a response, but we saw a letter had been sent to advise of the delay.

Managers investigated complaints and had identified themes. When we spoke with the leadership team, they told us they had an oversight of all complaints, and it was clear they understood what the issues were. They confirmed that waiting and access were the main themes. They told us they had some complaints around professional communication. For example, some patients had stated they felt things had not been fully explained. However, this did not relate to one particular

ward, service or member of staff. They also spoke compassionately about a patient death, the subsequent investigation, and supporting the patient's family with the results of the investigation.

Summary of complaints

Trust level

From December 2018 to November 2019, the trust received 65 complaints in relation to surgery (22.3% of total complaints received by the trust). The trust took an average of 32.1 days to investigate and close complaints. This was just over the trust's deadline in the complaints policy, which stated complaints should be answered within 30 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Treatment	37	56.9%
Diagnosis	7	10.8%
Discharge	6	9.2%
Assessment	5	7.7%
Care	5	7.7%
Appointment	4	6.2%
Referral	1	1.5%
Total	**65**	**100.0%**

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

Number of compliments made to the trust

From December 2018 to November 2019, there were 93 compliments about surgery at Torbay Hospital, 20% of the total compliments made about the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the experience, knowledge, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We met with the surgical leaders from the Coastal integrated service unit (ISU). This unit covered all planned care, including all surgical disciplines, pre-assessment and screening services. Coastal ISU had a leadership team which included an associate director of medicine, associate director of operations, and associate director of nursing and professional practice. They were supported by clinical leads and matrons. The ISU had been created in May 2019. However, the leadership team told us they had working relationships prior to the creation of the new ISU. They described this as a strong base.

The leadership team told us they felt supported by the executive team to drive progress and make improvements. They could describe to us the risks and the challenges to the service. Most staff we spoke with in theatres and on the wards also told us the Coastal ISU leadership team were visible and approachable and listened to their feedback and concerns.

We found the leaders enthusiastic about shaping the future of surgical services in Torbay, focusing on patient experience, while recognising the challenges they faced.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

There was no current strategy for Coastal ISU. We spoke with the leadership team who told us about business plans to improve the service, but there was no overarching strategy for the service. When we spoke with the leadership team, we were told they were working on identifying all key areas within the ISU and dealing with the biggest problem which was the infrastructure. They were doing planned refurbishments, to look at how services fit in with acute and elective capacity and how to provide a service to the population. They confirmed each specialty will have a plan, and 2021 would be a consolidation year for the ISU.

The trust had vision and values of 'starting and developing well, living and working well, ageing and dying well'. The trust's quality strategy reflected the triple aims of better outcomes, better experience and better use of resources. We were told there was a golden thread of quality defined as safe, efficient and best experience (SEE) which was embedded in the governance framework to ensure there was a clear link between system and organisational priorities and quality.

The service did not have a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with in theatres and on wards stated there was a good culture and they enjoyed working for the trust. We found there was a 'grow your own' culture within the ISU. We identified many members of staff who had been encouraged and supported for promotion, and staff spoke very positively about the opportunities they had. Staff were confident to raise any issues. They were aware of the freedom to speak up guardians and how they could be used to raise any concerns.

The trust had implemented a staff heroes award to celebrate and recognise the good work different teams were doing. There had been several teams and team members nominated for the awards across the wards and theatres.

Most staff told us they felt respected and valued by their managers. Nursing staff told us ward managers were supportive and understood their concerns. Managers at all levels told us they were proud of their staff. They told us staff were very caring and committed, and they were proud of the care staff gave, and their teamwork.

Patients we spoke with told us they felt they could raise concerns without fear. We saw patients were encouraged to speak up, with comment boxes available in ward reception areas.

Prior to the inspection we had received a number of concerns raised about a culture of bullying in theatres. We spoke with staff during the inspection, but we did not find any evidence to substantiate the concerns. We asked the senior management team about the culture within the ISU. They explained how they encouraged staff to report on what had gone well, such as learning from excellence. A cultural review had been undertaken in theatres, and subsequent staff surveys and feedback showed a positive culture in theatres.

Governance

There were some governance processes, but these were not effective in gaining full assurance for, improving or developing the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The ISU had specialty governance meetings and clinical effectiveness meetings used for information sharing. There was also an anaesthetic department meeting. For nurses there was a monthly Band 7 meeting which included governance. The associate director of nursing and professional practice reviewed the minutes of these meetings, and reviewed actions, chased up delays, and identified any overarching themes. There was a divisional board that had oversight of governance. However, the trust was unable to provide evidence which showed minuted meetings of clinical governance and effectiveness at Coastal ISU level. The trust wide quality improvement group (QIG) looked at outputs from each ISU, which was the means by which Coastal ISU could escalate to the board and executives.

We reviewed a range of examples provided of governance and effectiveness meeting minutes. The quality of specialty governance meeting minutes were varied. We found the minutes of the breast service governance and clinical effectiveness meetings were comprehensive and included satisfaction survey results, audits, complaints and mortality and morbidity reviews. However, there was no dated action log to identify actions and progress made. Minutes of the anaesthetics and theatre, the maxilla-facial, and the ear nose and throat governance meetings included the risk register, incidents, litigation and complaints. However, the details within the minutes were basic. The trauma and orthopaedic, and the general surgery clinical governance meeting minutes contained no actions with target dates of progress made. This did not show the depth of discussion and scrutiny within the meetings. Minutes lacked enough detail and limited insight to provide the reader with enough information to understand what was discussed and agreed.

We were not provided with evidence of governance meetings where topics such as safeguarding, training, and staffing issues such as sickness and vacancies were discussed.

At our last inspection we said the trust should introduce a standard agenda for mortality and morbidity meetings and ensure actions from these were clearly tracked. At this inspection we found a standard agenda introduced for the quality improvement group, and the terms of reference had been updated. Evidence templates had also been created since the last inspection. Local morbidity and mortality meeting agendas were being reviewed as part of the new impending Medical Examiner role.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. Staff could confidently talk to us about their involvement in governance. The ISU used daily safety briefs, newsletters, reports, and quality boards in wards and theatres to share information and performance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making but there were times where potentially financial pressures compromised the quality of care.

The management and oversight of the risk register was clear. We saw that risks and concerns staff talked to us about were on surgical risk register, and the senior managers told us these were discussed and updated every month.

The trust had effective systems for identifying risks and had the action summary and actions completed. Risk was identified and managed at a local level, for example in wards, units and theatres and included in the departmental risk register. The senior leadership team told us each team or ward had their own red/amber/green (RAG) rating to monitor risks and staffing. These were completed every month and shared with leaders. Higher risks were escalated to the Coastal ISU risk register, and then the trust risk register, depending on the severity of risk. Staff at all levels we spoke with told us that they were confident the risks they were aware of were included in risk registers.

We saw risk registers where risks were well defined, with mitigating controls. Actions were detailed with due dates recorded. Actions were reviewed and updated regularly. There were 27 risks relating to surgical care on the trust's risk register. These included: long waits for urology service users; general surgery waits breaching 18 weeks; lack of recovery space for procedure rooms; and care plan summaries not being completed in a timely fashion.

However, we found there was one area where financial pressures could potentially compromise the quality of care. Senior managers told us there was a rolling replacement programme for equipment, but this had been put on hold. We were told that equipment was used until it broke, before replacement was considered. This was not on the risk register.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Key performance indicator dashboards and assessments were available to them. Managers used meeting agendas to address quality sufficiently. We saw examples of agendas for meetings both at a divisional and local level. Senior managers told us detailed quality data and performance information was provided at these meetings.

Notices were displayed on wards informing patients of how their information was used by the hospital in line with general data protection regulations.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust engaged with staff through multiple channels. Staff we spoke with were aware of trust-wide communication emails and bulletins.

Patients' views and experiences were gathered and acted on to shape and improve the services and culture. Patients were able to give feedback on their experiences through the NHS friends and family test. Results were mostly above 90% for surgical wards in May 2017. These were supplemented by the patient engagement network interviews which provided real time feedback on experience. The real time patient survey collected feedback from patients when they were still in hospital. We saw the results of these services for each ward. One common theme reported by patients related to noise at night, and we saw that the trust provided ear plugs and eye masks for patients following this feedback. We also saw that the lowest scoring area involved medication information provided to patients. A poster was made which provided information on medication for display on ward drug trolleys and in patient bays. A subsequent real-time patient survey

showed an improvement in patients' understanding of medication information.

The trust's feedback and engagement team were available Monday to Friday from 9am to 4pm, by telephone, freephone, text or email. The trust also had a leaflet which provided detailed information about our services and how to complain if required.

The trust had links to organisations which could provide additional support to patients and carers. This included local support groups, drug and alcohol support, as well as links to national charities such as the Alzheimer's Society and cancer charities.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service made use of internal and external reviews, and learning was shared effectively and used to make improvements.

The trust had strengthened its focus on quality improvement (QI) and engaged more staff in this approach through training over the last year, and this was confirmed by the medical staff we spoke with. The projects had improved patient experience in hospital, reduced waiting lists, and improved the efficiency of trust clinical processes. For example, in the day surgery emergency service, the team had expanded its service for more complex conditions such as cholecystitis and appendicitis. This had reduced waiting times for emergency procedures, improved the quality of care delivered, reduced the workload on the dedicated emergency operating theatre, and released hospital beds. The day case team had also provided a service for total hip replacements (building on the successful partial knee replacements service). This was a treatment pathway enabling patients to undergo a hip replacement as a day-case patient.

Clinicians had won a prize for the use of ultrasound investigations to provide imagery during keyhole surgery of gallbladder removal in Torbay Hospital. The technique allowed clinicians to detect and remove any gallstones that had passed out of the gallbladder during gallbladder removal and reduced the risk of any harm caused by these gallstones.

Maternity

Facts and data about this service

Maternity services at Torbay and South Devon NHS Foundation Trust provide antenatal, intrapartum and postnatal maternity care at Torbay Hospital and in local community settings across South Devon. There are 29 maternity beds at Torbay Hospital and two birthing rooms at Whitelake Unit at Newton Abbot Hospital.

The trust reported 2,042 babies were born at the trust from October 2018 to September 2019. During this inspection we inspected maternity services at Torbay Hospital and Whitelake Unit at Newton Abbot Hospital. The service also provided community maternity services to women across South Devon. The Special Care Baby Unit was located alongside the maternity unit providing level one care to babies (level one care is for babies who need extra monitoring but do not need intensive care). Babies who needed level two care or higher were transferred to the closest local hospital with these facilities.

We inspected the following areas at Torbay Hospital:

- Delivery Suite with seven ensuite rooms including one with a birthing pool.
- John Macpherson antenatal and postnatal ward with 20 beds.
- Antenatal clinic and day assessment unit.
- Mary Delve bereavement suite.

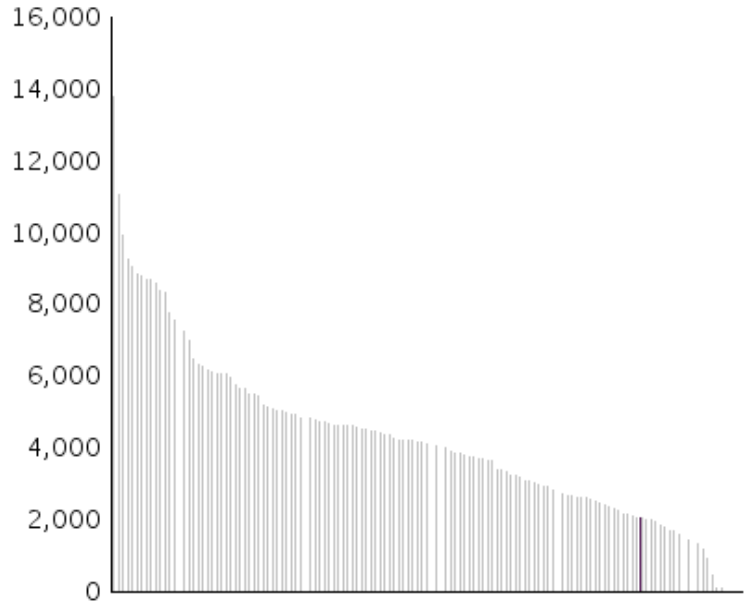
We also inspected Whitelake Unit with two birthing rooms, one of which has a birthing pool, at Newton Abbot Hospital.

During the inspection, we observed care provided by staff and spoke with fourteen women about their care and treatment and three relatives or partners of women receiving care. We spoke with 67 staff including the head of midwifery, matron, the clinical director, obstetricians, anaesthetists, theatre staff, the risk and governance midwife, junior through to senior midwives, specialist midwives, maternity support workers, maternity voices partnership lead and domestic staff.

We attended three handover meetings, reviewed eighteen care records and analysed data provided to us by the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below:

Number of deliveries at Torbay and South Devon NHS Foundation Trust – Comparison with other trusts in England.



(Source: Hospital Episode Statistics (HES))

A profile of all deliveries and gestation periods from July 2018 to June 2019 can be seen in the tables below.

Profile of all deliveries (July 2018 to June 2019)			
	Torbay and South Devon NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	2,070	99.0%	98.6%
Multiple	25	1.0%	1.4%
Mother's age			
Under 20	70	3.3%	2.9%
20-34	1,615	77.3%	74.5%
35-39	330	15.8%	18.5%
40+	75	3.6%	4.1%
Total number of deliveries			
Total	2,090		571,848

(Source: Hospital Episode Statistics, July 2018 to June 2019)

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.

Gestation periods (July 2018 to June 2019)			
	Torbay and South Devon NHS Foundation Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Gestation period			
Under 24 weeks	*	*	0.8%
Pre term 24-36 weeks	*	*	7.4%
Term 37-42 weeks	1,960	94.2%	91.6%
Post Term >42 weeks	*	*	0.1%
Total number of deliveries with a valid gestation period recorded			
Total	2,085		448,170

(Source: Hospital Episode Statistics, July 2018 to June 2019)

Notes: This table does not include deliveries where delivery method is 'other', 'Missing' or 'unrecorded'. Gestation periods were unrecorded for 0.4% of deliveries at this trust compared to 21.6% nationally.

To protect patient confidentiality, figures between one and seven have been suppressed and replaced with "*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed. Values (including totals) greater than seven have been rounded to the nearest five with the delivery rate calculated with the rounded figures. This does not apply to the 'other/unrecorded' method of delivery as patients are not identifiable.

Please note because row/column totals will be calculated and then rounded, the total of rounded values may differ from the rounded total, and row/column percentages may sum to more than 100%, as in row E above.

(Source: Hospital Episode Statistics (HES))

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to staff and had processes to make sure midwifery staff completed it. However, medical staff were not always up to date with training.

Mandatory training completion rates

Midwifery staff received and kept up-to-date with their mandatory training. This had improved since the last inspection. The trust set a target of 85% for completion of mandatory training for all courses except for information governance, which had a trust target of 95%. The trust reported training performance on a rolling month by month basis.

Midwifery staff compliance with mandatory training modules from December 2018 to November 2019 was 90%. Of the training modules provided six achieved compliance and two failed to reach the trust target.

One module failed to score above 75%.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance <75 %	Trust Target Met	Compliance change when compared to previous year
Conflict resolution	98	70	71%	✗	↓

The midwifery team worked as an integrated team so midwives who worked at the hospital or in the community received the same training programme.

Medical staff received but were not always up-to-date with their mandatory training. The compliance for mandatory training modules from December 2018 to November 2019 was 70% at trust level for medical staff in maternity. Of the training modules provided two achieved compliance and six failed to reach the trust target.

Five modules failed to score above 75% as outlined below.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Medical staff mandatory training compliance below 75%:

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance <75 %	Trust Target Met	Compliance change when compared to previous year
Fire Safety 2 years	16	11	69%	✗	↑
Infection Prevention (Level 2)	16	10	63%	✗	↓
Equality and Diversity	16	9	56%	✗	→
Conflict Resolution	16	9	56%	✗	↑
Health and Safety (Slips, Trips and Falls)	16	9	56%	✗	→

(Source: Routine Provider Information Request (RPIR) – Training tab)

The mandatory training was comprehensive and met the needs of patients and staff. All staff attended a health and safety day which included basic life support and neonatal life support training. Midwives and obstetricians undertook further role specific training called practical obstetric multi-professional training (PROMPT), this included fetal monitoring training. The study days were multidisciplinary with midwives, midwifery care assistants and medical staff attending. Mandatory training for clinical staff included sepsis awareness.

Staff were up-to-date with mandatory training courses specific to maternity. The January to March 2020 training report showed: 95% of midwives and 100% of medical staff had completed the health and safety training day, 96% of midwives and 94% of medical staff had completed cardiotocography (CTG) training and 95% of midwives and 94% of medical staff had completed PROMPT training.

Managers monitored mandatory training and alerted staff when they needed to update their training. The practice development midwife ensured staff were up to date with mandatory training by booking staff on two mandatory study days every year. Midwives we spoke with confirmed they had enough time to complete mandatory training.

Clinical staff received some mandatory training on how to recognise and provide a first response to patients with mental health needs or learning disabilities. The perinatal mental health team delivered a mental health update every year as part of mandatory training. The perinatal mental health team told us this was the only mental health training staff received and was a brief introduction rather than comprehensive training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Midwifery staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff were not all up to date with their safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with could give examples of identifying

safeguarding concerns and knew how to make a safeguarding referral and who to inform if they had concerns. Community midwives and hospital staff supported people who experienced domestic abuse. Women attending the antenatal clinic were seen privately to discuss any concerns. The service monitored staff compliance to ensure women were always asked about domestic abuse at an antenatal appointment and this audit was shared with staff at the senior midwives meeting. There were discreet posters in the maternity unit to encourage people to access support.

Safeguarding needs were identified during the antenatal booking process to identify at risk women and the Local Authority would be notified where necessary. Where child protection concerns were identified the lead midwife for safeguarding would liaise with the relevant Local Authority. There were procedures to protect children who were to be placed in the care of the Local Authority and we observed these procedures during our inspection.

Midwives on the unit and the community had access to safeguarding supervision provided by the safeguarding lead midwives or community team leaders. The supervision enabled midwives to reflect on the safeguarding needs of women they cared for. All staff undertook training in recognising and responding to female genital mutilation (FGM) and child sexual exploitation (CSE) which was included in mandatory safeguarding training.

A safeguarding lead midwife and a named safeguarding midwife were available to support staff to manage safeguarding. Midwifery staff we spoke with were aware of the safeguarding leads but most medical staff we spoke with were not.

There was an abduction policy and staff told us they followed the guidelines set out in the policy and the hospital security team and the police were notified. The service had not recently carried out baby abduction drills with staff to tests the effectiveness of the procedure, which would be in line with good practice.

Midwifery staff received training specific for their role on how to recognise and report abuse. The compliance for safeguarding training modules from December 2018 to November 2019 was 84% at Torbay Hospital for qualified midwifery staff in maternity. Of the training modules provided three achieved compliance and two failed to reach the trust target.

Safeguarding training completion rates

The trust sets the following targets for the safeguarding courses for which medical and midwifery staff are eligible.

- 90% for safeguarding levels 1
- 80% for safeguarding level 2 and 3

The tables below include Prevent training as a safeguarding course, which had a trust target of 85%. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

The compliance for safeguarding training modules from December 2018 to November 2019 was 89.5% at Torbay Hospital for midwifery staff in maternity. Of the training modules provided three achieved compliance.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children (Level 2)	1	1	100%	✓	N/A
Safeguarding Adults (Level 1)	98	95	97%	✓	→
Basic Prevent Awareness	98	94	96%	✓	→
Safeguarding Adults (Level 2)	98	87	89%	✓	→
Safeguarding Children (Level 3)	97	74	76%	✗	→

Medical staff received training specific for their role on how to recognise and report abuse, but were not always up to date with training updates. The compliance for safeguarding training modules from December 2018 to November 2019 was 61% at Torbay Hospital for medical staff in maternity. Of the training modules provided none achieved compliance.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Basic Prevent Awareness	16	12	75%	✗	↑
Safeguarding Adults (Level 1)	16	12	75%	✗	↑
Safeguarding Adults (Level 2)	16	12	75%	✗	→
Safeguarding Children (Level 2)	5	3	60%	✗	↓
Safeguarding Children (Level 3)	11	0	0%	✗	→

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust provided data during the factual accuracy process with safeguarding training data for nine obstetricians, of these seven had completed foundation and refresher courses for safeguarding children (level 3) and two were due to complete refresher courses. However, as the original data from the trust submitted in the RPIR was for 16 medical staff this was not sufficient assurance that medical staff were up to date with safeguarding children level 3 training.

Cleanliness, infection control and hygiene

The service usually controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They generally kept equipment and the premises visibly clean.

At the last inspection we found the infection control policy was not always fully complied with. This had improved. However, we found some items of equipment were visibly dusty.

Ward areas were visibly clean and had suitable furnishings which were clean and well-

maintained. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. For example, we saw cleaning records were completed consistently in all areas of John McPherson ward. However, we found visible dust on equipment in some areas. For example, a table used for serving breakfast on John Macpherson ward had thick dust underneath. We raised this with the head of midwifery at the time and the table was cleaned immediately and a reminder to staff arranged. In the antenatal clinic we found a fan with a thick layer of visible dust.

At the last inspection we found hand hygiene audits were not always completed. This had improved. Data showed senior midwives completed hand hygiene audits the delivery suite, antenatal clinic and John Macpherson ward every month. We saw staff washed their hands or used hand sanitiser gel before patient contact. Handwashing facilities and hand sanitiser gel were available throughout wards for staff and visitors to use.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed all staff were bare below the elbow in clinical areas and protective equipment was used appropriately. Staff had access to gloves and aprons stored throughout all clinical areas. We saw staff using PPE when providing care and treatment to women. We observed staff washing their hands before contact with women. This was in line with National Institute for Health and Care Excellence (NICE) QS61 statement 3.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was visibly clean most of the time and staff used ‘I am clean’ stickers to show the date of cleaning and that equipment was ready for use.

The birth pool on the delivery suite was visibly clean. The procedure for cleaning the birthing pool was displayed in the room and staff we spoke with were aware of the cleaning procedure.

The service did not include data on the incidence of puerperal sepsis and other puerperal infections within 42 days of delivery or readmission rates for infections in mothers and babies on the maternity dashboard.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, areas throughout the service needed updating and modernising and staff did not always complete checks of emergency equipment.

The design of the environment followed national guidance. There was one obstetric theatre that was easily accessible from the delivery suite. The delivery suite was located next to the main surgical theatres for the hospital and a second theatre could be accessed in an obstetric emergency.

The service had suitable facilities to meet the needs of women's families. Areas had been refurbished in recent years, with the exception of the delivery suite which was ageing and in need of refurbishment. The trust told us this was part of the trust refurbishment programme. The flooring in the delivery suite was due for replacement and this was noted in the last inspection report. The flooring had recently been reviewed by a microbiologist and the need for replacement added to the risk register.

The maternity unit was secure to ensure the safety of women and children. Staff gained access to the unit through a swipe card system. Visitors to the unit gained entry through an intercom system and there was CCTV above all entrances to the unit. Midwives could monitor the CCTV of entrances to the unit as this was displayed by the main desk on delivery suite. Notices were displayed on ward doors to remind visitors not to let anyone in before staff had identified them.

All areas of the maternity service had access to specialist emergency equipment. However, staff did not always carry out daily safety checks of the equipment. During our last inspection we found daily checks were not always completed on emergency resuscitation trolleys, this had not improved. There was a risk the equipment may have expired, be unavailable or in need of repair. For example, on John MacPherson ward, there were two daily checks missing for February 2020. The resuscitation team regularly audited completion of daily checks and the audits of equipment on John MacPherson ward was failed in October 2019 (with 16 daily and five weekly checks missing) and January 2020. Ward managers were responsible for ensuring equipment checks were completed.

In the community, at the Newton Abbott Hospital, daily checks on the resuscitation trolley were not always completed. We observed for January 2020 two missing checks, February 2020 one missing check and as at 10 March 2020 one missing check. At this site there was one audit of the resuscitation checks, by the resuscitation team, on 3 April 2019 and none thereafter.

We also reviewed the adult resuscitation trolley in antenatal clinic and the delivery suite and found no omissions of daily or weekly checks January 2019 to March 2020.

Staff received training in evacuation of the birth pool through a video training session.

Women could reach call bells and staff responded quickly when called. Women we spoke with confirmed midwives responded to call bells in a timely way.

The service had enough suitable equipment to help them to safely care for women and babies. Ward staff had the equipment they needed to do their job and women told us they had all they needed to care for their babies. Staff in the community told us they had good access to equipment. They had their own antenatal kit with everything they needed. The community midwives were responsible for ensuring the maintenance of their equipment took place as needed. They told us there was a procedure for faulty equipment. The service had access to bariatric equipment and all women requiring this equipment were seen at the main site, and not in the community.

Electrical safety testing was completed most of the time. We reviewed a randomly selected sample of equipment on delivery suite and John MacPherson ward and found all items were up to date with electrical safety testing. However, we found a fan on the antenatal unit which was overdue for electrical safety testing.

Staff disposed of clinical waste safely. Waste was segregated and managed according to the risk of infection. Sharps boxes were labelled appropriately, not overfilled, closed and tagged to prevent access to discarded sharp items.

Staff had access to equipment to make lone-working safer. Community midwives and midwifery support workers working in the community carried lone worker alarm systems.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks most of the time. However, staff did not always use tools to identify risk of deterioration, and escalate these risks, consistently.

Staff used a nationally recognised tool to identify women at risk of deterioration, but these were not always used appropriately. There were processes to identify and respond to changing risk, deteriorating health and medical emergencies. Staff completed the Maternity Early Obstetric Warning Scores (MEOWS) to monitor and recognise the deteriorating patient, including those at risk of developing sepsis. However, this was not always used consistently.

At the last inspection records documenting deterioration in health were not consistently completed and escalated correctly. The service had worked to improve this, but the changes were not fully embedded. We reviewed 17 MEOWS charts of which five were not completed or not fully completed and 12 were completed correctly.

We reviewed the care of a woman who was transferred and found they did not have a MEOWS chart completed for almost ten hours following having a raised temperature.

The service audited completion of MEOWS charts. MEOWS audits showed MEOWS charts were not always escalated appropriately. The service set an aspirational target of 95% and a realistic target of 80%).

The service noticed a deterioration in three aspects of the MEOWS chart completion in November 2019: yellow rated observations completed in one hour, documentation of escalation if MEOWS triggered and whether the woman was seen by a doctor. Following the deterioration in performance the service started sampling between four and eleven MEOWS charts every week. Data from the MEOWS sampling showed between 11 November 2019 and 2 March 2020 there were nine instances (out of 22) where MEOWS charts showed escalation should have occurred but did not, and nine cases (out of 22) that were applicable for a doctor referral, but a doctor referral was not completed.

Staff monitored fetal heartbeat and uterine contractions using individual cardiotocograph machines. Staff used the ‘fresh eyes’ approach where another member of staff reviewed cardiotocograph readings every two hours. A sticker was put in the record to show this had been done in most of the records we reviewed. However, in five of 13 records we reviewed use of fresh eyes was not recorded.

Staff carried out comprehensive risk assessments for women at the time of their first antenatal appointment. These included regular risk assessments for raised BMI (body mass index), smoking, gestational diabetes and pre-eclampsia, mental health issues and pre-existing health problems, vulnerable circumstances or environmental risks. Risk assessments were continually evaluated throughout a woman's pregnancy. Community midwives held a register of all women with risk factors. If a woman reported reduced fetal movements, midwives arranged an urgent scan at the antenatal clinic.

Staff knew about and dealt with any specific risk issues such as sepsis and venous thromboembolism. Staff risk assessed women’s risk of venous thromboembolism at booking, on arrival in labour and during post-natal care in line with national guidance. All eighteen records we reviewed showed venous thromboembolism risk assessments had been completed.

Staff shared key information to keep women safe when handing over their care to others. Staff used the SBAR (situation, background, assessment, recommendation) technique to share information. However, on John MacPherson ward we observed a telephone handover from the delivery suite where the senior midwife in charge was calling the delivery suite to clarify a miscommunication. John MacPherson ward midwives told the woman transferring had 200ml blood loss, but the post-operative notes said the woman had post-partum haemorrhage.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed a consultant led handover on the delivery suite and found the care of all women, including high risk women and women who were going to have induction of labour and saw the care of all women was discussed.

However, medical staff we spoke with raised concerns about the staggered handover times leading to confusion, especially where consultants did handover over the phone and plans for

women were changed. On the delivery suite there was a midwifery handover at 7.30am and a medical handover at 8.30am attended by doctors and band 7 midwives and at 11am there was a safety huddle to check on activity and risks. Anaesthetists attended handovers at 8.30am, 1pm, 6pm and 7:30pm.

Medical staff we spoke with told us they had good access to referrals to other medical specialities. Staff could access the trust wide critical care outreach service to review women whose health had deteriorated.

Triage

Staff completed risk assessments for each woman on admission / arrival and updated them when necessary and used recognised tools. Women could call the delivery suite 24 hours a day, seven days a week if they had urgent concerns. A midwife would make an initial assessment for each woman expected on the unit. This information was handed over to midwives working on the unit, so they were able to prioritise care and treatment.

Theatres

There were arrangements to ensure checks were made before and after surgical procedures. This included the World Health Organisation (WHO) checklist, used to identify risk factors, before a procedure. The use of the checklist is a requirement of the National Safety Standards for invasive procedures, introduced by NHS England in 2015 to improve patient outcomes. We observed a caesarean section and found good practice use of WHO checklist – time out called, and swab count recorded on whiteboard and on paper record.

At the last inspection there was no audit to confirm World Health Organisation (WHO) checklist was used in obstetric theatres. In response to a data request following the current inspection to request the last six months of audit data we were provided with audit minutes from September 2018. This evidenced the service completed a retrospective review of WHO checklists in the obstetric theatres for February – April 2018 after lack of auditing of WHO checklists was identified at the last inspection in February 2018. The results of the audit showed 95% compliance, it was unclear from the minutes if the audit process continued as there was reference to no further audit work being required. The trust confirmed theatres developed an ongoing process for auditing so there was no requirement for the maternity service to complete this separately. The trust did not submit any further evidence of obstetric theatre WHO audits, which were requested for the previous six months leading up to our inspection.

As part of the factual accuracy return the trust were able to provide audit data from January 2019 to March 2020. The trust's audit was a simple tally of procedures completed and compliance of WHO forms which showed 100% compliance for all months. With full compliance it was difficult to establish how actions were monitored if areas for improvement were identified.

The service had staff trained to carry out cell salvage (a process to collect blood from an operating site which was then processed in a cell salvage machine and given back to the patient as an autologous transfusion). This meant patients would not react to blood products given to them during their surgery as it was their own blood being transfused back to them.

Mental Health

The service included 24 hours a day, seven days a week access to mental health liaison in the maternity unit if staff were concerned about risks associated with a patient's mental health. However, staff told us maternity was not prioritised and the target response time was within 24 hours of referral.

Staff completed or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff used an initial screening tool to identify mental health risks and flagged these to the perinatal team, who completed full mental health risk assessments. The perinatal mental health team were not a crisis service and so out of hours and in emergencies people were supported by psychiatric liaison.

Nurse and midwifery staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing, midwifery and support staff to keep patients safe. At the time of inspection, the service had only two vacancies not recruited to. This was due to an increase in retirement in the last year with six retirements.

The minimum staff requirements for the service were nine midwives per shift (for three shifts a day, three maternity care assistants on early and late shifts, two maternity care assistants on the night shift. The December monthly staffing report showed the minimum staffing levels for midwives and maternity care assistants was met 62% of the time (58 out of 93 shifts). The report noted there was a significant rise in sickness absence. With the exception of the Christmas period, where there was some short notice sickness, the service was generally able to meet staffing requirements through use of bank and overtime. In December 2019 while the service did not always meet minimum planned staffing requirements the birth rate plus acuity tool showed 92% of the staffing levels met the acuity levels of the women using the service.

Managers accurately calculated and reviewed the number and grade of midwives and maternity care assistants needed for each shift in accordance with national guidance. During the inspection we observed an up-to-date staff rota which demonstrated a number of unfilled shifts. There was escalation plans to ensure safe staffing at all times, especially at short notice; these included an on call rota for senior members, and managers, of the team.

The board reviewed the midwifery establishment regularly in line with NICE guidance, NG4 (2015) recommendation that the board should review it every six months. We saw the midwifery staffing oversight report was viewed at the March 2020 board meeting. The Chief Nurse, System Director of Nursing and the Head of Midwifery met every three months to review monthly midwifery staffing summary reports that included the staffing establishment, sickness rates, red flag issues, escalation and actions.

The table below shows a summary of the nursing and midwifery staffing metrics in maternity at Torbay Hospital compared to the trust's targets, where applicable:

	Maternity annual staffing metrics						
	November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	135	-2%	16%	5.2%			
Midwifery staff	79	-1%	12%	5.3%	3,428 (4%)	0 (0%)	054 (<1%)

Note: Vacancy rates under 0% signify when the trust were over established in a particular year.

The ward manager could adjust staffing levels daily according to the needs of women. The percentage of women who had one to one care during labour was recorded on the maternity dashboard and was achieved over 95% of the time April 2019 to January 2020 except in November 2019 when performance was 94%.

The number of nursing staff, midwifery staff and healthcare assistants matched the planned numbers. Staffing numbers were displayed on boards outside all ward areas. The labour ward coordinator was supernumerary. Data from the December 2019 staffing report showed there were nine instances recorded on the acuity tool where the delivery suite co-ordinator was not supernumerary for the whole of the shift. For three out of the nine instances minimum staffing levels were below nine midwives. The co-ordinators would usually provide care to a woman with low acuity in these instances and return to being supernumerary as soon as possible afterwards.

Maternity duty rotas were completed eight weeks in advance. This gave managers time to ensure an appropriate skill mix and consider any supervision requirements and flexible working agreements.

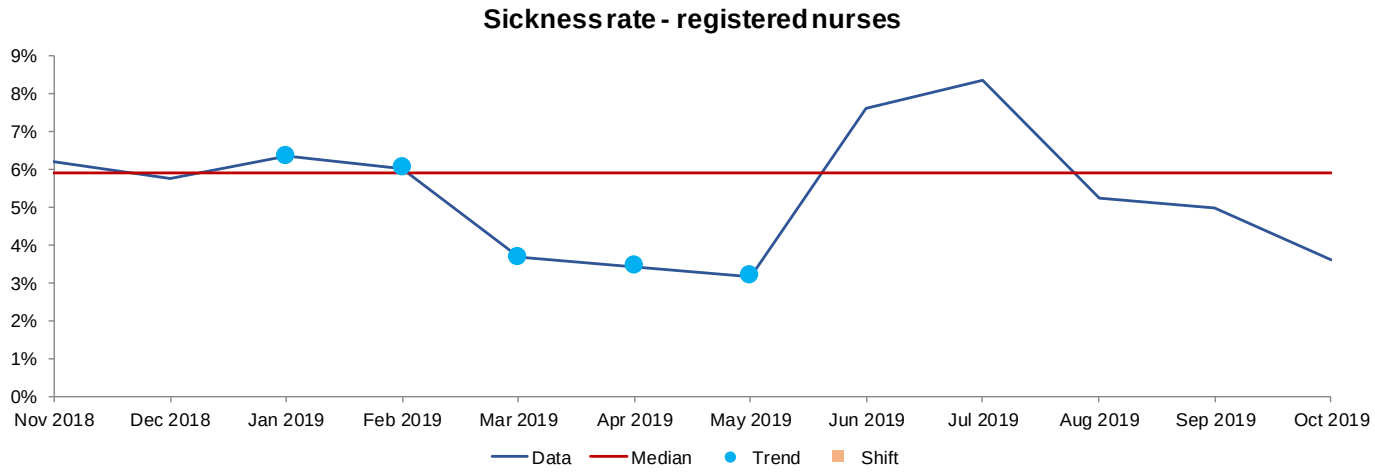
Nursing and midwifery staffing rates within maternity at Torbay Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, bank use or agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The service had low vacancy rates and turnover rates.

Sickness rates

The service had reducing sickness rates overall.



Monthly sickness rates over the last 12 months for registered nurses showed a downward trend from January 2019 to May 2019.The March 2020 board report stated sickness had been as high as 8% due to some long-term sickness, however this was now reducing.

Bank and agency staff usage

The service had low rates of bank and agency nursing and midwifery staff. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Most of the bank staff used by the service were previously employed members of staff who had retired and returned to work on the bank.

Midwife to birth ratio

From July 2018 to June 2019 the trust had a ratio of one midwife to every 24.7 births. This was similar to the England average of one midwife to every 24.6 births.

(Source: Electronic Staff Records – EST Data Warehouse)

Medical staffing

The service had enough medical staff most of the time with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, at the time of the inspection consultant medical staffing did not meet the planned number.

The service had enough medical staff to keep patients safe most of the time. Consultant hours on the labour ward were consistently between 43 and 46 hours every month between December 2018 and November 2019. This met the Royal College of Gynaecologists and Obstetricians Good Practice Guideline (2010) which recommends consultant cover for a unit with less than 2500 births a year is 40 hours per week. Consultant cover was planned between 8.30am to 5pm on weekdays and 8.30am to 1.30pm on weekends.

On-call consultant cover was available from 5pm to 8.30am provided by a rota of seven consultants. At the time of the inspection there were seven obstetrics and gynaecology consultants, of which two were on sick leave. A locum consultant was being arranged to support and non-urgent planned gynaecological work was being reduced to ensure there was enough

staff to cover all emergency work.

On call consultants covered maternity and gynaecology so were not always present on the delivery suite as they worked across maternity and gynaecology services. Staff we spoke with told us there was not much consultant presence on the delivery suite.

The medical staffing did not always match the planned number. There were six speciality level trainee doctors at the time of inspection but eight were needed for a compliant rota. Trainee doctors we spoke with told us this had an impact on training as they were pulled to cover the on call rota to cover in other areas. This meant they could not attend clinics which they attended in a supernumerary capacity for learning and development.

Medical staff we spoke with were concerned about medical staffing at night. There were nine registrars, with two of these working part time. Only one registrar working at night supported by the on call consultant who was not on site but would come in if needed.

Anaesthetic staff were based in the maternity unit every day until 5pm. After 5pm anaesthetists working across the hospital were available to immediately attend the maternity unit. This met the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guideline which states a duty anaesthetist must be immediately available on the labour ward 24 hours a day, seven days a week.

The table below shows a summary of the medical staffing metrics in maternity at Torbay Hospital compared to the trust's targets, where applicable:

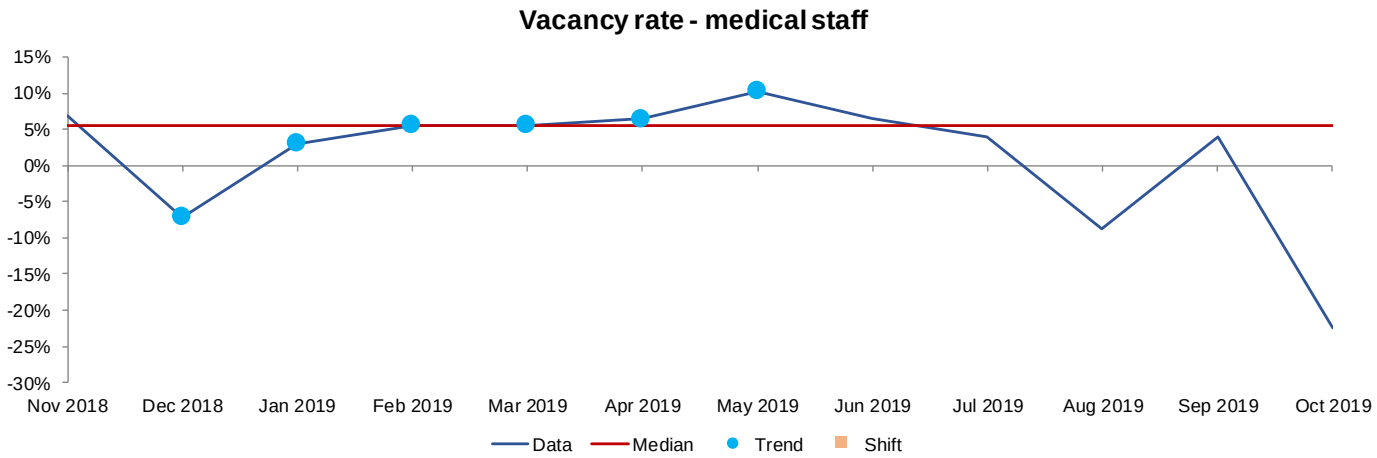
	Maternity annual staffing metrics November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	135	-2%	16%	5.2%			
Medical staff	16	1%	64%	2.6%	1,516 (1%)	484 (<1%)	144 (<1%)

Note: Vacancy rates under 0% signify when the trust were over established in a particular year.

Medical staffing rates within maternity at Torbay Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use or agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Vacancy rates



Monthly vacancy rates over the last 12 months for medical staff show an upward trend from December 2018 to May 2019. This could be an indicator of deterioration.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The service had low turnover rates for medical staff.

Sickness rates

The service had low sickness rates for medical staff overall. However, two out of eight consultants were on sick leave at the time of inspection.

Bank and locum staff usage

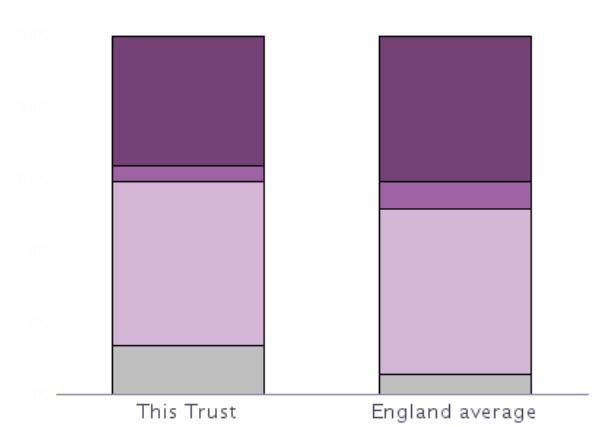
The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. For example, a locum consultant was being recruited at the time of inspection to cover shortfalls in consultant staffing. Managers made sure locums had a full induction to the service before they started work.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In October 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 22.1 whole time equivalent staff working in maternity at Torbay and South Devon NHS Foundation Trust.



	This Trust	England average
Consultant	36%	40%
Middle career^	5%	8%
Registrar group~	46%	46%
Junior*	14%	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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. Maternity records were a combination of hand held paper records, written paper records and electronic records. Pregnant women had hand held records (a file of all the information related to their pregnancy) which was started at their first antenatal booking appointment. The service employed a digital midwife to progress plans to prepare for a paperless electronic records system. We reviewed 18 sets of women’s records and found all records were legible, dated, timed and signed.

When women transferred to a new team, there were no delays in staff accessing their records. Community midwives were contacted when a woman was discharged, and an electronic discharge summary sent to the GP. The service had created letter templates to ensure more detailed information was sent to GPs.

Records were stored securely. In the antenatal clinic records were stored in a locked room and no records were left unattended.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, systems to ensure medicines available were within expiry dates were not always followed.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Regular balance checks were performed in line with trust policy. Staff monitored the temperature of treatment rooms and when the temperature in the delivery suite treatment room was high a hot air extractor was provided.

Staff recorded minimum and maximum medicines fridge temperatures every day. Pharmacy technicians regularly checked stocks medicines cupboards and removed expired or unused stocks and returned to pharmacy.

Staff reviewed women's medicines regularly and provided specific advice to women and carers about their medicines. Patients received medicines advice from midwives and doctors throughout their stay and on discharge. Staff could contact a pharmacist for additional advice via phone or email. We reviewed a sample of drug charts and found these were completed regularly and accurately. The drug chart has a dedicated page for PRN (pro re nata) or 'when required' dose medicines making easy review of use. The ward pharmacist checked safe use of drugs in breast feeding mothers.

Staff stored and managed medicines and prescribing documents in line with the provider's policy most of the time. We found opened bottles of oxycodone liquid and morphine oral solution with no opened date stickers. We raised this with the pharmacy technicians on the unit and the chief pharmacist at the time of inspection and they agreed all liquid medicines should have an opened date recorded on the bottle to ensure staff could find out the expiry after opening.

Staff followed current national practice to check women had the correct medicines. Policies and procedures were available and accessible to staff via the trust intranet. Staff had access to the British National Formulary and medicines guidelines in the treatment room. Staff also had access to an application used to provide antimicrobial prescribing guidance.

Patient Group Directions (PGDs) complied with national legislation and were reviewed regularly.

PGDs used in antenatal clinic were kept in a folder next to where the medications were kept. The common ones administered were aspirin and omeprazole. All PGDs we reviewed were in date.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. For example, staff could describe the range of events which should be reported. This included, for example, medication errors, unintended outcomes such as significant blood loss in labour and 'near misses.' Staff were familiar with the incident reporting procedure and told us it was easy to use, and they were encouraged to use it. Managers we spoke with felt there was a good reporting culture; all midwives understood their responsibility to report concerns or mistakes. Learning from incidents was shared at senior midwives' meetings, handovers and by email.

Never events

The service had no never events on any wards. 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 2018 to November 2019, the trust reported no never events for maternity.

(Source: Strategic Executive Information System (STEIS)

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from December 2018 to November 2019. All three were classed as baby only maternity/obstetric incidents.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff and managers were able to describe the circumstances in which the duty of candour would apply. We saw evidence in the three serious incident investigations we reviewed duty of candour was followed and women had the opportunity to input questions into the investigation.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We reviewed three serious investigations and found learning was identified and action plans developed.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback from incidents which they had reported and those which had occurred in the maternity service. Staff we spoke with at Whitelake Unit at Newton Abbot Hospital told us learning from incidents was received from the main hospital site and discussed within the community teams. The community team had a closed and secure social media group to keep each other informed of any updates. Medical staff received learning from incidents via email or through Thursday afternoon teaching sessions.

Staff met to discuss the feedback and look at improvements to women's care. Staff discussed incidents at monthly senior midwife meetings. There was evidence changes had been made as a result of feedback. For example, following an incident where a woman had declined screening, staff were reminded that all women should be seen by the screening midwife, if women are needle phobic clinical psychology can support all cases where screening is declined should be recorded.

Managers debriefed and supported staff after any serious incident.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Safety thermometer data was displayed on wards for staff and women to see. The safety thermometer data showed the service achieved harm free care within the reporting period. The safety thermometer data showed the service achieved harm free care within the reporting period. The John Macpherson ward safety thermometer data for March 2019 to February 2020 demonstrated the service achieved 100% harm free care in all months except April 2019 where performance was 93%. Staff used the safety thermometer data to further improve services.

The service did not use the maternity specific safety thermometer.

Is the service effective?

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed the following guidelines and care pathways: management of post-partum haemorrhage, security in the maternity unit, fetal monitoring, anaesthetic and caesarean section guidelines. All guidelines we reviewed were up to date and included clear pathways for treatment and referenced the appropriate National Institute for Health and Care Excellence (NICE) clinical guidelines.

Guidelines were reviewed at maternity clinical governance meetings. Minutes of the January 2020 meeting showed four anaesthetic policies and guidelines were overdue for review and four obstetric guidelines were out of date.

Community midwives had access to a computer to review maternity guidelines. They were informed of important policy and guideline updates at meetings or by email. The midwives used their personal phone and had Wi-Fi data to access relevant information.

The service was implementing NHS England's 'Saving Babies Lives version two and the Perinatal Institute's Gestation Related Optimal Weight (GROW) guidance. Out of 16 records we reviewed, 11 had growth and height of the baby plotted but five did not. At the time of the inspection the service had only re-started plotting growth charts for the past week. This was because the service had been updating the 'growth scan in pregnancy policy.' The February 2020 senior midwives meeting minutes noted that from end March 2020 sonographers will be plotting estimated fetal weight on customised growth charts. This would enable the service to recognise where the normal growth velocity was not being met and would prompt the service to put the woman on the high risk pathway for antenatal monitoring. If there were changes in growth of the baby women were referred for further scans.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Staff raised any concerns about a woman's mental health with the perinatal mental health team or safeguarding midwives.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We attended a handover meeting on John Macpherson ward and saw emotional needs were discussed alongside physical health needs.

Nutrition and hydration

Staff gave women 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 women's religious, cultural and other needs. The service had achieved Level 3 in the Unicef Baby Friendly accreditation scheme.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff used a nationally recognised screening tool to monitor women at risk of

malnutrition. At meal times, women had a choice of meal options, including gluten free and diabetic menu choices. Snacks and drinks could be bought from vending machines at the entrance to the delivery suite. On John MacPherson ward, women could make their own hot drinks and had access to snacks.

Specialist support from staff such as dietitians was available for women who needed it. For example, for women with a raised BMI.

Women were supported to feed their babies well. Women we spoke with were very positive about the support for breastfeeding they received from midwives and maternity care assistants. On discharge women were given information about local breastfeeding support groups. Staff were reassuring, supportive and knowledgeable, and maternity care assistants were available at all times to assist as well as nursery nursing assistants on the transitional care ward. Staff took time to discuss feeding options available, including breast and bottle feeding.

An infant feeding specialist was available to support women. The infant feeding specialist was part of the National Infant Feeding Network and shared policies and guidelines with other maternity units in the South West.

Written information was readily available for both methods of feeding. We saw information boards, on all wards, displaying illustrations / photos of breastfeeding positions and methods. We observed staff assisting women to feed their babies. Women who could not breastfeed were supported to express milk.

Staff provided guidance for women to express milk. We saw expressed milk stored in a secure milk fridge, correctly labelled and only containing breast milk.

Breast feeding initiation at delivery for 2019 year was 76% against a target of 73%.

Data from the maternity dashboard for April 2019 to February 2020 showed the percentage of women who initiated breast feeding within one hour or 48 hours after birth was consistently above 70% and was also consistently above 70% at discharge for most months but performance dropped to 64% in November 2019.

The service had achieved Level 3 in the UNICEF Baby Friendly accreditation scheme and was working towards gold accreditation.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women told us they received pain relief soon after requesting it.

Women had a choice of pain relief options including: transcutaneous electrical nerve stimulation (TENS) machines, medical gas and air, strong opioid injection and epidurals. The service also provided aromatherapy and use of a birthing pool on the delivery suite and at Whitelake Unit at Newton Abbot Hospital, if it was deemed safe for women to use.

Staff prescribed, administered and recorded pain relief accurately. Pain scores were included on all the observation charts we reviewed.

The service monitored the number of epidurals in labour on the maternity dashboard but did not include data on waiting times for epidurals which should be less than 30 minutes in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The service completed an audit

to evidence compliance and provided data for October and November 2019. Performance was 20 minutes in October 2019 and 26 minutes in November 2019 of time from calling to arriving, which met the AAGBI standard.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. For example, the national neonatal audit programme and the national maternity and perinatal audit programme. Outcomes for patients were positive, consistent and met expectations, such as national standards. The service worked to reduce stillbirths by implementing guidance in NHS England's Saving Babies Lives a care bundle for reducing perinatal mortality version two and following Gestation Related Optimal Weight (GROW) guidance.

It demonstrated a number of performance metrics relating to numbers and types of delivery, staffing and clinical indicators. Clinical indicators included: smoking related indicators, rates of breast feeding, morbidity and mortality. Outcomes were rated as below, in line and above the national average.

Managers used the maternity dashboard to review patient outcomes. It demonstrated a number of performance metrics relating to numbers and types of delivery, staffing and clinical indicators. Clinical indicators included: smoking related indicators, rates of breast feeding, shoulder dystocia, post-partum haemorrhage, morbidity and mortality. Outcomes were compared to the national average.

The service participated in relevant accreditation schemes. For example, the service was accredited by the UNICEF UK Baby Friendly initiative and had achieved the Level 3 award in July 2019. The service was working towards the gold award at the time of inspection.

National Neonatal Audit Programme

The table below summarises Torbay Hospital's performance in the 2018 National Neonatal Audit Programme against measures related to maternity care. The service met the standard or performed similarly to other hospitals were there was no current standard.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Meets national standard?**
Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? (*Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)*	89.2%	Within expected range	Met
Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? *(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)*	Suppressed due to low numbers	Not applicable	No current standard

(Source: National Neonatal Audit Programme)

National Maternity and Perinatal Audit Programme

The table below summarises Torbay Hospital's performance in the 2018 National Maternity and Perinatal Audit Programme against measures related to maternity care. The service met the standard or performed similarly to other hospitals were there was no current standard for all metrics except Apgar score of less than seven at five minutes.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Meets national standard?**
Trust-level case ascertainment (*Proportion of eligible cases included in the audit)*	108.5%	N/A	Met
Antenatal measures (*before birth, during or relating to pregnancy)*			
Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date *(Babies who are small for their age at birth are at increased risk of problems before, during and after birth)*	62.1%	Within expected range	No current standard
Intra-partum measures (*during labour and birth)*			
Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37	20.3%	Within	No current

and 39 weeks with no documented clinical indication for early delivery (*For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)*		expected range	standard
Case-mix adjusted overall caesarean section rate for single, term babies (*The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)*	27.7%	Within expected range	No current standard
Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7 (*The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)*	3.5%	Higher than expected	No current standard
Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (*Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)*	3.8%	Within expected range	No current standard
Case-mix adjusted proportion of women with severe postpartum haemorrhage of greater than or equal to 1500 ml (*Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)*	2.2%	Within expected range	No current standard
Post-partum measures (*following birth)*			
Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit (*Breastfeeding is associated with significant benefits for mothers and babies. Higher values*	73.8%	Middle 50%	No current standard

represent better performance)			

(Source: National Maternity and Perinatal Audit Programme)

Standardised Caesarean section rates and modes of delivery

From July 2018 to June 2019 the total numbers of caesarean sections (elective, emergency and overall) were similar to the England average.

Standardised caesarean section rate (July 2018 to June 2019)					
Type of caesarean	**England**	**Torbay and South Devon NHS Foundation Trust**			
	Caesarean rate	**Caesareans (n)**	**Caesarean rate**	**Standardised Ratio**	**National comparison**
Elective caesareans	13.1%	205	9.8%	80.3	Similar to expected
Emergency caesareans	16.7%	365	17.5%	106	Similar to expected
Total caesareans	29.8%	570	27.3%	95	Similar to expected

(Source: Hospital Episode Statistics, July 2018 to June 2019)

Notes: *Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.*

Delivery methods were similar to the England average. In relation to other modes of delivery from July 2018 to June 2019 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method (July 2018 to June 2019)			
Delivery method	**Torbay and South Devon NHS Foundation Trust**		**England**
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Total caesarean sections[1]	570	27.3%	29.8%
Instrumental deliveries[2]	255	12.2%	12.3%
Non-interventional deliveries[3]	1,265	60.5%	57.9%
Total deliveries	2,090	100%	100% (n=571,848)

(Source: Hospital Episode Statistics, July 2018 to June 2019)

Notes: *This table does not include deliveries where delivery method is 'other' or 'unrecorded'.*

1.Includes elective and emergency caesareans.

2.Includes forceps and ventouse (vacuum) deliveries.

3.Includes breech and vaginal (non-assisted) deliveries.

(Source: Hospital Episode Statistics (HES))

Maternity active outlier alerts

As at December 2019 the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES)

Managers and staff investigated audit outliers, implemented local changes to improve care and monitored the improvement over time.

The trust had been identified as an audit outlier for the score at five minutes in the National Maternity and Perinatal audit for the period April 2016 to March 2017. Data on the maternity care for all babies with Apgar scores lower than seven at five minutes was reviewed the monthly clinical governance meeting. The quality improvement midwife completed audits of Apgar scoring every month. For example, the January 2020 clinical governance noted rates of low Apgar scores reduced for October 2019 and the service planned to continue monitor rates.

MBRRACE-UK Perinatal Mortality Surveillance Report

The table below summarises Torbay and South Devon NHS Foundation Trust's performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other trusts with similar service provision**	**Meets national standard?**
Stabilised and risk-adjusted perinatal mortality rate **(***The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK's death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)*	4.64 (3.94 to 5.73)*	Up to 10% lower than the average for the comparator group	No current standard

(Source: MBRRACE-UK)

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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The service employed a practice development midwife to oversee the training for all qualified midwives and support staff. Managers gave all new staff a full induction tailored to their role before they started work.

Staff felt supported with training and supervision. All newly qualified midwives undertook a 12-month preceptorship programme. This programme supported the newly qualified midwives to build confidence and consolidate learning gained as a student. Medical staff we spoke with were positive about supervision. Student midwives we spoke with were positive about the support they received.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. All midwives had access to reflective discussion with a Professional Midwifery Advocate (PMA), either individually or in a group. The service had five PMAs and two were in training at the time of inspection. All PMAs had seven and a half hours of protected time a month to dedicate to their role. The PMAs met monthly together and were part of the South West network of PMAs. Staff could access the PMAs through a dedicated email and suggest areas for support or discussion. PMAs could also support staff with revalidation.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We attended a cardiotocography review meeting where midwifery and medical staff discuss cardiotocography readings and reviewed care with a focus on learning and improvement. The infant feeding specialist midwife was supported by the trust to complete a lactation consultant course.

Staff had access to further training relevant to their role. For example, midwives completed Newborn Infant Physical Examination (NIPE) training delivered through a stand-alone degree level module at a local university.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with were positive about the appraisal process and access to further training.

Managers recruited, trained and supported volunteers to support women in the service. Volunteers worked alongside staff on John MacPherson ward most days supporting women by offering to keep them company and offer peer support. We spoke with women on John MacPherson ward and they felt very well supported by staff and volunteers.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From December 2018 to November 2019, 84.6% of staff within the maternity department at Torbay Hospital received an appraisal compared to a trust target of 90%. This compares to an appraisal rate of 93.2% in the previous financial year (April 2018 to March 2019).

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Midwifery staff	70	77	90.9%	90.0%	Yes
Additional clinical services	22	26	84.6%	90.0%	No
Administrative and clerical	12	20	60.0%	90.0%	No

Appraisal data provided by the trust for this core service did not include medical staff.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women most of the time. They supported each other to provide good care. However, working relationships between consultants and midwives needed to improve.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care.

Daily multidisciplinary handover on labour ward was attended by obstetricians, neonatal and anaesthetist consultants, a labour ward coordinator, midwives and maternity care assistants. Most staff we spoke with were positive about the team working between medical and midwifery staff. Midwives we spoke with told us consultants did not always attend and handovers were mostly led by the obstetric trainees.

Staff worked well as a team most of the time. However, some midwives we spoke with expressed a concern about the responsiveness of consultants. They told us they frequently contacted consultants who they knew to be more responsive rather than contacting other members of staff.

We observed a caesarean section and saw all members of the team in the theatre worked well together and communicated effectively. We attended a cardiotocography review meeting. This meeting was well attended by trainee doctors, an obstetric consultant, quality improvement midwife, practice educator midwife and other midwives. There was good team work and a focus on learning and improvement.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred women for mental health assessments when they showed signs of mental ill health, depression. For example, midwifery staff referred women suspected to be experiencing depression to the perinatal mental health team. The public health midwife chaired a multidisciplinary perinatal wellbeing group meeting every month. The meeting was attended by midwifery staff, consultant paediatrician, perinatal mental health team, paediatric pharmacist and specialist health visitors. The aim of the meeting was to develop care plans for babies with additional care needs due to issues such as maternal substance use.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards at Torbay hospital, including weekends. Women were reviewed by consultants depending on the care pathway. Obstetricians were available either in person or on call. Routine ultrasound scans were available 9am to 5pm for appointments, Monday to Friday.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Midwives provided care in the antenatal day assessment unit seven days a week for women who needed care as an outpatient or triage for admission to antenatal or intrapartum services. Women could access maternity triage through the delivery suite phone line 24 hours a day, seven days a week.

Community midwives were available at clinics Monday to Friday and saw women at home seven days a week. There was an on-call system for bank holidays.

Health promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards. For example, a health promotion video was on display in the antenatal clinic as well as posters advertising flu and whooping cough vaccination and free or low-cost children's activities in the local area. Women could access a health and care video library on the trust website including: eating the right diet during pregnancy, stopping smoking during pregnancy and diabetes in pregnancy.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. Specialist advice was available to women who smoked. In line with National Institute for Health and Care Excellence (NICE) guidance: Smoking: stopping in pregnancy and after childbirth, women were offered carbon monoxide tests and could be referred to a specialist midwife for smoking cessation support. Midwives measured women's carbon monoxide levels measured at the antenatal clinic, for all women seen, not just known smokers.

Midwives referred all smokers are to smoking cessation, but women could decline for their referral to be made. Smoking cessation outcomes were monitored on the maternity dashboard which included the percentages of women who smoked at the time of booking and who smoked at the time of delivery. Data showed smoking at delivery rates ranged between 10% and 17% between April 2019 and February 2020.

A public health midwife was employed to reduce the smoking rate during pregnancy. The public health midwife offered specialist advice to women who were alcohol or substance dependant. Women were encouraged to contact their GP, or midwife, for advice and support and could be referred to other organisations for specialist support.

There was screening and monitoring of women with diabetes or those at risk of developing gestational diabetes. A multidisciplinary diabetes clinic was held weekly to support these women.

Women were encouraged and supported to breastfeed their babies. Women were given written and practical advice by midwives. All women had access to information including breastfeeding advice videos on the trust website as part of the health and care video library. Women were supported to express (collect and store) colostrum (initial breast milk after birth) if they were likely to have difficulties feeding their baby or need to provide additional milk top ups in the first few days after birth. This included women who were diabetic.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from women for their care and treatment in line with legislation and guidance. If staff thought a patient lacked capacity, they would seek advice from their senior nurse and the mental health midwife. Staff would also alert the consultant obstetrician who was the lead in mental health.

Staff clearly recorded consent in the patients' records. Staff recorded mental capacity assessments in women's paper notes.

Staff understood how and when to assess whether a patient had the capacity to make decisions

about their care. Staff could access the safeguarding team for support with consent, mental capacity and deprivation of liberty safeguards.

The team had access to specialist advice from the Torbay hospital psychiatric liaison team and the perinatal team if they were working with a detained patient. They also had access to one to one support from a registered mental health nurse (on the bank team or agency). Staff could access the Mental Health Code of Practise online for guidance. A mental health liaison team, the perinatal team and safeguarding midwives could all advise staff on what to do if a patient attempted to discharge themselves or refused treatment.

When women could not give consent, staff made decisions in their best interest, taking into account the woman's wishes, culture and traditions. Staff had experience in taking part in best interest decision meetings, with support from the relevant consultant.

Staff made sure women consented to treatment based on all the information available. Staff discussed the procedure, outcomes and risks for elective caesareans with patients in their antenatal clinic. Any risks were reviewed by the anaesthetist and the doctor went through the consent form with the patient, documented in confidential files. The doctor checked the patient's consent again in the morning of the operation during the ward round.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported mental capacity act training including deprivation of liberty standards is delivered as part of the corporate and clinical induction for all new staff. No training data for these courses was provided to CQC as part of the provider information request.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Women we spoke with confirmed staff always introduced themselves. Women told us staff were 'very friendly.' To meet the requirements of 'Better Births' guidelines women were allocated a named midwife at booking. Midwives worked in buddy pairs so a familiar midwife could cover for the allocated named midwife if they were not at work. The service worked hard to promote continuity of care and we saw feedback from women who had appreciated the familiarity and the bond they had formed with their midwife.

Feedback from women, their partners and family, at the time of our inspection was excellent. We listened to numerous examples of staff excellence, including staff staying behind after their shift had finished and supporting women who had had previous difficult births.

Women said staff treated them well, with kindness, dignity and respect. We observed staff introduce themselves by name to women and their partners. We saw doctors in the antenatal clinic came out to the waiting room to greet women. Staff described their role and discussed their care and what would happen next. We saw staff ask women and their partners if they understood everything and asked if they had any questions.

Women we talked to told us:

- *"Utterly brilliant midwives."*
- "*They are truly wonderful and we are so grateful to them...".*
- "*I had a difficult birth before, but they really helped me enjoy this one".*

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgemental attitude when caring for or discussing women with mental health needs. Women we spoke with felt heard by and understood by staff. They felt like genuine partners in their care. We saw staff explaining treatment options to women and making decisions together. Women told us they felt valued in their choices. Staff followed policy to keep women's care and treatment confidential.

Staff supported women to make informed decisions about their care. In the community the midwives understood, and could give many examples, of care for women of different cultures. Community midwives were proud to tell us of examples of care which involved those close to women and the complexities of the cultural expectations.

Friends and Family test performance

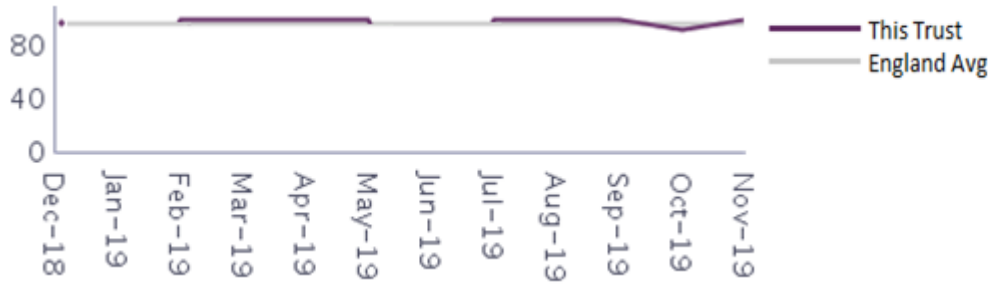
The service participated in the Friends and Family test. However, data showed results of the survey were not always collected every month.

The head of midwifery told us this was because the service had moved towards collecting the survey using an online system.

Friends and family test performance (antenatal), Torbay and South Devon NHS Foundation Trust

From December 2018 to November 2019 the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was generally better than the England average for the months where data were supplied.

Friends and family test performance (birth), Torbay and South Devon NHS Foundation Trust



From December 2018 to November 2019 the trust's maternity Friends and Family Test (birth) performance (% recommended) was generally better than the England average for the months where data were supplied.

Friends and family test performance (postnatal ward), Torbay and South Devon NHS Foundation Trust

From December 2018 to November 2019 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally better than the England average for three of the four months where data were supplied.

Friends and family test performance (postnatal community), Torbay and South Devon NHS Foundation Trust

From December 2018 to November 2019 the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was generally better than the England average for the months where data were supplied.

(Source: Friends and Family Test – NHS England)

CQC Survey of women's experiences of maternity services 2019

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey (2019). The board noted the performance in the January 2020 Maternity Services in the March 2020 board report. The performance in the survey was also discussed at the senior midwives meeting and staff congratulated for the positive performance.

Area	Question	Score (0-10)	RAG
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?	9.1	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	8.0	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.6	About the same
	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?	9.8	About the same
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	9.1	About the same
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	8.4	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.7	About the same
	If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time	9.2	About the same
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.5	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.9	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.4	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	8.9	About the same
	Were you given the opportunity to ask questions about your labour and birth?	7.1	About the same
Care in hospital after the birth	Looking back, was there a delay in being discharged from hospital?	6.3	About the same
	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	8.4	About the same
	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	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.6	About the same
	Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	9.3	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	9.2	About the same

(Source: CQC Survey of Women's Experiences of Maternity Services 2019)

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs. However, there were some concerns midwives did not always have enough time to provide bereavement follow up care with no funded full-time bereavement midwife.

Staff gave women and those close to them help, emotional support and advice when they needed it. Women we spoke with told us staff were very reassuring and supportive.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. A quiet room was available in the antenatal clinic, so staff had a confidential space if they needed to give bad news. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Midwives we spoke with were concerned they did not always have enough time to provide bereavement follow up care. We were told during inspection there was no full-time funded specialist midwife but a bereavement champion who supported women and staff alongside their midwife role. The trust confirmed staff had access to bereavement support. There was a named band 7 midwife who took the lead for bereavement services and co-ordinated bereavement care, in addition a named band 6 midwife provided support. These individuals are responsible for ensuring local policy and procedures follow current recommendations, provide advice and support to staff, link with bereavement charities and provide training days.

The trust organised a 'baby and young children remembrance' weekend every year at Torbay Hospital. Staff from the maternity unit, chaplaincy services and children's community nursing team, together with some local parents planned the remembrance weekend, which included a craft morning for all ages on the Saturday and a special service in the hospital chapel on the Sunday. The event was open to all families who had lost a child in the early years of life as well as those who had experienced baby loss.

Understanding and involvement of patients and those close to them

Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. Women we spoke with were positive about the way staff explained the care to them. For example, women told us they appreciated when midwives used visual aids to explain treatment.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. We observed a caesarean section and saw staff explained all the procedures thoroughly. A picture was used to explain the position the woman needed to be in for the epidural.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. For example, the ward manager of John MacPherson ward had made a poster, which people could take away, that clearly explained the different visiting times for partners, children and grandparents.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service worked with the local maternity system in Devon and met regularly with leaders of the other maternity providers in the county to plan services to meet the needs of the local population.

To implement the continuity of care model the service had, at the time of inspection, recently moved from having five to six integrated teams. Four teams were compliant with the continuity of carer staffing model. However, two teams based on the edge of the locality were non-compliant due to part-time working arrangements.

The age of the maternity unit was a recognised risk. The trust had plans to redevelop an empty ward, adjacent to the current antenatal and postnatal ward, on the Torbay hospital site to provide an along-side midwifery-led service. At the time of inspection these had not been approved by the trust board.

Facilities and premises were appropriate for the services being delivered. There was space for partners to stay on John MacPherson ward and recliner chairs were available. All rooms on the delivery suite had tea and coffee making facilities for mothers and partners.

Managers monitored and took action to minimise missed appointments. A policy on missed appointments was available for staff to refer to.

Women could choose where to birth their baby. There were three options: at home, Whitelake Midwifery Led Birthing Rooms or Delivery Suite at Torbay Hospital. In the year November 2018 to 2019 there were 100 home births, 43 births at Whitelake Unit and 2052 births at Torbay hospital.

The Whitelake midwifery-led maternity unit based at Newton Abbott Hospital had two birthing rooms, one with a birthing pool. The unit was well sign-posted from the main entrance and there was a large car park, close to the entrance of the hospital. There was information about car parking and hospital maps available on the trust's website. The environment was bright and there was 'home from home' items or areas for women to keep their belongings or walk during labour. There were murals on the walls to soften the environment and birthing balls were available. We were told women in the community regularly gave birth at the birthing unit and often accessed the breastfeeding support in the community.

The service minimised the number of times women needed to attend the hospital by ensuring women had access to the required staff and tests on one occasion. For example, the service held flu and whooping cough vaccination clinics at the antenatal clinic.

The service had systems to help care for women in need of additional support or specialist intervention. For example, the service had six tongue tie practitioners who were able to carry out tongue tie divisions at the maternity unit to reduce delays in treatment for babies.

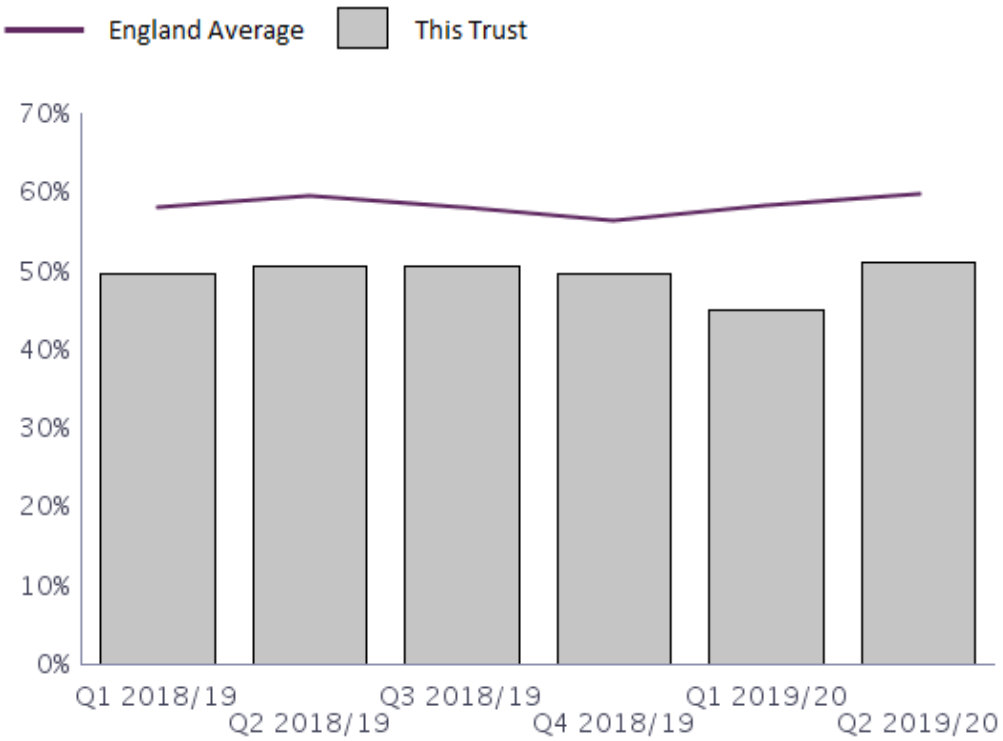
The service had arrangements, known to all staff on duty, to meet patients' urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. Staff and the care systems they followed helped to provide good care to patients in need of additional support.

The service had systems to help care for women in need of additional support or specialist intervention. The department had a public health midwife who could support teenage pregnancy.

Bed Occupancy

From April 2018 to September 2020 the bed occupancy levels for maternity were generally lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Women with mental health difficulties we spoke with told us staff were understanding and supportive. Midwives could refer women to mental health support including local peer support groups, online resources and the perinatal mental health team.

Midwives in the antenatal unit assessed the needs of women with learning disabilities at the booking stage and involved key workers where needed. The learning disability nurse for the trust would support women and accompany them to their appointments.

The service supported those needing wheelchair access and doors were wide enough to allow access for their equipment. Staff were confident in supporting women with additional and complex needs.

Managers made sure staff, women and their loved ones and carers could get help from interpreters or signers when needed. Women were asked to specify their first (native) language when they booked, and to state whether an interpreter was required. Staff could arrange face-to-

face interpreters to accompany women to clinic appointments and they could access telephone interpretation services. The service had information leaflets available in languages spoken by the women and local community.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. If the patient was deaf or deaf blind, the trust could arrange an interpreter.

Staff had access to communication aids to help women become partners in their care and treatment. Staff had access to, and used, pictorial aids, translation services and additional support from specialist teams throughout the trust.

The service did not have a specific service to support Traveller women, but midwives told us Traveller women were treated equally and community midwives visited Travellers antenatally and postnatally as needed.

A bereavement suite was available to women who experienced pregnancy loss and gave birth to a stillborn baby. The separate bereavement suite, Mary Delve suite, had a delivery room with a bathroom, sofa, table and chairs and facilities to make hot drinks. The room was decorated in a homely way.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

The service monitored flow, staffing and efficiency to ensure women could be supported to give birth where they chose, unless complications prevented this. The midwifery team supported women, who were assessed as being low risk, to choose to have their babies at home or at the Whitelake Unit at Newton Abbott Hospital. Options were discussed during pregnancy and care plans developed, which were tailored to women's needs and preferences. Women who were assessed as being high risk had care plans to offer safe choices.

Community midwives ran antenatal clinics from local GP surgeries and community premises.

Women we spoke with in the antenatal clinic reported they had not experienced any delays in access to the service.

Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards. The service monitored flow, staffing and efficiency to ensure women could be supported to give birth where they chose, unless complications prevented this. The delivery suite held regular huddles to discuss the flow of women through the maternity unit.

Managers and staff worked to make sure women did not stay away from home longer than they needed to. Women were discharged home from the delivery suite or transferred to John MacPherson ward for additional care. There were transitional care beds on John MacPherson ward which provided additional specialist care for babies when the woman was well. These beds were located closest to the special care baby unit. The special care baby unit was attached to the John Macpherson ward and this allowed women to stay on the ward and be close to their baby. There was also a family room on the special care baby unit available for parents to remain with their baby.

A discharge information video was shown to women before they left hospital to provide advice on safely caring for their baby and themselves.

Staff supported women and babies when they were referred or transferred between services. The

service would accept women from other hospitals if there was space and capacity. Managers monitored transfers and followed national standards. Staff maintained a folder with details of transfers in and out. If women were transferred in, they would come with a midwife.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Leaflets about how to make a complaint were available on the delivery suite and John Macpherson ward.

Women, relatives and carers knew how to complain or raise concerns.

Managers investigated complaints and identified themes. Ward managers told us the main theme of complaints was communication.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

We reviewed two maternity complaint responses and found all the points of the woman's complaint were investigated and responded to. An apology and details of action to ensure care would be improved in future were included. Women were offered an opportunity to meet with the ward manager, matron and obstetrician involved in their care.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw records of discussion of complaints in senior midwives' governance meeting minutes. For example, in the February 2020 meeting minutes learning from a complaint was discussed relating to pregnancy bookings not being cancelled on the electronic system when women's circumstances had changed.

Summary of complaints

From December 2018 to November 2019 the trust received six complaints in relation to maternity at the trust (2.1% of total complaints received by the trust). The trust took an average of 19.0 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be answered within 30 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Treatment	4	66.7%
Non-Clinical Support	1	16.7%
Record Management	1	16.7%
Total	**6**	**100.0%**

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

Number of compliments made to the trust

From December 2018 to November 2019 there were 20 compliments about maternity at Torbay Hospital, 4% of the total compliments made about the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, the visibility and support from leadership needed to improve.

Maternity services at Torbay Hospital were led and managed as part of the Torbay integrated service unit for young people, families and women's health services. The Torbay integrated service unit was led by a system director, a medical director and a system director of nursing and professional practice. The head of midwifery and gynaecology provided strategic leadership for midwifery.

At the last inspection staff told us senior midwives were disconnected to more junior staff. This had improved but some of these issues continued.

The head of midwifery often visited maternity wards but midwives we spoke with told us senior managers did not fully understand the issues experienced by midwives on the frontline. Most staff in all parts of the service and staff told us they were approachable and supportive. However, staff also expressed a concern that matrons were not always supportive and accessible to staff.

Community midwives felt connected with the main site and enjoyed working alongside their colleagues on the labour ward.

At the last inspection there were no clear succession plans for maternity leadership roles. This had improved. Managers had access to leadership training and mentoring funded by the trust.

The head of midwifery reported to the trust's chief nurse and had direct access to the board and presented quality reports to them every six months or more regularly as needed. They were positive about the support from the board. There was a board level maternity safety champion.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The maternity strategy was included in the trust wide strategy. The maternity strategy and plans were aligned to Devon-wide local plans and national priorities outlined in Better Births: Five year Forward View for Maternity Services (NHS England 2016). Two midwives were employed to develop and implement the Better Births guidelines.

To implement 'Saving Babies lives version 2 guidance the service was working on a business case for the fetal monitoring lead and sonography support to meet increased demand for scanning based on risk factors.

The service was implementing the continuity of carer model at the time of inspection. The head of midwifery was in discussion with NHS England about their plans for continuity of carer model. At the time of the inspection four out of six teams were compliant with the new model. The remaining two teams had a higher number of midwives who worked part time and so were not compliant.

The trust had plans for refurbishing the maternity unit. Refurbishment plans for the maternity unit included: plans for an alongside midwifery-led unit with five beds, two birthing pools and transitional care next to the John MacPherson ward on the Torbay Hospital site. A business case was submitted in January 2020 that had been submitted but not yet approved at the time of

inspection.

The service had a mental health strategy which the board approved and reviewed every three years. During our inspection staff told us they were unaware of this strategy.

Culture

The service had a culture that needed to improve. Staff did not always feel valued or that their concerns were understood by senior leadership. However, staff we spoke with demonstrated a strong focus on the needs of women, partners and the babies they cared for.

Staff satisfaction was mixed, and staff did not always feel empowered. An inconsistent approach to applying human resources policies was impacting on staff morale. Staff we spoke with told us differences in consultant ways of working and responsiveness impacted negatively on the culture. Staff were confident to raise concerns, but not always confident things would change.

All staff we spoke with told us they felt able to raise concerns and found the ward managers approachable. However, not all staff were confident to speak up to managers higher than the ward manager or did not feel their concerns were listened to or addressed.

Staff we spoke with were aware of the freedom to speak up guardian and many staff had contacted them with their concerns. Staff were positive about the support from the freedom to speak up guardian but not always confident their concerns would be resolved.

The service focused on improving the wellbeing of staff. To encourage staff to celebrate their achievements the service had made two ‘love trees’ in the staff rooms of the delivery suite and John MacPherson ward. Staff could add leaves with messages of appreciation for staff. A midwife we spoke with was positive about the initiative and told us they had put some for the feedback they received in their revalidation file. Going home wellbeing checklists were displayed on the back of staff room doors to encourage staff to wind down at the end of a shift.

Medical staff we spoke with were positive about staff behaviours. However, midwifery staff we spoke with told us consultants could be more responsive.

Governance

Leaders operated governance processes but the effectiveness of these needed to improve. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure. The governance midwife produced monthly maternity governance reports. We reviewed the December 2019 maternity governance report which included: items added to the risk register, complaints by area, serious adverse events, incidents and issues for escalation to clinical governance. All incidents of term admissions to special care baby unit, low Apgar scores, and babies born small for gestational age were monitored on the report.

The head of midwifery, governance lead, matrons and consultant for delivery suite held a risk review meeting every week. At this meeting cases were considered, incidents monitored, and complaints reviewed. A database of actions was recorded, but minutes of this meeting were not kept. The database of actions was accessible to senior midwives.

The service held monthly maternity clinical governance meetings. We reviewed December, January and February clinical governance meetings and found attendance was 12 out of an attendee list of 20, which met the maternity clinical governance terms of reference of an expected

50% attendance. The maternity clinical governance meeting had a standard agenda including the following items: obstetric guidelines, risk register, maternity staffing, training and education, NICE guidance.

We reviewed the last two senior midwives meeting minutes and found they also had a standard agenda which included: updates from the head of midwifery and matrons, staffing, IT update, antenatal and newborn screening, public health safeguarding, audit, learning from complaints and positive feedback.

Governance processes needed to improve to ensure action taken to improve the service was effective. For example, at the last inspection we found MEOWS charts were not always completed consistently. While the service had taken action to improve this by re-designing the MEOWS chart the improvements were not fully embedded. The service recognised in the December 2019 recognised maternity clinical governance meeting MEOWS chart audit results were not improving, and the service planned to take the issue to the trust wide deteriorating patient group to get an outside view.

The board reviewed performance against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme standards four times year. The March 2020 board report stated last year the trust met all standards and received a CNST rebate based on performance. The board noted the service was challenged by the environment.

The service had a maternity dashboard and compared performance with local maternity services in Devon and national averages. The maternity dashboard included metrics on: types of deliveries and location of deliveries, post-partum haemorrhage, shoulder dystocia, one to one care in labour, smoking at delivery, teenage pregnancy, admissions to special care baby unit and body mass index of mothers. The maternity dashboard was reviewed at the monthly clinical governance meeting.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, not all risks identified during the inspection were recorded on the risk register.

The service had governance processes for review of risks, but these needed to improve. The head of midwifery and governance lead midwife had a weekly risk review meeting and risk were also reviewed at the monthly clinical governance meeting. However, we reviewed December 2019, January and February 2020 clinical governance meeting minutes and found risk was not always discussed. The risk register was not formally reviewed at the December 2019 meeting, instead between the head of midwifery and clinical governance coordinator during their monthly meeting.

Not all risks identified during the inspection were on the risk register. For example, the risk of reduced consultant staffing due to sickness was not included on the risk register. The ageing environment and associated infection control risk was also not included on the risk register in December 2019, although in January 2020 it was discussed, following review by a consultant microbiologist, the environment on the delivery suite should be added to the risk register.

All risks on the risk register were graded and included mitigating actions and a record of regular review. For example, we reviewed the maternity risk register as submitted in December 2019 and found the risk of midwifery staffing levels being below recommended levels was mitigated by ongoing recruitment and active management of absence. However, long term and short term

sickness continued to be high.

Staff we spoke with were aware of current risks. The head of midwifery was clear about current top risks which included: midwifery staffing levels and increased demand for scans. The clinical director stated the top risks were Apgar scores and perineal tears. However, medical staff we spoke with were not always aware of the top risks relating to the unit.

Reviews of deaths and unexpected outcomes were discussed at perinatal mortality and morbidity meetings every other month. We reviewed the minutes of the last three meetings and found meetings were attended by a multidisciplinary team. Staff prepared presentations which included a chronology of the woman's maternity care, the meeting included discussion to identify learning points. We saw action was taken to improve care following reviews. For example, a new template for handover to paediatrician attending delivery was created using the situation, background, assessment, response (SBAR) format.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information systems were secure. The risk and governance meeting had tracking systems to ensure data or notifications were consistently submitted to external organisations as required.

The service mostly used paper records at the time of inspection. Staff we spoke with expressed frustration more progress had not been made with moving to electronic records.

The service had a recorded risk relating to the patient information record management systems on the delivery suite as the software was out of date. The risk was mitigated by regular backups of information.

During our inspection staff were alert to their responsibility to protect personal data and took steps to ensure the safe storage and movement of records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service was committed to improving services by engaging with women and their families and capturing their feedback. The service worked with the Devon maternity voices partnership, which was a collaborative of parents, parents-to-be and other stakeholders, reviewing local maternity care and supporting service users to share their experience to improve care. The maternity voices partnership participated in the local maternity systems review and were invited to relevant meetings.

The service had participated in a public engagement exercise over eight weeks in the summer of 2018 gathering the views of 2,700 parents about maternity care in Devon.

The maternity service was active on social media. The service used social media to interact with women, to promote the service and give health promotion advice.

Staff were kept up to date on changes to the service. Key messages were communicated to staff during the daily handovers and through email. Staff told us team meetings were held but not held very regularly.

The service was reviewing its communication strategy at the time of inspection. Matrons and the governance midwife were working to implement the 'five ways, five times' methodology to communicate with staff using email, posters on the back of toilet doors, social media, and message of the month whiteboard on delivery suite. The first message of the month for January 2020 was about embedding the 'fresh eyes' approach.

The service had recently at the time of inspection completed a consultation with midwifery staff about changes to the services relating to implementing the continuity of carer model.

The service completed 'pulse check' staff surveys every six months. Managers monitored the results of these surveys through the performance assurance framework.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service employed a quality improvement midwife to support continuous improvement and innovation in the department.

The department was part of the NHS Improvement maternity and neonatal safety improvement programme to prevent hypoglycaemia in new-born babies. The aim of the project was to reduce the number of term babies (born over 37 weeks) being admitted to the special care baby unit (SCBU) to below the national target of 5%. The project was focused on keeping babies warm by encouraging skin to skin contact between mothers and babies, increased monitoring of temperature and using knitted hats and clothes to keep babies warm. A poster was displayed on the delivery suite to remind midwives how to most effectively take babies temperature by testing the temperature of the armpit rather than the ear.

To support recording of fetal monitoring the service had developed stickers for antenatal and intrapartum cardiograph scans and intermittent auscultation (fetal monitoring during labour) stickers using a quality improvement methodology. Staff we spoke with told us these had been very helpful.

Services for children and young people

Facts and data about this service

Children's services comprised the following departments and wards at Torbay Hospital:

Ward / Team name	Details of services provided	Number of inpatient beds (if applicable)
John Parkes - children	The Child Developmental Centre is based at the John Parkes Unit. It provides the means for multi-disciplinary assessment and management of children with suspected developmental impairment. The team consists of nursery nurses, physiotherapists, speech therapists, occupational therapists, clinical psychologist, and paediatricians.	-
Louisa Cary	This is a paediatric ward with 14 standard beds, two high dependency unit beds and six beds for older children.	22
Paediatric outpatients	Specific area in main outpatients dedicated for paediatric outpatient clinics.	-
Special care baby unit	The Special Care Baby Unit (SCBU) is for babies who are small, premature or who need extra care or observation as well as those who have difficulties when feeding.	10

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

The trust additionally provided the following information about their children's services:

The child health directorate includes acute hospital-based care for children aged 18 years and under and covers all referrals for both community and general paediatrics.

Louisa Cary ward provides care for acutely unwell children. The ward covers children aged 18 years and under with varying conditions from medical, surgical, orthopaedic and other specialities. The ward also has a six bedded young person's unit for teenagers, and a two bedded high dependency unit.

Alongside Louisa Cary there is a five bedded short stay paediatric assessment unit for direct GP access and patients are streamed from the emergency department.

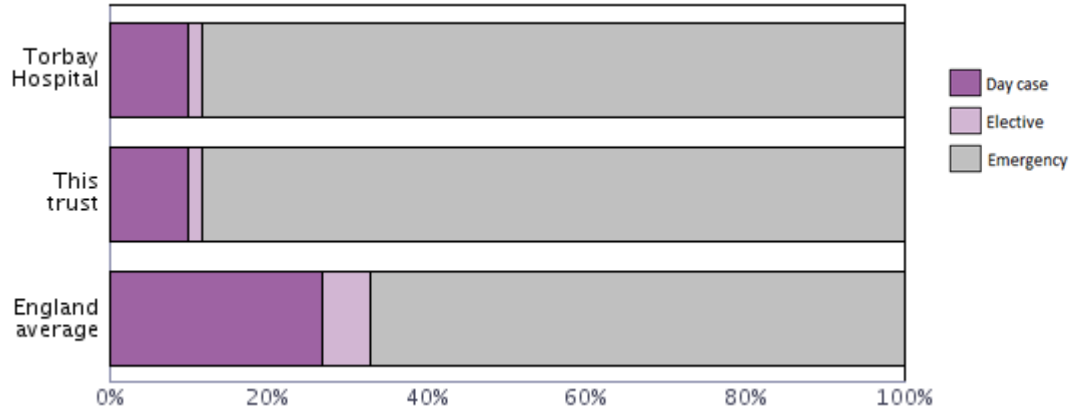
The special care baby unit (SCBU) is a service for babies who are small, premature or who need extra care or observation.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust had 3,370 episodes of activity from October 2018 to September 2019.

Emergency episodes accounted for 88% (2,980), 10% (330) were day case episodes, and the remaining 2% (60) were elective episodes.

Percentage of episodes in children's services by type of appointment and site, from October 2018 to September 2019, Torbay and South Devon NHS Foundation Trust:



Total number of children's spells, Torbay and South Devon NHS Foundation Trust:

Site name	Total episodes
Torbay Hospital	3,370
England total	1,161,445

(Source: Hospital Episode statistics)

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff. However, medical staff were not always meeting trust mandatory training targets.

Mandatory training completion rates

Nursing staff received and kept up-to-date with their mandatory training. Most staff were up-to-date with the trust's mandatory training programme. This meant most staff were up-to-date with their skills and knowledge to enable them to care for children and young people appropriately. There was a clear focus on improving compliance for mandatory training and achieving the target rates of completion.

Most staff said they were up-to-date with their mandatory training or had dates booked to attend training in the near future. Most staff told us mandatory training updates were delivered to meet their needs and they were able to access training as they needed it.

The trust set a target of 85% for completion of mandatory training for all courses except for information governance, which had a trust target of 95%. All training performance at the trust was reported on a rolling month by month basis to the quality improvement group.

The compliance for mandatory training modules from December 2018 to November 2019 was 92% for qualified nursing staff in children's services. Of the training modules provided, seven achieved compliance and one failed to reach the trust target.

No training modules scored below 75%.

Medical staff received and kept up-to-date with their mandatory training.

The compliance for mandatory training modules from December 2018 to November 2019 was 84% at Torbay Hospital for medical staff in children's services. Of the training modules provided three achieved compliance and five failed to reach the trust target.

One module failed to score above 75% as outlined below:

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance <75 %	Trust Target Met	Compliance change when compared to previous year
Infection Prevention (Level 2)	39	27	69%	✗	↓

(Source: Routine Provider Information Request (RPIR) – Training tab)

However, there had been a clear focus on improving compliance for mandatory training. Data we were shown on inspection showed an improving picture since November 2019 with compliance having increased to 77% for infection prevention (level 2).

The mandatory training was comprehensive and met the needs of children, young people and staff. There were a range of topics including conflict resolution, health and safety, infection

prevention, moving and handling and basic life support. Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning. Most training was delivered through an annual mandatory child health training day.

At least one nurse per shift in each clinical area was trained in advanced paediatric life support or European paediatric advanced life support as identified by the RCN (2013) staffing guidance. It was recommended in the trust's training needs analysis for paediatric nurses to undertake paediatric immediate and advance level resuscitation training. The trust were unable to supply compliance against this. The paediatric high dependency unit nurses were 100% compliant with advanced paediatric life support training.

European paediatric advanced life support was mandatory for paediatric registrars. For foundation year two doctors this was also recommended. Paediatric medical staff were recommended to complete paediatric advanced life support. The trust were unable to supply compliance with this training and were working to pull a central record together, so this information was available and monitored.

Clinical staff received (mandatory) training on how to recognise and provide a first response to patients with mental health needs, learning disabilities or autism. Nurses on the ward completed mental health training modules and staff said they considered this very much part of their core business, however, these were not mandatory.

Managers monitored mandatory training and alerted staff when they needed to update their training. Bi-monthly training competency reports were available to review training attendance and staff could check their compliance with mandatory training. This supported the appraisal discussion and personal development planning. Managers saw which members of their team were in date and were able to plan when team members needed to complete refresher training. Email reminders were sent to all staff reminding them in advance of when the training was due. Compliance was reported bi-monthly to the trust board as part of the child health dashboard.

Safeguarding

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.

Nursing and medical staff received training specific for their role on how to recognise and report abuse in line with the renewed Intercollegiate Guidance Adult Safeguarding: Roles and Competencies for Health Care Staff (Aug 2018) and the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Jan 2019).

Safeguarding training completion rates

The trust set the following targets for the safeguarding courses for which medical, nursing and qualified allied health professional staff were eligible.

- 90% for safeguarding levels 1
- 80% for safeguarding level 2 and 3

The tables below include PREVENT training as a safeguarding course, which has a trust target of 85%. PREVENT works to stop individuals from getting involved or supporting terrorism or extremist activity.

All training performance at the trust was reported on a rolling month by month basis.

The compliance for safeguarding training modules from December 2018 to November 2019 was

92% for qualified nursing staff in children's services. Of the training modules provided, three achieved compliance and two failed to reach the trust target.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Basic Prevent Awareness	75	75	100%	✓	→
Safeguarding Adults (Level 1)	75	74	99%	✓	→
Safeguarding Adults (Level 2)	75	66	88%	✓	↑
Safeguarding Children (Level 3)	75	63	84%	✓	↑
Safeguarding Adults (Level 3)	3	2	67%	✗	↑

There had been a clear focus on improving compliance for safeguarding training. Data we were shown on inspection showed an improving picture since November 2019 with compliance having increased to 80% for safeguarding adults level 3.

The compliance for safeguarding training modules from December 2018 to November 2019 was 81% for medical staff in children's services. Of the training modules provided two failed to reach the trust target.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children (Level 2)	3	3	100%	✓	↑
Safeguarding Adults (Level 1)	39	37	95%	✓	→
Basic Prevent Awareness	39	35	90%	✓	→
Safeguarding Adults (Level 2)	39	30	77%	✗	↑
Safeguarding Children (Level 3)	36	21	58%	✗	↓

(Source: Routine Provider Information Request (RPIR) – Training tab)

There had been a clear focus on improving compliance for safeguarding training. Data we were shown on inspection showed an improving picture since November 2019 with compliance having increased to 81% for safeguarding children level 3 and 79% safeguarding children level 2.

There were recognised governance processes for oversight and monitoring of the safeguarding children statutory duties. The safeguarding children operational group (SCOG) reported to the integrated safeguarding and inclusion group.

Mandatory safeguarding children training compliance was monitored monthly and reported on the child health dashboard to the safeguarding children operational group (SCOG).

Trust compliance data was shared on a monthly basis with the named nurse and at SCOG. There was a review process for the named nurse supported by the safeguarding administration team, to ensure key staff groups were prompted to attend their relevant training.

The safeguarding children team supported additional training for staff including the corporate induction programme.

A report including the safeguarding activity monitoring and work and action plans were shared at the integrated safeguarding and inclusion group, chaired by the chief nurse.

Information was shared at the quality improvement group and where required, escalated to the quality assurance committee and trust board.

The trust provided information to staff within safeguarding and child protection policies and procedures. This included the action to take when staff had concerns regarding child protection, female genital mutilation, child sex exploitation, neglect of children, fabricated or induced illnesses, and domestic abuse. Staff were able to show us a safeguarding notice on the notice board with relevant phone numbers, policy and pathways to inform and guide staff practice.

The policy contained guidance for staff where a child did not attend clinic appointments, which were cancelled for no good reason or the patient did not arrive as booked. A safeguarding referral was generated following three failure to attend appointments in the outpatient department.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about the trust's safeguarding children policy and processes and were clear about their responsibilities. They described what actions they would take should they have safeguarding concerns about a child or young person. All staff were confident to challenge to ensure the safety of children.

Children and young people with a learning disability were identified when they were pre-assessed and / or admitted to the hospital. This was recorded and filed in their medical records and alerted staff to contact the learning disability liaison team who could then provide appropriate support.

Babies on the special care baby unit were tagged and during our inspection we heard these alarms activated inadvertently and saw staff respond immediately.

There was an abduction policy. Staff told us they followed the guidelines set out in the policy and the hospital security team and the police would be notified if such a situation arose.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust was actively involved with partner agencies to improve the identification, response and disruption of child exploitation in Devon. Working to prevent, respond and disrupt sexual exploitation was integral to the safeguarding children agenda.

The safeguarding children team had representation at a number of multiagency meetings; including MACE (Missing and Child Exploitation) for both South Devon and Torbay, Missing meetings and "Turning Corners" meetings for Teignbridge and Torbay. Any cases identified from these meetings were then shared with the relevant staff involved in the care of the young person.

The service had continued to develop special case flags to ensure relevant and accurate information was accessible to frontline practitioners, including adding targeted special case flags (steroid dependent child flag and deliberate self-harm management flag) enabling individualised and informed decisions to be made about the care delivered to children and families. The service received flag requests from different service providers and managed 199 active special case flags. This was an increase of 26% from last year. The current special case flags included; medical flags

(73), safeguarding flags (28), high risk missing person flags (2) and drug box flags (96). These flags were reviewed annually and audited to ensure they were relevant and up to date.

In line with latest policy, all cases of identified or suspected sexual exploitation were discussed at supervision and any necessary referrals completed and submitted to the multiagency safeguarding hub (MASH) to the allocated social worker, as directed. Modern slavery, including sex working, and sexual abuse were discussed in the adult safeguarding mandatory training courses.

The chief nurse was the executive lead for safeguarding and was supported by the system director and the named professionals in this role. There was a safeguarding children named nurse.

A safeguarding children annual report (for the period April 2018 to March 2019) outlined the activities of the safeguarding children team and the activities of the wider safeguarding duties and activities completed by trust staff, both directly and indirectly to safeguard children. The report also informed children's safeguarding activities and outlined the trust's progress and activities in ensuring there was a child protection framework for all children and young people who were patients.

The paediatric liaison service was a point of contact to all agencies as well as providing supervision to trust staff. Within the last term, the service has received 442 contacts and/or supervisions requests - an increase of 33 (8%) contacts compared to last year.

The paediatric liaison nurses supported the training of staff through one to one support to newly recruited emergency department nursing staff during their supernumerary phase. There was also induction training to the junior and middle grade doctors within their rotations into paediatrics and emergency medicine, and recently working alongside the named nurse and the education team to develop a new level 2 training package that was introduced/delivered in August 2019.

There was one-to-one and group safeguarding supervision. This was a component of safeguarding children practice and was integral to practice for all Level 3 trained staff across the trust. There were three trained safeguarding nurse practitioners within the team, and all members of the wider safeguarding children team, including the named professionals, were trained safeguarding supervisors. There were 40 additional supervisors who had undertaken the two day "in house" training course, delivered by the named nurse.

The safeguarding supervision policy had been updated and an audit had been completed and reported to SCOG, to consider the effectiveness and compliance of staff with the policy. The audit also monitored qualitative data to gain feedback from staff, which was captured anonymously. The audit showed an improvement in compliance with the safeguarding supervision and that the practice was becoming embedded into clinical practice.

Safeguarding supervision considered the potential for child exploitation. The safeguarding team attended strategy meetings and multi-agency safeguarding hub (MASH) meetings daily, where child exploitation was always considered in relation to all child protection referrals.

Staff said they valued supervision as a supportive resource. Staff were also offered opportunities for debriefing and learning following difficult safeguarding events. They were encouraged to use reflection to record their learning.

The named doctors also provided regular formal group peer review of safeguarding cases, including review of child protection medical examinations. This was for quality assurance and to support consistent practice amongst the paediatric consultants.

From April 2018 to April 2019 there had been a rise in numbers of children and young people who were subject to child protection planning. A slot in clinic was allocated every day to offer increased flexibility in the provision of time for child protection medicals. This allowed many medicals to take place at a set time, in an outpatient setting, reducing the need for children, families and social workers to wait in the busy short stay paediatric assessment unit out of hours until the paediatric acute consultant or on-call consultant was able to do the medical. The best interests of the child concerned were prioritised. This improved patient safety considerations, by taking the pressure off the out of hour's paediatric service reducing the demand on the service at its busiest time for medical paediatric emergencies.

In October 2018, new Statutory and Operational Guidance (England) was published, updating the setting out processes following the death of a child in the statutory requirements of 'Working Together 2015 Chapter 5', clarifying how individual professionals and organisations across all sectors should contribute to reviews into child deaths. The new guidance had been adopted in trust practice.

Following the update to the working together to safeguarding children guidance, the named doctor for child death had been working jointly with the child death overview panel (CDOP). This had resulted in an update to processes to review all child deaths; expected or unexpected. Staff members had been included in rapid review meetings to ensure support for families and any appropriate actions were initiated as early as possible. Following an incident relating to information sharing/notification of a child's death to their school, trust processes were changed.

Continued training opportunities and networking was planned for the future to maintain networking relationships across the peninsula.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained.

In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. Bed and cot spaces were also visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, clean and free from stains or damage to the material.

Staff, patients and visitors to the ward had access to antibacterial gel and handwashing facilities. We saw these used regularly throughout our inspection. Nursing and medical staff washed their hands and applied hand gel between each patient contact. We also saw non-clinical staff, including reception and administrative staff and cleaning staff using hand gel. The hand gel was located at the entrance to and throughout the ward.

The children's ward, special care baby unit (SCBU) and the outpatient department were well equipped with hand wash basins with good access to liquid soap and paper towels for staff to use. There were hand basins at the entrance to the SCBU and visitors, including CQC staff, were asked to wash their hands before entering the unit. All staff were bare below the elbow when working on the units.

The ward staff carried out monthly audits of effective hand hygiene. Compliance between March 2019 and January 2020 ranged from 80% in July to 100% for the remaining months.

Parents said the ward, SCBU and the outpatient department were clean and hygienic, and they had been given advice about handwashing and the use of hand gel on the ward. We observed all

visitors being asked to use hand gel.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as gloves and aprons. These were readily available to staff.

When necessary, children and young people with an infectious disease or illness were nursed in a separate area and appropriate signage identified the risk. Staff were knowledgeable and took prompt action to isolate patients when necessary.

Staff informed us toys were cleaned regularly using disinfectant wipes or more frequently if they were observed to be soiled. We saw cleaning schedules to support this. The toys we saw all looked clean and in good condition and were made from materials that were easily cleaned.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. There were dedicated teams of a housekeeper and cleaning staff who ensured the areas were clean and tidy and they were fully integrated with the clinical teams. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. Cleaning staff were able to show us their work schedules. Cleaning equipment was colour coded, clean and well maintained, and stored in a locked area. Workloads were high in all areas.

When speaking to parents they commented on the frequency and quality of the cleaning. One parent said, “the cleaners are marvellous and work very hard to keep things clean.”

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment appeared clean and we saw green ‘I am clean’ labels placed on trolleys and equipment that had been cleaned and were ready for use.

There were regular matron’s audits of infection control and cleanliness.

There were no unit-acquired meticillin resistant *Staphylococcus aureus (*MRSA) infections or incidences of unit-acquired *Clostridium difficile* during the past year*.*

CQC Children and Young People’s Survey 2018

In the CQC Children and Young People’s Survey 2018 the trust scored 8.9 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2018)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept children, young people and their families safe. Staff managed clinical waste well.

Storage facilities for breast milk on Louisa Cary ward and in the special care baby unit (SCBU) had improved since the last inspection. Breast milk was stored for 24 hours in the fridges and for 48 hours in the freezers. Temperatures of the fridges and freezers were checked daily and recorded.

Access to the treatment room on Louisa Cary ward was through the medication preparation room. This compromised children’s safety and could cause distress to children and young people in the vicinity. A health and safety risk assessment had been carried out to consider the hazards and actions taken. Further details are outlined in the ‘management of risk, issues and performance’ section of the report.
There was equipment for the safe transfer of patients from the emergency department to the ward whilst receiving high flow warmed and humidified respiratory gases.

There were new incubators for the SCBU, and new storage was available on level four of the hospital. There was a separate area on the Louisa Cary ward called ‘The Cove’ for teenagers up to the age 18 to use.

The design of the environment followed national guidance. The service was divided into Louisa Cary ward, with 14 standard beds for babies and small children and two high dependency beds and six beds for older children, and a short stay paediatric assessment unit with five beds.

Facilities and premises were appropriate for the services being delivered. The environment on the children’s wards, the outpatient department and the SCBU were designed to meet the needs of babies, children and young people and their families. However, the environments presented challenges because of their distance from key areas of the hospital, for example the emergency department and theatres.

There were ten cots on the SCBU, three of which were for high dependency. There were reclining chairs for each space.

A specific area in the main outpatient department was dedicated for paediatric outpatient clinics for use by children and young people.

Visitors to the ward and to the SCBU announced their presence by a door bell and CCTV. Staff assistance was required to enter and exit the ward. This was to ensure the safety of babies, children and young people. Staff were mindful to monitor the exits to ensure children and young people did not exit with other people. There was a reminder for staff to ensure the door was completely closed before walking away.

The wards were decorated and furnished to be appealing to children and young people. For example, there were colourful wall murals and furniture in varying sizes, pictures, and toys and games were readily available. Toilets and handwashing facilities were available at a low level to be accessible to smaller children. There were plastic steps to help smaller children reach the sink and potties available if required.

In surgery there was no dedicated recovery area for children. However, there were two dedicated spaces for children. There was specialist equipment designed for children, including for resuscitation.

The service had suitable facilities to meet the needs of children and young peoples’ families.

Accommodation was provided for a parent to stay overnight with their child on the ward. Each bed space had a pull-out bed next to it so parents could stay on the ward. There were also two bedrooms available on Louisa Cary ward for parents to use throughout their child’s stay.

The trust had reviewed and improved facilities for parents on the SCBU and had provided sufficient chairs to enable mothers to nurse their babies appropriately. Parent accommodation had also been improved.

Children, young people and their families could reach call bells and staff responded quickly when called. We observed staff responding quickly to call bells and addressing requests efficiently.

Staff carried out daily safety checks of specialist equipment.

There was access to emergency equipment which was appropriate for use for children and young people. The emergency trolleys on the ward, the high dependency unit and SCBU were clean, tamperproof and ready to use. Staff carried out daily and weekly checks of the equipment and medicines to ensure they were ready to use and in date. This was evidenced by the signature of the staff member carrying out the check. From the records we reviewed during a three-month period there were a handful of gaps in the log. There were bag valve masks by all cubicles in the

short stay paediatric assessment unit and neonatal grab bags in case there was an emergency the unit staff had to attend on the labour ward.

Storage of breast milk on Louisa Cary ward and the special care baby unit had improved since the last inspection. The temperature of the refrigerators was monitored daily and recorded on checklists.

The service had enough suitable equipment to help them to safely care for children and young people. We saw a range of equipment was readily available and most staff said they had access to the equipment they needed for the care and treatment of babies, children and young people.

There was a monthly inspection to identify any faulty equipment and this was removed from use and the fault reported. A sticker system was used to identify when each piece of equipment was due to be serviced. This informed staff, so they did not inadvertently use equipment which was overdue servicing or maintenance.

The medical devices support services managed the medical devices using a central medical device management system. Medical devices were supported and maintained from in-house specialist teams and other external providers. There was a risk based medical device maintenance strategy. Maintenance was categorised in three areas: high risk devices, medium risk devices and low risk devices. Risk assessments were completed using several factors including age and performance for all medical equipment replacements. There was a medical device replacement programme.

Staff disposed of clinical waste safely. Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.

The special care baby unit had dedicated laundry services, a washing machine and tumble dryer, to make sure laundry items were washed with detergents sensitive to the baby's skin.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and took action to remove or minimise risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments relating to patients needs were completed and evaluated. There were clear processes to deal with children, young people and babies where their medical condition was deteriorating.

Staff knew about and dealt with any specific risk issues. Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately.

There was a range of processes and policies routinely used to monitor, assess, identify and respond to patient risks. The service used nationally recognised early warning scores to help detect if a patient's condition had deteriorated. These were paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS), the aim was for these to be completed within 15 minutes of arrival where the necessary clinical observations such as pulse, temperature and respirations were recorded. Observations were recorded on iPads. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the child or baby to be seen by medical staff. We reviewed eight records on the paediatric ward and four on SCBU and saw they had been completed according to guidance.

The service had 24-hour access to mental health liaison and specialist mental health support (if

staff were concerned about a child or young person's mental health). Access to the child and adolescent mental health services (CAMHS) had improved since the last inspection. The service included access to mental health liaison and/or other specialist mental health support if staff were concerned about risks associated with a patient's mental health. There was regular triage of any new referrals admitted with a mental health need with the CAMHS team.

There were comprehensive risk assessments for children and young people with mental health concerns when they were seen in the emergency department by the CAMHS team. However, there were some issues relating to accessing timely CAMHS support, that often led to young people being admitted to the ward.

We reviewed one patient's care record who had been admitted with a mental health need. They had a comprehensive risk assessment and staff had completed the CAMHS checklist and safety plan.

There had been improvements in training for staff to support young people with mental health Issues. Staff said they were more confident in supporting these patients.

Shift changes and handovers included all necessary key information to keep children and young people safe. Safety huddles took place and there were three handovers each day. We observed a meeting and saw the handover was comprehensive and each patient was discussed including the presenting problem, background, investigations and care plans and additional patients expected that day.

At weekends and out of hours, staff were also able to access the trust's site management team for additional support.

The security staff, employed by the trust, provided support to staff to manage patients or retrieve a patient who had absconded from the ward. On rare occasions when the security staff could not respond promptly, the police could be called to the ward.

The special care baby unit was located in the maternity block to ensure prompt access to the delivery ward, theatre and the post-natal ward. This meant in an emergency, new born babies could be transferred to the unit quickly to receive their care and treatment.

There was a policy to guide staff in the transfer and discharge of seriously unwell babies, children and young people including patients with complex continuing care needs.

Records demonstrated all nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support. Staff were also trained to recognise sepsis and guidelines were available to follow.

Surgical services for children and young people were delivered through general surgery. Processes were followed to support safe care in theatres. The World Health Organisations (WHO) surgical safety checklist recommendations were followed when children and young people attended theatre. Following these procedures is known to increase the safety of patients. We observed patients attending theatre as part of our inspection and saw all elements of the checklist had been followed. Of the four records we reviewed where children had undergone procedures, all had a checklist completed with patient details and the completion of the sign in, time out, sign out and confirmation was entered in clinical notes.

Children were recovered in the same area as adults. There was one long corridor with two dedicated spaces for children with ceilings decorated with child friendly pictures. Children arrived in recovery through one of two doors following their operation. There was a specific paediatric resus trolley with required airways for children of all ages.

Recovery was overseen by staff who had paediatric intermediate life support (PILS) and anaesthetists who had advanced paediatric life support (APLS). Two recovery nurses were with the child until airway adjustments were made and removed. An anaesthetist was available for support.

CQC Children and Young People's Survey 2018

In the CQC Children and Young People's Survey 2018 the trust scored 7.8 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

CQC Children and Young People's Survey 2018 questions, safe domain, Torbay and South Devon NHS Foundation Trust

Question	Age group	Trust score	RAG
Were the different members of staff caring for and treating your child aware of their medical history?	0-15 adults	7.8	About the same as other trusts
How clean do you think the hospital room or ward was that your child was in?	0-15 adults	8.9	About the same as other trusts

(Source: CQC Children and Young People's Survey 2018)

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. Nurse staffing had improved since the inspection in 2016 and was now meeting Royal College of Nursing (RCN) (2013) guidelines on Louisa Cary ward. Staffing in the special care baby unit was meeting the British Association of Perinatal Medicine Guidelines (2011) (BAPM) so 1:1 and 1:2 care for babies who required high dependency care was provided.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There was a process for monitoring and ensuring safe staffing in line with current national recommendations. These were presented monthly and for six monthly review to the trust board and the quality improvement group.

The ward manager could adjust staffing levels daily according to the needs of patients. Daily nurse staffing was monitored and reviewed at each control meeting to ensure the right staff were in the right place at the right time. This was confirmed through senior oversight by a matron/associate director of nursing against a standard operating procedure for safe staffing.

Staff were moved in line with acuity and dependency measures and ratio of agency to substantive staff. Any additional requests for agency were escalated for review and assessment by the director of nursing for approval.

A six-monthly review of staffing levels was conducted as required nationally, which used recognised methodology including: National Institute for Clinical and Healthcare Excellence (NICE) guidance, acuity and dependency tool/ Shelford Group Safer Nursing Care Tool, together with professional judgement and workforce metrics.

Rosters were written at least six weeks in advance and any shortfall in rostering was released to the temporary staffing to try and fill to this level.

There was a mix of skilled and experienced nurses and healthcare assistants in both departments. There was a senior nursing staff in band eight (matron), seven (ward managers) and six (sisters) and supporting band five nurses. The band seven nurses oversaw the day-to-day running of the nursing teams in the departments. Nurses in charge were not supernumerary.

Paediatric nurses on the children's wards were complimented by healthcare assistants and play specialists. On the special care baby unit, nurses were also supported by healthcare assistants.

Staff said they had been stretched at times during the last year when capacity and demand had been consistently high.

A business case was submitted and approved for five whole time equivalent (WTE) advanced nurse practitioners (ANPs) in 2018. There was a phased approach to their appointment over three years to ensure adequate mentoring and support was provided, and there was no further impact on doctors training on the ward.

The aim was to recruit further ANPs to work alongside the middle grade doctors as a senior decision maker once skills embedded. It was anticipated two ANPs could fill two slots on the rota on the middle grade. However, there would be some flexibility to work across both the junior and middle grade rota depending on where the gaps were. There were also plans for ANPs to run the short stay paediatric assessment unit in the future once trained and skills had embedded, releasing the consultant to triage calls and provide GP advice and guidance.

The special care baby unit supported an enhanced neonatal nurse practitioner (ENNP) to work alongside the nursing and medical staff to assist with day to day cover on SCBU.

The table below shows a summary of the nursing staffing metrics in children's services compared to the trust's targets, where applicable:

	Children's services annual staffing metrics						
	November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	130	5%	11%	3.2%			
Qualified nurses	64	8%	6%	3.3%	2,006 (3%)	802 (1%)	420 (1%)

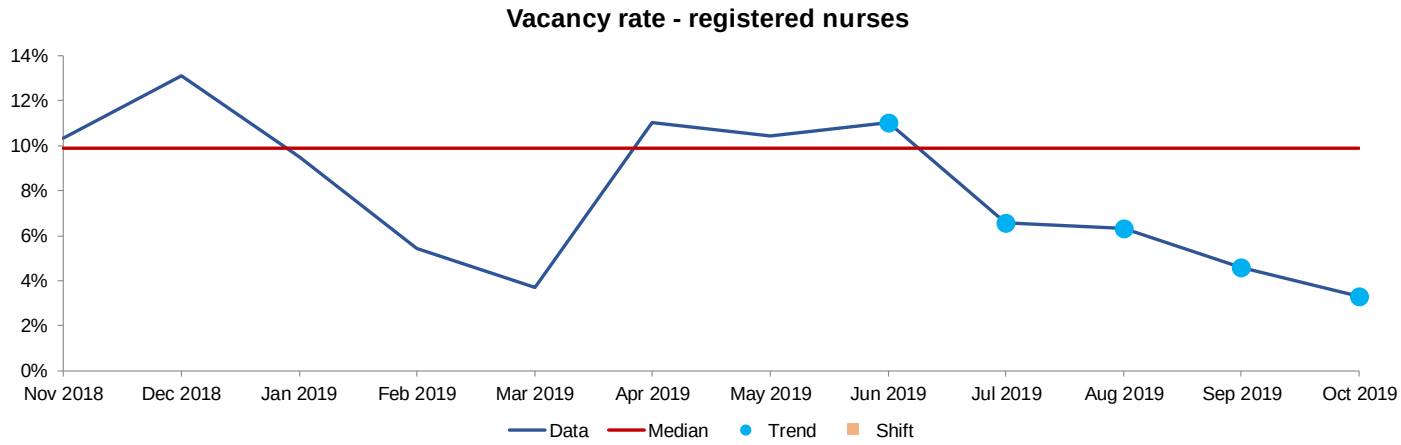
(*Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)*

The number of nurses and healthcare assistants matched the planned numbers. Nurse staffing

rates within children's services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

Vacancy rates

The service had reducing vacancy rates.



Monthly vacancy rates over the last 12 months for registered nurses showed a downward trend from June 2019 to October 2019. This was an indicator of improvement and the trust were maintaining the improvement. Managers said there was no difficulty in recruiting staff. They had plenty of applications from regional universities and had a waiting list of staff wishing to join the team.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The service had low turnover rates and most staff had been part of the team for many years. Staff who had retired after many years' service had returned to the team.

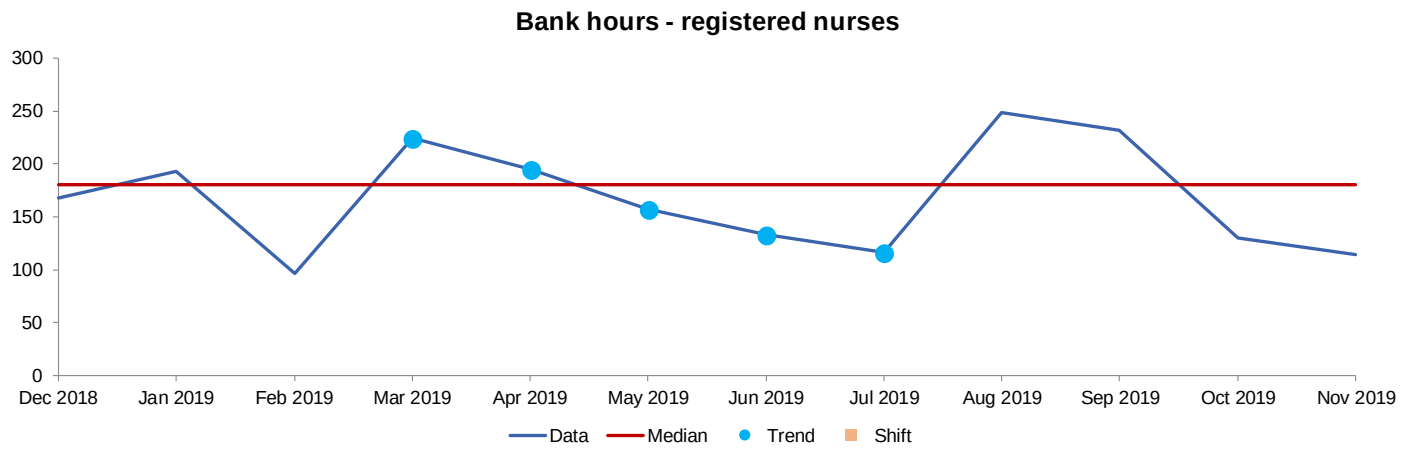
Sickness rates

The service had increasing sickness rates as a result of continued high capacity and demand over the past year. Staff said they were physically and mentally drained and managers were concerned gaps were emerging in cover.

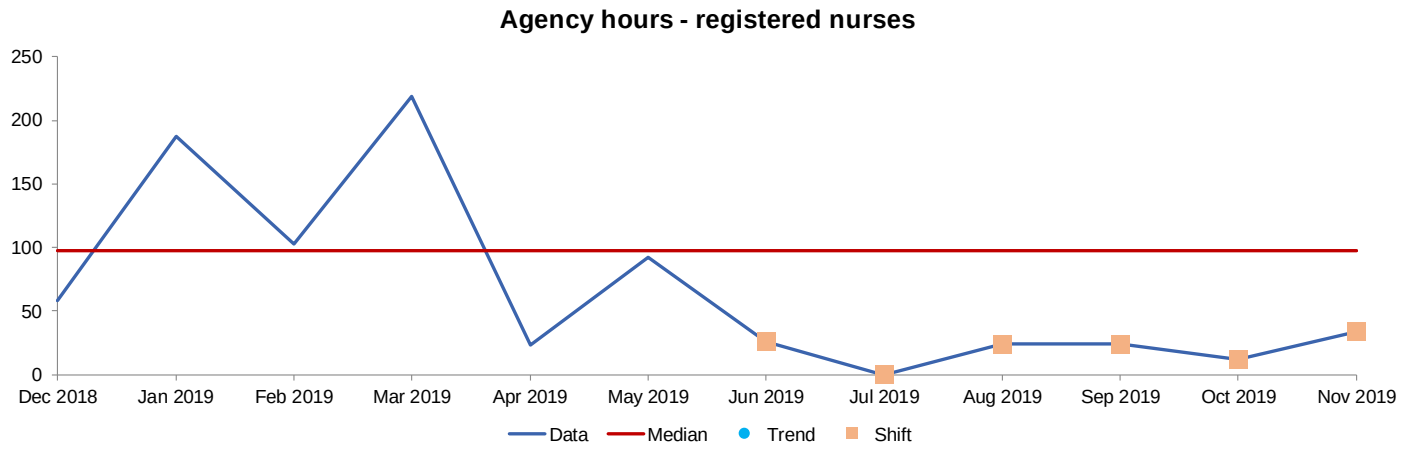
There was a mixture of short term and long-term sickness absence which was being managed in line with trust policy. HR undertook regular sickness absence audits with managers to ensure absence was being managed in the most appropriate way and enabled better conversations regarding wellbeing.

Bank and agency staff usage

The service had reducing rates of bank and agency nurses.



Monthly bank use over the last 12 months for registered nurses showed a downward trend from March 2019 to July 2019. This could be an indicator of change.



Monthly agency use over the last 12 months for registered nurses showed a downward shift from June 2019 to November 2019.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Bank shifts were generally covered by staff within the service working extra shifts. In the event of any agency use managers made sure staff had a full induction and understood the service.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service generally had enough medical staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Medical staffing levels were compliant with the Royal College of Paediatrics and Child Health and the British Association of Perinatal Medicine standards.

The table below shows a summary of the medical staffing metrics in children's services compared to the trust's targets, where applicable:

	Children's services annual staffing metrics						
	November 2018 to October 2019 (Vacancy and sickness rates) December 2018 to November 2019 (Turnover, bank, agency and unfilled hours)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		5%	12%	4.0%			
All staff	130	5%	11%	3.2%			
Medical staff	33	3%	27%	1.2%	888 (1%)	1,265 (1%)	526 (1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs).

Consultants and trainees provided cover for Louisa Cary ward, SCBU and all outpatient attendances and this was delivered by a three-tier rota: junior doctors, middle grade doctors and consultants.

The junior doctor rota was currently 1:7 whole time equivalent (WTE) having lost posts over the past two years. The trust advised this did not provide adequate training opportunities or cover for the wards for annual leave and study leave and was not sustainable at this number.

The middle grade rota was currently 1:6 whole time equivalent (WTE). It had been a challenge to maintain this level over the past few years due to the lack of middle grade doctors. There was currently a 2.8 WTE gap on the rota with locums and consultants covering the gaps including at night and weekends.

The service always had a consultant on call during evenings and weekends. There were 18 consultants (16.20 WTE) and two (1.6 WTE) specialty doctors. There was a rotational consultant of the week. There were no vacancy gaps for the consultants.

The medical staff operated an on-call rota so there were always appropriately qualified staff to contact in an emergency. Doctors covered both the wards and the SCBU at night. Staff said it would be preferable to have a dedicated consultant for each service. Although doctors could take a shortcut route it was quite a distance between the units and staff would have to run the distance between the units.

The trust outlined plans for the ideal rota position:

- To have 1:9 WTE on the junior rota to enable adequate provision of training and service delivery. Nine doctors would enable two junior doctors to work in the evenings and also gain experience in SCBU, outpatients, Louisa Cary ward and the short stay paediatric assessment unit (SSPAU). This number would also enable doctors to attend study days both mandatory and additional opportunities.

- To have 1:8 WTE on the middle grade rota to ensure adequate training during their rotation alongside service delivery. The doctors covering this rota could either be general paediatric trainees or community trainees and therefore needed to gain these competencies before they were signed off. However, due to the numbers on the rota the community trainees were still required to cover the acute service for out of hours and occasionally during the day from 9am to 5pm when the rota had gaps.

The trust had joined the British Association of Physicians of Indian Origin (BAPIO) in 2018. The three doctors selected had yet to start working at the hospital and a further review would be undertaken in March 2020 and a decision made as to whether to join the BAPIO process again in October 2020 to recruit more doctors.

A Band 4 clinical scribe administrative role was being trialled to work alongside the consultant ward round to help facilitate early discharge and timely patient management. The post began in September 2019 and data was being collated and audited to evidence the effectiveness of this support role on the Louisa Cary ward.

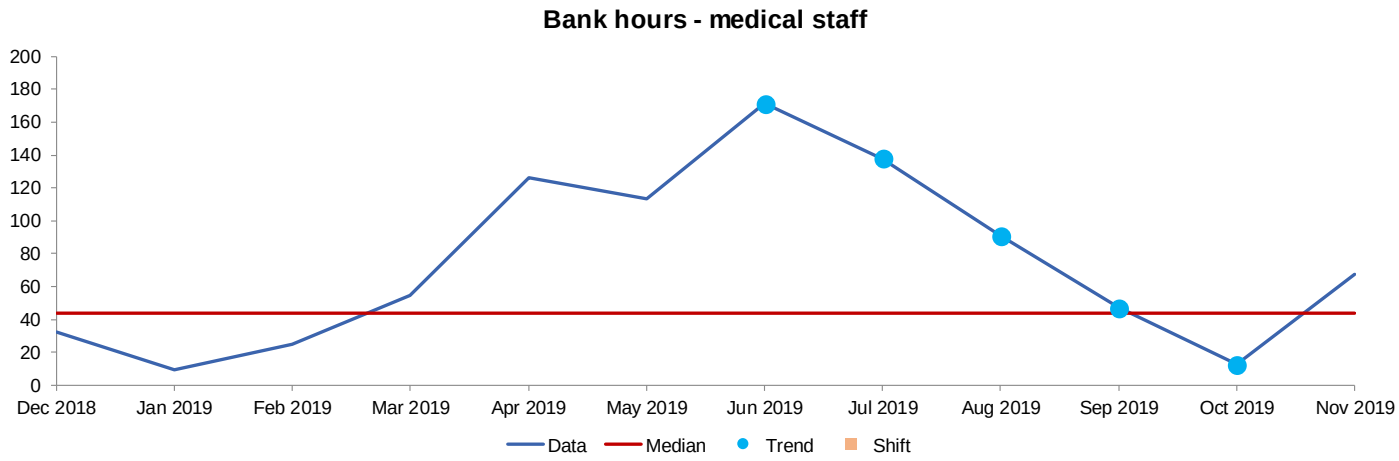
Medical staffing rates within children's services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and agency use.

Vacancy rates

There was currently a 2.8 WTE gap on the rota with locums and consultants covering the gaps including nights and weekends.

Bank and locum staff usage

The service had reducing rates of bank and locum staff.



Monthly bank use over the last 12 months for medical staff showed a downward trend from June 2019 to October 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

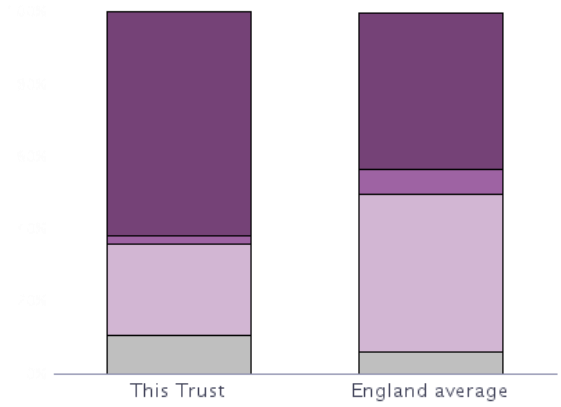
Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In October 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was also higher.

Staffing skill mix for the 28 whole time equivalent staff working in services for children and young people at Torbay and South Devon NHS Foundation Trust



	This Trust	England average
Consultant	62%	43%
Middle career^	3%	7%
Registrar Group~	25%	44%
Junior*	11%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Allied Health Professional staffing

There was provision of physiotherapy, occupational therapy and speech and language therapy for children and young people in both acute and community services.

Other professionals supporting the care of children while they were patients on the ward included dieticians and the pharmacist team.

Records

Staff kept detailed records of children and young peoples' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

During the inspection in 2016 there was a lack of clarity and inconsistency around care planning for children and young people on Louisa Cary ward. This had improved.

Records were stored securely. There was improved access and safe storage of notes. Cabinets and trolleys were locked and could only be accessed by appropriate people.

Patient notes were comprehensive, and all staff could access them easily. We reviewed ten sets of patient records. They had a standard layout and format which assisted the clinician to locate the information they needed specific to the patient's condition.

All notes were signed and dated. Information was complete and concise and care plans were up-to-date. The records were well completed and reflected the needs of children and young people. Each set of records provided detail of the care and treatment plan and included information from the multi-disciplinary team. For example, we saw the medical staff, therapists and dietitian had written in the notes and detailed the action staff needed to take to meet the individual needs of the patient. This ensured co-ordinated care with clear and effective communication between the relevant clinicians. Medical case notes were flagged to highlight allergies and special conditions.

Consent forms for sharing information and consent for procedures or operations were completed. All paediatric early warning scores were completed and scored. There was also evidence of discussion with the child or young person and/or their parents or carers.

Records contained all previous notes from the patient's mental health assessments. Staff were able to easily identify where mental health assessments were in patients' files. Patient records showed the child and adolescent mental health services checklist and safety plans had been completed and reviewed. Safety plans detailed the patient's known risks, an action plan for them, assessed observation levels and when plans needed reviewing. Plans included an emergency department risk assessment.

Child protection concerns were highlighted within the patient records and the electronic system showed an alert to ensure all staff were aware of any additional safeguarding actions they were to take.

Medical notes in the outpatient departments were stored securely to ensure confidentiality. Medical case notes could be tracked and located using a tracer system. On occasions when records had not been correctly tracked for outpatient attendance, staff said it was easily rectified and did not cause any delays in treatment.

On the special care baby unit information was clearly and concisely recorded with details of what was happening now, the long-term goals, how they would be achieved, and clear review dates. Care plans were reviewed and updated regularly in conjunction with the baby's family. All neonatal early warning scores were completed and accurately recorded to reflect the routine observations undertaken to determine where intervention might be required.

There were regular monthly note keeping audits. The average completion and compliance for the period from January to March 2020 was 93.1%.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Nursing and medical staff had access to pharmacists who were available between 8.30am and 5pm on Monday to Friday, and from 8.30am to 12.30pm at weekends. At all other times the on-call pharmacist was available to address urgent enquires, supplies and discharge requests from 5.30pm Monday to Friday and after 12.30pm at weekends. Opening hours extended in periods of high demand.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked cupboards and trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely and managed appropriately. Regular balance checks were performed in line with trust policy. The cupboards were well organised and functional.

However, not all bottles were marked clearly with expiry dates. Morphine sulphate solution bottles had no dispensing stickers or non-opening stickers on the bottle and a Gabapentin liquid bottle had a dispensing sticker but no date of opening sticker. The importance of having marked open bottles with the open on date and expiry date was fed back and discussed with the chief pharmacist.

Medicines to take away were stored in cupboards in the main ward and in the short stay paediatric assessment unit. They were administered using triplicated forms and ward staff transferred information of the discharge medications to the GP.

Triple checks of all chemotherapy prescriptions were made by the pharmacist, the consultant or staff grade doctor in line with trust policy.

The temperature was around 23 degrees in the room where medicines were stored on Louisa Cary ward. Staff said it could get hot in the summer months and quotes had been obtained for the installation of air conditioning.

Staff stored and managed most medicines and prescribing documents in line with the provider's policy. Medicines refrigerators and treatment room temperature records showed medicines were stored at the correct temperatures. However, we found the refrigerator door was open and bleeping when we arrived, and the temperature was 15 degrees. We advised staff that temperatures discrepancies with a range of between 2 and 8 degrees must be acted on and not just recorded in the log book.

We also queried a refrigerator temperature reading of minus 44. The technician manager, who oversaw any problems with refrigerator temperature probes, was informed of the discrepancy. We were assured this was not a true reading of the temperature and was instead an incorrect setting of the maximum and minimum temperature. The nurse checking the temperature would have pressed the correct button to look at the actual temperature recorded in the refrigerator. One of the technical team visited Louisa Cary ward shortly after we raised the query and reset the parameters of the refrigerator probe. The refrigerator was reading within the normal values and had been checked over a 30-minute period.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines. We saw nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. Information about medicines was provided to children and their parents. A pharmacist visited daily to review prescriptions and advise medical staff when doses needed to be revised.

Drug charts were well designed to ensure safely administration of medicines. The medicine administration chart had different colour-tagged pages to indicate the categories of medicines from acute, regular oral, anti-coagulant injection and oral, warfarin, diabetic injections with clinical blood monitoring, medicines taken as needed and other injectables and infusions.

We saw prescriptions were signed and dated. Antibiotics were prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines. We also saw from records on the children's wards documentation was complete and legible. It was signed and dated, with children's age, weight and allergies recorded.

Medicines were reconciled in line with current national guidance on transfer between locations or changes in levels of care. Doctors and ward pharmacy technicians on the wards ensured medicines reconciliation.

Staff followed current national practice to check children and young people had the correct medicines. Policies and procedures were available and accessible to staff on the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Information was also available to all staff on an App for guidance and local formulary for antimicrobial prescribing and reference books.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Staff knew how to report incidents or near misses via the trust's electronic reporting system. Staff felt confident in raising an incident should they need to. Managers investigated incidents and shared lessons learned with the whole team and the

wider service. They gave us examples of what they would report as an incident and how they would respond to the person involved.

Decision making processes ensured children and young people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' and parents' consent.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. All incidents were reported directly onto the incident reporting system. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff said they were encouraged to report incidents promptly and staff received feedback from investigation of incidents, both internal and external to the service.

We reviewed four incidents and saw the details of the investigation, the root cause and recommendations and the action plan to address them. The top incident categories from December 2018 to November 2019 concerned drug errors, security and delays in treatment.

Staff confirmed they received feedback after reporting an incident and an action plan was shared. Feedback was shared through ward handovers, newsletters and safety huddles.

Never Events

The service had no never events on any wards.

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 2018 to November 2019, the trust reported no never events for children's services.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere. Learning was shared at unit meetings and minutes were emailed to staff and a paper version was displayed in staff areas.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents and were clear about how they would report them. All staff received training on incident reporting.

Managers investigated incidents thoroughly. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and

the roles and responsibilities of staff involved in the process.

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) which met the reporting criteria set by NHS England from December 2018 to November 2019, classified as abuse/alleged abuse of a child by staff. We saw the investigation report. Root cause analysis and the actions taken.

(Source: Strategic Executive Information System (STEIS))

There was evidence changes had been made as a result of feedback. We saw the actions taken immediately following a drug error when the child's weight was incorrectly recorded, and the process was changed requiring a double check and sign off each day.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents started at the point where the event happened, with any necessary local action being taken to minimise a similar event from reoccurring.

From the incident system and through the quality improvement group dashboard common themes and concerns could be identified which allowed a quick and simple deeper dive when necessary.

Learning was shared using a variety of methods. Firstly, there was an immediate response and any local action taken to help prevent a reoccurrence. There were daily safety briefings or formal feedback methods such as team meetings to help spread any learnings from events.

Feedback from incidents was shared at the integrated service unit's various governance meetings. Issues involving numerous departments were often shared with other specialities where co-share meetings existed, for example child health and the emergency department.

Feedback was also shared through various other meetings and avenues including quality improvement projects, newsletters and intranet sites.

The governance coordinator meetings and the quality improvement group meeting also allowed sharing and learning from events. Serious events were also viewed at the serious adverse events group.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Although we did not see any examples of where duty of candour had been applied, staff demonstrated an understanding of their responsibilities and could describe the process and what they would do. 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.

There was a trust policy on being open and the duty of candour. Integrated service units were responsible for managing their incidents and the subsequent duty of candour.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

Staff used the safety thermometer data to further improve services. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Safety thermometer data was displayed on wards for staff, children, young people and their families to see. The safety thermometer data showed the service achieved harm free care within

the reporting period. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

The safety thermometer data showed the service achieved harm free care within the reporting period. Data from the patient safety thermometer showed the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from December 2018 to November 2019 for children's services.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. There was an in-house database to manage NICE guidelines holding information for all guidance. New or updated guidance was distributed at the end of each month to clinical leads and integrated service units.

Policies were available to all staff on the trust intranet system and staff demonstrated they knew how to access them.

The service undertook national audits including the National Paediatric Diabetes Audit (NPDA) for 2017-2018 and the National Neonatal Audit performance. Results are reported in the Patient outcomes section below.

Staff followed best practice for assessing and monitoring the physical health of people with severe mental illness. Staff received support and guidance for NICE guidelines and the child and adolescent mental health service from the local mental health trust. Staff obtained updates about following best practice from clinical leads through information sharing in staff meetings or sharing information on the intranet.

Children and young people received a comprehensive assessment, including a history of any past or current mental health problems alongside the assessment of their physical health needs. Nursing and medical staff were members of regional networking groups to share learning, knowledge and updated information between trusts.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Children and young people were provided with a choice and variety of meals. Specialised diets, such as vegetarian or dairy free, were catered for. Most children and young people we spoke with were positive about the food and the options they had. Snacks, sandwiches and drinks were available for children in addition to the regular

breakfast, lunch and tea.

Staff fully and accurately completed children and young peoples' fluid and nutrition charts where needed. We reviewed ten records and charts were completed regularly to respond to nutritional and hydration needs. We saw a nutritional needs assessment had been completed.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. The assessment and response to children and young people's nutritional and hydration needs were managed effectively. Children and young people were screened to identify those who were malnourished or at risk of becoming malnourished.

Specialist support from staff such as dietitians and speech and language therapists was available for children and young people who needed it. Dieticians provided nutritional support, advice and education to children and parents about diet, supplements and enteral feeding. They were also involved with the planning of nutritional regimes, for example, for young people with an eating disorder.

Breast feeding support was provided by the team who gave advice on milk supply, initiating lactation, pumping, transition to responsive feeding, and any other feeding issues. We saw information boards, in all bays, displaying illustrations and photographs of breastfeeding positions and methods. We observed staff assisting women to feed their babies. Women who could not breastfeed were supported to express milk.

There were milk refrigerators on Louisa Cary ward and the specialist care baby unit. Once milk had been expressed a label with the name of the baby, date and time of expression was placed over the lid and down the bottle. Staff encouraged parents to label their own milk.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young peoples' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was guidance in care plans about pain management for children where it was appropriate, for example, after surgery. Children and young people had their pain assessed and appropriate methods of reducing pain were offered. Nurses assessed children's pain by using age appropriate assessment tools such as smiley faces, indicators from behaviour or responses, and numbers for older children. These assessment tools helped children of all ages and abilities to communicate about any pain. The assessments were included in every child's nursing record we looked at.

For babies in the SCBU, pain and stress were monitored and registered simultaneously with other physiological parameters such a temperature and blood pressure. This made it possible to continuously evaluate any pain and the need for pain relief or comfort measures. Every baby was assessed on admission to the SCBU, before and after potentially painful interventions, and at regular intervals.

Children and young people received pain relief soon after requesting it. We observed staff asking the children and young people if they had any pain or discomfort. Parents said staff regularly checked with their child asking them if they had any pain and gave pain relief when it was required. Parents and carers were involved in discussions about the pain management for their babies.

Staff prescribed, administered and recorded all pain relief accurately. From the records we

reviewed we saw pain relief was prescribed to be given regularly and as needed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. There was an annual audit plan which enabled the service to benchmark the standard of paediatric and specialist baby care provided at the trust against local and national standards. Local audits included barriers to implementing the NICE guidelines for jaundice in new born babies under 28 days, the outcome of waterbirth babies and the reasons for admission to the SCBU, paediatric head injury (post injury observations), neonatal lumbar puncture in sepsis, diagnosis and initial management of juvenile idiopathic arthritis, and seizures and epilepsies in children and young people.

Short stay paediatric assessment unit (SSPAU) standards had highlighted the need to audit some areas within the pathway to ensure adherence and to provide evidence against the national standards issued.

There had been a review of the paediatric acute care pathway to redesign the current pathway to manage the increase of demand and ensure children were prioritised appropriately. Actions had been identified with target dates and who had responsibility.

There were a number of pathways and projects including a mental health care pathway for the children and young people's service and the emergency department and a multicentre hypertension in children project.

Managers and staff used audit results to improve patient outcomes. Audits were monitored and action plans to address areas of improvement were regularly reviewed.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. Accurate and up-to-date information about effectiveness was shared internally and externally and understood by staff. Results were used to improve care and treatment and this improvement was checked and monitored.

There were clinical pathways for the most frequent reasons children came to hospital including head injury, abdominal pain and fever. These gave clear and consistent guidance about how to treat these conditions. We saw details of the bronchiolitis care bundle and the trial from October 2019 to February 2020 for babies or children presenting with bronchiolitis, and details of the children's acute surgical abdomen programme.

The service maintained a clinical child health dashboard of outcomes which was reviewed and updated every month. Information was audited and actions taken with regards to quality and safety outcomes. Information from the dashboard was shared with staff and with the board through governance meetings.

Managers shared and made sure staff understood information from the audits. Information was shared at unit meetings and by email. Staff confirmed they were kept up-to-date with results and any actions required.

The service was accredited by the UNICEF Baby Friendly Awards. This was an initiative launched by the World Health Organisation and UNICEF to implement practices that protect, promote and support breastfeeding. Staff supported mothers with breastfeeding offering advice and guidance where necessary.

There were good results for young people with eating disorders following the appointment of a

specialist nurse and a reduction in the number of patients admitted with a low weight.

The table below summarises performance in the 2017-18 National Paediatric Diabetes Audit:

Metrics *(Audit measures)*	**Hospital performance**	**Comparison to other Trusts**	**Met national standard?**
Completion rate for key health checks for patients aged 12+ *There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually*	88.3%	Within expected range	No current standard
Case-mix adjusted mean HbA1c *HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year*	72.2	Worse than expected	No current standard
Median HbA1c *This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant*	68.5	Clinically significant improvement	No current standard

(Source: National Paediatric Diabetes Audit)

National Neonatal Audit Programme

The table below summarises performance in the 2018 National Neonatal Audit Programme:

Metrics *(Audit measures)*	**Hospital performance**	**Comparison to other Trusts**	**Met national standard?**
Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc? *Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants*	59.3%	Within expected range	Did not meet (Audit recommendation 90%)
Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? *Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience*	82.1%	Negative outlier	Did not meet (Audit recommendation 100%)

Metrics *(Audit measures)*	Hospital performance	Comparison to other Trusts	Met national standard?
Do all babies < 1501g or a gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) *ROP is a preventable cause of blindness in pre-term infants provided it is detected and treated in a timely way*	97.1%	Within expected range	Did not meet (Audit recommendation based on specialist guideline 100%)
Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age? *It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit*	61.8%	Within expected range	Did not meet (Audit recommendation 100%)

(Source: National Neonatal Audit Programme)

Emergency readmission rates within two days of discharge

From August 2018 to July 2019 no specialty had more than eight readmissions following an elective admission.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded.

The data shows from August 2018 to July 2019 there was a similar percentage of under ones readmitted following an emergency admission compared to the England average for paediatrics:

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (August 2018 to July 2019)

Specialty	Torbay and South Devon NHS Foundation Trust			England
	Readmission rate	Discharges (n)	Readmissions (n)	Readmission rate
Paediatrics	3.8%	790	30	3.7%
No other specialty at the trust had eight or more readmissions				

For patients aged 1-17 years old, there was a lower percentage of patients readmitted following an emergency admission compared to the England average for paediatrics.

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (August 2018 to July 2019)

Specialty	Torbay and South Devon NHS Foundation Trust			England
	Readmission rate	Discharges (n)	Readmissions (n)	Readmission rate
Paediatrics	1.8%	2,185	40	2.9%
No other specialty at the trust had eight or more readmissions				

(Source: Hospital Episode Statistics)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes.

From September 2018 to August 2019 the rate of patients aged 1-17 years old who had multiple readmissions for asthma and epilepsy was higher than the England average.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (September 2018 to August 2019)

Long term condition	Torbay and South Devon NHS Foundation Trust			England
	Multiple admission rate	At least one admission (n)	Two or more admissions (n)	Multiple admission rate
Asthma				
Under 1	-	-	-	8.3%
1 to 17	20.0%	50	10	15.8%
Diabetes				
Under 1	-	-	-	12.5%
1 to 17	*	30	*	13.0%
Epilepsy				
Under 1	-	-	-	35.0%
1 to 17	60.0%	25	15	28.6%

Notes: To protect patient confidentiality, figures between 1 and 7 and their associated proportions have been suppressed and replaced with "" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed. Numbers of admissions have been rounded to the nearest 5 and the trust's multiple admission rate is based on the rounded figures. The "-" (a hyphen) in the table indicates that there were no admissions for these long-term condition or age groups.*

(Source: Hospital Episode Statistics)

There was an internal mortality and morbidity structure where deaths were reviewed locally, a central serious adverse events group, where deaths were reviewed corporately and also a mortality surveillance group. All paediatric mortality was reviewed as standard and linked into the child death process. The trust's aim was for any learning and sharing to take place at the local integrated service delivery unit level. There was also visibility of the learning within the quality improvement group, through trust wide discussions at serious adverse events group, as well as through policy change, quality improvement programmes, educational programmes, alerts, and procurement changes to help prevent a reoccurrence.

During the last inspection there was a backlog of discharge summaries on Louisa Cary ward, in part due to the changeover of medical staff and high levels of patient activity. This had improved and GPs were receiving information in a timely way to ensure continuity of services to the child and their family.

The team had been working closely with colleagues in maternity and were involved in the avoiding term admissions into neonatal units (ATAIN) programme. Mothers and babies were cared for together on the post-natal ward. Through this transitional care model there were 60 fewer babies admitted to the SCBU, a reduction in length of admission and almost half the number of antibiotics prescribed.

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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. 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.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical supervision enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Most staff were positive about the frequency of clinical supervision they received.

All staff were encouraged to access clinical supervision, but this was not a mandatory requirement within nursing. There was a process for medical supervision, and this was documented within appraisals.

All nursing staff received regular one-to-ones with their line manager and individual records were kept for reference. There was monthly group supervision at Band 7 ward managers' meetings. Matrons received regular one-to-ones with their line manager, individual records were kept for reference. In addition, there was a weekly huddle for early escalation of issues and support.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Minutes of meetings were emailed to all staff and a paper version was available in staff rooms.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training and development in paediatric specific areas.

Managers made sure staff received any specialist training for their role. The service undertook a range of education and practice development activities aimed at enhancing the knowledge, skills and awareness and development of the staff. There were study days including training on paediatrics and new born babies and speciality training. There was regular simulation training and opportunities to develop new skills, for example, IV medications and breast pump training.

The clinical educators supported the learning and development needs of staff. There was a practice educator role for the specialist care baby unit to assist with all training and all medical and nursing induction.

The ward had received a certificate of recognition for the outstanding contribution to the support of practice learning of the pre-registration nursing students.

The advanced nurse practitioner (ANP) role had been introduced on the ward and physicians' associate training in child health was also supported.

There was a trust-wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training through regular competency reports.

Surgeons and anaesthetists had appropriate training and competence to handle emergency surgical care of children, and nurses were required to maintain paediatric competency.

Physiotherapist and occupational therapists were paediatric trained.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Most staff felt the training was sufficient to provide them with the knowledge and skills required to care for patients with mental health needs, learning disabilities and autism. Staff said they learned on the job and relied on specialist teams (such as the child and adolescent mental health service for specialist skills and support.

At the previous inspection there were shortfalls in staff training which related to children with mental health issues. This had improved and staff said they had completed mental health training modules, and saw this as part of their core business and daily responsibility.

Managers gave all new staff a full induction tailored to their role before they started work. Staff confirmed they received a comprehensive induction and shadowed shifts before they started on the wards. They felt confident and prepared to work on the units.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. Annual appraisal and clinical supervision structures enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Most staff said they had received an appraisal during the last year. Most staff were positive about the quality and the frequency of appraisal and clinical supervision they received.

From December 2018 to November 2019, 89.5% of staff within children's services received an appraisal compared to a trust target of 90%. This compared to an appraisal rate of 82.1% in the previous financial year (April 2018 to March 2019).

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and ancillary	1	1	100.0%	90.0%	Yes
Additional clinical services	23	23	100.0%	90.0%	Yes
Nursing and midwifery registered	57	65	87.7%	90.0%	No
Administrative and clerical	4	6	66.7%	90.0%	No
Total	**85**	**95**	**89.5%**	**90.0%**	**No**

Appraisal data provided by the trust for this core service did not include medical staff.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Revalidation for nursing staff was supported well and the trust had received good feedback from the General Medical Council (GMC) regarding their training for junior doctors. Revalidation is the process by which the GMC for medical staff and the Nursing and Midwifery Council (NMC) are assured of the clinician's ability to continue practice and retain their registration with the appropriate professional body.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. There were multidisciplinary (MDT) clinical team meetings and conference calls and MDT ward rounds. There were MDT integrated clinical pathways to improve the patient outcomes and experience during their stay.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. There were joint community-based MDT clinics with the integrated therapy service providing regular clinics for chronic long-term conditions.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health or depression. There was close working with the child and adolescent mental health service who contacted the ward every day to check for any new referrals and conducted any assessment when necessary.

There was also close working with social services and education services.

CQC Children and Young People's Survey 2018 – Q23

In the CQC Children and Young People's Survey 2018 the trust scored 8.7 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2018)

Seven-day services

Key services were available seven days a week to support timely care for children, young people and their families.

Consultants led daily ward rounds on all wards, including weekends. Children and young people are reviewed by consultants depending on the care pathway. There was 24-hour medical cover seven days a week on the children's ward and the special care baby unit. Consultants were available in the hospital each day to oversee and provide care and treatment, supported by junior and middle grade medical staff.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Child and adolescent mental health service were available seven days a week.

There was access to pharmacy seven days a week between 8.30am and 5pm on Monday to Friday and from 8.30am to 12.30pm at weekends. On call services were available in the evenings and at weekends to address urgent enquires, supplies and discharge requests. Opening hours extended in periods of high demand.

Health Promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards/units.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. Health promotion was a routine part of all care provided to children and young people. All staff worked collaboratively to assess all aspects of general health and to provide support and advice to promote healthy lifestyles.

Staff provided support to parents and families to stop smoking by providing advice and information on the negative effects of smoking around babies, toddlers and older children. Leaflets about the health problems caused by second hand smoke and the stop smoking services and the smoke free homes initiative available in Torbay were readily available

Staff also provided support for breast feeding and promoted the importance that every contact counted.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty when appropriate.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff said they were confident in making capacity assessments.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had attended training and knew what their responsibilities were and how to apply them within everyday practice when required.

Staff made sure children, young people and their families consented to treatment based on all the information available. Staff said they obtained consent from children, young people and their parents / carers prior to commencing care or treatment. They said children and young people were given choices when they accessed their service. Staff told us about how they dealt with consent issues for young people who did not want to tell their parents. They always tried to sensitively manage the situation while ensuring the young person received the help they needed.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The guidelines are used in medical law to establish whether a child (16 years or younger) can consent to his or her medical treatment without the need for parental permission or knowledge. We saw written evidence within patient records where children had been assessed as having Gillick competency and where they had not. This demonstrated each child was assessed on an individual basis. Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parents' consent. Staff were knowledgeable about the guidelines.

Gillick competencies were reviewed with support from the child and adolescent mental health service who came onto the ward to assess young people under the age of 16 and their capacity to consent to treatment. If a young person refused treatment, staff conducted best interest meetings and documented this in their care files.

We saw evidence of consideration of Gillick competence. There was a query relating to the use of parental consent for a patient about to turn 16 who did not appear to consent to stay on the ward. However, following discussions with staff we were assured this was not the case and this was more a case of notes not fully reflecting the true situation.

Staff had advised the young person of their rights as an informal patient when they turned 16 (and parental consent no longer being appropriate in light of them having mental capacity to make this decision). The young person had agreed to stay on the ward.

When children, young people or their families could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. These decisions and the rationale were documented in children and young people's records.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Throughout the inspection we saw staff explaining the assessment and consent process to parents / carers and any need to share information with other professionals such as GPs, nursery or school before obtaining written consent. We saw consent forms signed appropriately by parents.

Staff clearly recorded consent in the children and young people's records. This was clearly recorded in all the records we reviewed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were aware there were additional steps to consider if the patient did not consent to treatment. Staff contacted the approved mental health practitioner (AMHP) team at the local mental health trust and gave an example of supporting a young person to appeal their detention under Section 2 of the Mental Health Act. Staff could access the Code of Practise online if they needed to reference this.

Mental Capacity Act and Deprivation of Liberty training completion

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We were shown data to show most staff (87%) were compliant with Mental

Capacity Act and Deprivation of Liberty Safeguards.

Trust level

The trust reported mental capacity act training including deprivation of liberty standards was delivered as part of the corporate and clinical induction for all new staff. No training data for these courses was provided to CQC as part of the provider information request.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Other CQC Survey Data

CQC Children and Young People's Survey 2018 Data

The trust performed about the same as other trusts for all four questions relating to effectiveness in the CQC Children and Young People's Survey 2018.

CQC Children's Survey questions, effective domain: **Torbay and South Devon NHS Foundation Trust**

Question	Age group	Trust score	RAG
Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	8.6	About the same as other trusts
Did staff play with your child at all while they were in hospital?	0-7 adults	7.7	About the same as other trusts
Did different staff give you conflicting information?	0-7 adults	7.6	About the same as other trusts
During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	7.5	About the same as other trusts

(Source: CQC Children and Young People's Survey 2018)

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families and staff took time to interact with them in a respectful and considerate way. During our inspection we observed positive interactions between staff, children, young people and their families. Staff were open, friendly and approachable and interactions were very caring, respectful and compassionate.

Children, young people and their families said staff treated them well and with kindness. Care from the nursing, medical staff, play specialists and support staff was delivered with kindness and patience. The atmosphere was calm and professional, without losing warmth. Staff were focused on the needs of the patients and ensured children, young people and their parents felt respected and valued as individuals.

Staff were skilled in talking with and caring for children and young people. They spoke kindly and in an age appropriate way to children and young people. We saw staff always had a smile for

children and young people and made the ward feel like a fun environment.

Staff involved and encouraged both children and parents as partners in their own care. Parents, siblings and grandparents were encouraged to provide as much care for their children as they felt able to, while young people were encouraged to be as independent as possible.

Play specialists supported siblings and other children to help them understand what their brother, sister or friend was experiencing.

Children, young people and their families and carers spoke positively about their experience. They confirmed the staff were kind and helpful to them. We observed medical and nursing staff interacting and engaging with the child, not only during episodes of care, but also in the day to day routine of the ward.

The comments we received from parents on the children's ward included, "the team are wonderful "I can't thank them enough … they're all so kind and helpful and nothing is too much trouble," and another said, "I'm so grateful for everyone's kindness and support and special care helping our daughter and my family."

The children and young people said how friendly the staff had been during their stay. One child told us they liked coming to the ward and other comments included, "the nurses are nice and make me feel better," "everyone's really friendly and they make me smile," and another said, "I really like all the toys and watching the fish."

Staff told us how they had moved an oxygen saturation machine just outside the cubicle at night to prevent the child's mother being disturbed through the night by the noise of the machine. Staff told us about how they decorated one of the rooms with banners and messages to welcome back a child to the ward and praised the kindness of the hotel service staff and cleaners who were the eyes and ears on the ground and took time to talk to a child or young person if they seemed sad and needed extra support.

Managers told us about staff who had volunteered to provide extra support to parents who had arrived in the emergency department with small babies.

Parents on the special care baby unit were also unanimous in their praise and many parents had written cards to express their thanks. Comments included, "they are amazing and the care has been great," "I was very scared when I came here but they are so calm and explained everything."

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Children we spoke to said they had seen a nurse straight away who explained what would happen next. Young people said they were treated with respect and staff understood their mental health condition. They said they felt safe in their environment. We saw examples in notes of personalised care taking into account the young person's individual needs in line with their mental health.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. They were knowledgeable about the trust framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for families with hearing or visual impairment, or who had learning disabilities.

CQC Children and Young People's Survey 2018 questions, compassionate care, Torbay and South Devon NHS Foundation Trust

CQC Children and Young People's Survey 2018

The trust performed better than other trusts for one question and about the same as other trusts for the remaining nine questions relating to compassionate care in the CQC Children and Young People's Survey 2018.

The trust performed better than other trusts for staff being available to give children attention when needed.

CQC Children and Young People's Survey 2018 questions, compassionate care, Torbay and South Devon NHS Foundation Trust

Question	Age group	Trust score	RAG
Did new members of staff treating your child introduce themselves?	0-7 adults	8.6	About the same as other trusts
Did you have confidence and trust in the members of staff treating your child?	0-15 adults	8.7	About the same as other trusts
Were members of staff available when your child needed attention?	0-15 adults	8.6	Better than other trusts
Do you feel that the people looking after your child were friendly?	0-7 adults	8.8	About the same as other trusts
Do you feel that your child was well looked after by the hospital staff?	0-7 adults	9.1	About the same as other trusts
Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	8.7	About the same as other trusts
Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	6.7	About the same as other trusts
If you had any worries, did a member of staff talk with you about them?	8-15 CYP	8.6	About the same as other trusts
Do you feel that the people looking after you were friendly?	8-15 CYP	9.2	About the same as other trusts
Overall, how well do you think you were looked after in hospital?	8-15 CYP	8.8	About the same as other trusts

(Source: CQC Children and Young People's Survey 2018)

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families and those close to them help, emotional support and advice when they needed it. We observed staff providing emotional support to children, young people, their parents, siblings and grandparents during their visit to the unit. Children's individual concerns were promptly identified and responded to in a positive and reassuring way.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Throughout our inspection, we saw children and young people being treated with dignity and respect. Curtains were drawn around bed spaces for intimate care or procedures, voices were lowered to avoid confidential or private information being overheard. All parents said their privacy and dignity was maintained.

Staff understood the emotional and social impact a child or young person's care, treatment or condition had on their, and their family's wellbeing. Children, young people and their families were spoken with in an unhurried manner and staff checked if information was understood. Staff talked about children and young people compassionately and with knowledge of their circumstances and those of their families.

There was good support from the hospital multi-faith chaplaincy and pastoral team who were available in the hospital during normal office hours (9am to 5pm) including weekends. A chaplain was always on call, day and night to respond to urgent requests for children and young people, and their family and friends.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Difficult information was discussed in a sensitive manner and a parent told us how supportive the entire team had been, "everyone has helped me get through things ... they'll never know how grateful I am to them."

There were frequent attenders who had formed a relationship with doctors and nurses. Parents said, "they're like a second family and always make us feel safe and secure."

Parents on the SCBU also confirmed the support they had received from staff. One mother said, "everyone's so supportive … I don't know where I'd be without them."

Staff encouraged families, friends and carers to visit the ward and the SCBU. Facilities were available for parents to stay overnight with their children and babies. Visiting times were flexible so children could receive comfort from their family or carer at significant times to them.

CQC Children and Young People's Survey 2018

The trust performed about the same as other trusts for all five questions relating to emotional support in the CQC Children and Young People's Survey 2018.

CQC Children and Young People's Survey 2018 questions, emotional support, Torbay and South Devon NHS Foundation Trust

Question	Age group	Trust score	RAG
Was your child given enough privacy when receiving care and treatment?	0-7 adults	8.9	About the same as other trusts
If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	8.8	About the same as other trusts
Were you treated with dignity and respect by the people looking after your child?	0-15 adults	9.5	About the same as other trusts
Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	9.3	About the same as other trusts
If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	8.8	About the same as other trusts

(Source: CQC Children and Young People's Survey 2018)

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment.

Children, young people and their families were involved with their care and decisions taken. Parents said all procedures had been explained and they felt included in the treatment plan and were well informed. This included the consultant explaining the surgery events in detail to a parent and nurses talking parents through information leaflets.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. We observed staff explaining things to parents, children and young people in a way they could understand to help them become partners in their care and treatment.

Staff supported children, young people and their families to make informed decisions about their care. Parents were encouraged to be involved in the care of their children as much as they felt able to. We observed children and young people were also involved in their own care. Children, young people and parents we spoke with all confirmed this was the case. One parent on the ward told us how staff had taken time to advise her about the importance of a smoke free zone at home and the support available to the family locally to stop smoking.

Staff recognised when children, young people and their families needed additional support to help them understand and be involved in their care and treatment. We observed a ward round, where the child was the focus and included in discussions and asked for their opinion about the treatment plan and if they had any questions.

Staff made sure children, young people and parents knew who the staff were and what they did. All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities.

Staff showed understanding and a non-judgmental attitude when caring for or talking about children and young people with mental health needs, learning disabilities or autism.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. The trust used the NHS Friends and Family Test to find out if children, young people and their parents would recommend their services to friends and family if they needed similar treatment or care.

A high proportion of children, young people and their families gave positive feedback about the service in the Friends and Family Test. Comments included "I had detailed discussions each day and I can always ask questions." Another said, "everyone's been amazing and all my questions were answered in a language I understood."

CQC Children and Young People's Survey 2018

The trust performed better than other trusts for one question and about the same as other trusts for the remaining 20 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2018.

The trust performed better than other trusts for staff being available to answer questions.

CQC Children and Young People's Survey 2018 questions, understanding and involvement of patients, Torbay and South Devon NHS Foundation Trust

Question	Age group	Trust score	RAG
Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	9.1	About the same as other trusts
Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	8.1	About the same as other trusts
Did a member of staff agree a plan for your child's care with you?	0-15 adults	9.2	About the same as other trusts
Did staff involve you in decisions about your child's care and treatment?	0-15 adults	8.4	About the same as other trusts
Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	8.5	About the same as other trusts
Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	8.3	About the same as other trusts
Were you able to ask staff any questions you had about your child's care?	0-15 adults	9.0	About the same as other trusts
Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	9.1	About the same as other trusts
Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	9.5	About the same as other trusts
Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	8.6	About the same as other trusts
When you left hospital, did you know what was going to happen next with your child's care?	0-15 adults	7.8	About the same as other trusts
Do you feel that the people looking after your child listened to you?	0-7 adults	8.4	About the same as other trusts
Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	8.9	About the same as other trusts
When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.4	About the same as other trusts
Did you feel able to ask staff questions?	8-15 CYP	10.0	Better than other trusts
Did the hospital staff answer your questions?	8-15 CYP	9.2	About the same as other trusts

Were you involved in decisions about your care and treatment?	8-15 CYP	6.4	About the same as other trusts
Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	9.3	About the same as other trusts
Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	7.6	About the same as other trusts
When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	7.9	About the same as other trusts
If you had been unhappy with your child's care and treatment, do you feel that you could have told hospital staff?	0-15 adults	8.0	About the same as other trusts

(Source: CQC Children and Young People's Survey 2018)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the changing needs of the local population. They worked with others in the wider health and social care system and local organisations to plan care.

All planned and emergency inpatients were admitted to the paediatric ward. This included children admitted for planned surgery.

On rare occasions when a child required care to be provided in another ward in the hospital, they remained the responsibility of the paediatric services to oversee their care. For example, when a young person was distressed and displaying behaviours that might put themselves and other children on the paediatric ward at risk, arrangements would be made for them to be cared for in an environment where this risk was reduced.

The patient flow team had the hospital-wide oversight of admissions and ensured all children were directed to the unit for admission, including from emergency department.

The service relieved pressure on other departments when they could treat children and young people in a day. Staff said there had been a couple of occasions when children and young people attending the emergency department, had been directed to the ward during extremely busy periods in escalation.

Staff could access emergency mental health support for children and young people with mental health problems and learning disabilities. There were arrangements to meet children and young people's urgent or emergency mental health care needs, including outside office hours and in an emergency. The child and adolescent mental health service (CAMHS) were available to provide support from 9am to 10pm during week days, and from 9am to 5pm at weekends and bank holidays.

Referral to the CAMHS service was by made by an email referral form, generally with a follow up teleconference. Waiting times for a CAMHS review and assessments were variable depending on

the responding team. The Torbay team, who had a crisis response service, aimed to attend within 2 hours. However, the South Devon team, who did not have a crisis response team, took longer.

Where a CAMHS review did not happen during the same day, a patient was admitted to the ward to prevent unsafe discharges home.

Young people were admitted to the ward and not discharged until they had been seen by CAMHS and a safety plan was developed. Despite the current delays staff said there had been a significant improvement in CAMHS response and fewer young people were having to be admitted to the ward.

There was a paediatric psychiatric liaison service to offer support to the wards and the emergency department (ED). They aimed to respond within one hour to ED and within 24 hours to the wards. However, this was not a 24-hour service.

The team had worked with a young person who was transitioning gender and although they had not had any formal training, the team were confident they had managed this well and provided appropriate support.

We saw evidence in patient's notes of physical health checks to rule out physical causes for mental health issues. There was also evidence of consideration of the appropriateness of the environment for those with mental health needs.

The service was in the process of completing an emergency sedation protocol with CAMHS and drafting a multiagency crisis support toolkit including an escalation framework.

CQC Children and Young People's Survey 2018

The trust performed better than other trusts for three questions, worse than other trusts for one question and about the same as other trusts for the remaining 13 questions relating to responsiveness in the CQC Children and Young People's Survey 2018.

The trust performed better than other trusts for the following questions:

- Did you have access to hot drinks facilities in the hospital?
- Were you able to prepare food in the hospital if you wanted to?
- If you used the hospital Wi-Fi, was it good enough to do what you wanted?

The trust performed worse than other trusts for the following question:

- For most of their stay in hospital what type of ward did your child stay on?

CQC Children and Young People's Survey 2018 questions, responsive domain, Torbay and South Devon NHS Foundation Trust

(Source: CQC Children and Young People's Survey 2018)

Question	Age group	Trust score	RAG
For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	9.3	Worse than other trusts
Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	9.2	About the same as other trusts
Did you have access to hot drinks facilities in the hospital?	0-15 adults	9.6	Better than other trusts
Were you able to prepare food in the hospital if you wanted to?	0-15 adults	7.7	Better than other trusts
How would you rate the facilities for parents or carers staying overnight?	0-15 adults	7.8	About the same as other trusts
Was the ward suitable for someone of your age?	12-15 CYP	8.7	About the same as other trusts
Were there enough things for your child to do in the hospital?	0-7 adults	8.0	About the same as other trusts
Did your child like the hospital food provided?	0-7 adults	5.7	About the same as other trusts
Did a staff member give you advice about caring for your child after you went home?	0-15 adults	8.7	About the same as other trusts
Did a member of staff tell you what to do or who to talk to if you were worried about your child when you got home?	0-7 adults	8.4	About the same as other trusts
Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?	0-15 adults	8.0	About the same as other trusts
Were there enough things for you to do in the hospital?	8-15 CYP	6.4	About the same as other trusts
Did you like the hospital food?	8-15 CYP	6.7	About the same as other trusts
Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	7.0	About the same as other trusts
Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	8.1	About the same as other trusts
If your child used the hospital Wi-Fi to entertain themselves, was it good enough to do what they wanted?	0-7 adults	7.0	About the same as other trusts
If you used the hospital Wi-Fi, was it good enough to do what you wanted?	8-15 CYP	7.9	Better than other trusts

Meeting people's individual needs

The service was inclusive and took account of children, young people and their family's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Wards were designed to meet the needs of children, young people and their families.

Children and young people were accommodated in small bay areas with peers of the same age range or in individual rooms. All patients were risk assessed as safe to be in a side room, and subject to availability. Young people aged between 16 to 18 were risk assessed in the emergency department and admitted to an adult ward if the assessment found this to be a more suitable location.

There were no dedicated paediatric inpatient surgery lists. Children requiring inpatient surgery were admitted through the paediatric ward and placed on main theatre lists; however, 90% of elective paediatric surgery was day surgery.

Paediatric surgical interventions were in general theatres and in recovery there were two bays for children to segregate children from adults to protect their privacy and dignity.

Day surgery units provided dedicated weekly children's lists: there were two paediatric ear, nose and throat (ENT) lists and one community dental list. There were also monthly lists: one urology list and two general surgical lists. Where possible paediatric lists were grouped together to make the day surgery unit more child-friendly, by increasing the proportion of children being managed in the day surgery unit that day. When a paediatric list was being run, a paediatric nurse and play specialist were always in the unit.

Historically children had been pre-assessed along the adult pathway, however, a dedicated paediatric pre-assessment service with a band 6 paediatric nurse had recently commenced in post.

There were reclining chairs in the discharge lounge, and these were used for secondary recovery of children where appropriate, to separate the children form adults in the unit, if possible, at secondary recovery stage. As part of the day surgery pathway, all families were telephoned the day following attendance.

Children and young people attended the hospital for outpatient appointments. There was a separate area within the main outpatient clinics which was divided into zones for children of differing ages. This was decorated in a child friendly way and had toys, games and books to distract the children and young people. This included a soft play area, suitable for very young children, a games area for small children, a teenage games area and a separate TV area.

The outpatient area had been redeveloped with advice from the play specialist team. Play specialists phoned the team within the outpatient department to find out if they needed any help with blood tests.

There were treatment rooms and therapy rooms for physiotherapy, occupational therapy, a play area and soft play area. There were clinics for children and young people who had long term, chronic and ongoing conditions, physical disabilities, learning difficulties, social communication difficulties and other long-term disabilities.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions, received the necessary care to meet all their needs. The ward accepted referrals of patients with a variety of physical health conditions, making it a multi-speciality ward.

There had been increasing numbers of children and young people admitted with mental health care needs to the ward. We were told the provision of care and treatment to children and young people with mental health illnesses had at times impacted upon others on the ward. The team had worked quickly and closely with senior managers to mitigate any risks to other children. Senior managers were working closely with system partners and commissioners to manage these admissions.

The ward did not have a specific room for child and adolescent mental health service patients and used whatever room was available at the time. The room was risk assessed and any items considered unsafe were removed. Young people were generally admitted for one or two days and additional mental health nursing support would be secured where appropriate.

There was a new pathway for young people receiving care and treatment with an eating disorder. A specialist nurse and dieticians delivered an individualised plan of care.

A learning disability specialist nurse was employed by the trust and available to provide additional support and guidance for staff and patients, including children and young people. The clinical coding system identified children and young people with a learning disability. There was a daily report generated for the specialist learning disability nurse which highlighted any admissions. There was also a weekly report generated to highlight when those with a learning disability would be attending as outpatients.

These patients were assessed in the same way as any other patient for their acute health but where necessary, reasonable adjustments were made to help facilitate these assessments.

The trust palliative care team worked with the paediatric team to care for children and young people in the immediate and long-term aspect of palliative care planning.

During the last inspection staff said there were insufficient rooms available for parents to stay overnight and there was a shortage of chairs to enable mothers to nurse their babies appropriately. This had improved and parents and carers could stay with their babies and children on the ward and in the specialist care baby unit. On the ward accommodation was provided for one parent to stay overnight with their child. Each bed space had new pull-out beds next to it so parents could stay on the ward.

There were also two bedrooms and shower facilities available for parents to use throughout their stay at hospital. Parents had access to a lounge and kitchen area to make hot drinks or prepare their own food during their stay.

There was parent accommodation available in the SCBU and pull-out beds next to cots. There was also a family room where baby and parents could stay ahead of their discharge from hospital. The family room included a double fold out bed, TV, soft lighting and toys for other children of the family. There were no restrictions to visiting times. There was also access to a bereavement room for parents.

The access to the wards and use of equipment met the needs of patients and visitors with a disability.

Breastfeeding mothers were provided with additional support by staff if this was required to establish and sustain breast feeding.

Staff used transition plans to support young people moving on to adult services. A framework was available for all healthcare professionals to enable them to deliver a well-planned transitional process for young people with long-term health conditions and complex health needs as they moved from child-centred to adult-orientated services. This ensured all young people received a

high-quality service that was coordinated, uninterrupted, patient-centred, age and developmentally appropriate.

The team in the SCBU were working closely with colleagues in maternity services to facilitate a smooth transition of babies from postnatal to neonatal care.

Staff supported children and young people living with complex health care needs by using patient passports. This recorded what mattered to the child or young person and constructed a written portrait of the child to ensure there were no gaps between clinical assessment and over acceptance of the level of illness and behaviour.

The service also had discharge arrangements for children and young people with complex health and social care needs. Staff ensured the onward care team supported them to plan the discharge of patients with complex health and social care needs.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. The trust provided a framework to support communication with patients and carers for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. There was face-to-face interpretation, telephone interpreting, video conferencing and written translation services. Information could also be provided in large print, in braille, or a British Sign Language interpreter was available. In addition there was an internal service supported by speech and language therapists to address communication needs. There were speaking passenger lifts and directional signage throughout the hospital.
The service had information leaflets available in languages spoken by the children, young people, their families and local community. The hospital provided leaflets to ensure patients and their families and carers had access to written information about their illness and/or conditions. These were located in all areas and included conditions such as asthma, croup, eczema, nasal surgery, wheeze management, febrile convulsion. There were also leaflets with advice on going home.

Developmental care leaflets were available on the SCBU about topics such breast feeding, sensory light, sound and touch, and skin to skin. There were parent information boards on the children's wards, outpatient department and the SCBU giving details of meal times, infection control, activities and chaplaincy services.

Children and young people were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs. Services in both paediatrics and the SCBU promoted a family integrated service. Parents were encouraged to take the lead, where appropriate, in caring for children and babies.

The hospital's spiritual and pastoral care team provided pastoral support and spiritual care to children, young people and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community. The chaplaincy service consisted of free church, Anglican and Roman Catholic chaplains. They were supported by a team of trained volunteers who visited clinical areas. The chaplains were also able to contact other faith/ belief leaders for support where needed. Members of staff of Muslim faith were also able to offer support for other staff and patients when requested. There was a chapel on the hospital site open at all times, including a separate prayer room for those who preferred a space without Christian symbols. The chaplaincy service also provided an on-call service.

There was an annual baby and young children remembrance weekend held at the hospital. Staff from the maternity unit, chaplaincy services and children's community nursing team, together with some local parents planned the remembrance weekend, which included a craft morning for all ages on the Saturday and a special service in the hospital's chapel on the Sunday. This year, the

event was expanded to include those who had lost a child in the early years of life, as well as those who had experienced baby loss.

There were three play specialists who were available between 8.30am and 4.30pm. They provided a service across the hospital, in the emergency department, surgery and outpatients. The play specialists accepted referrals from both clinicians and families to support children and young people who were due to be admitted to hospital. When a child was booked for a planned admission, for example for surgery, the play specialist always contacted the family prior to admission. This enabled the play leader to assess any issues that may be present, such as procedural anxiety and they meet with the family and child to help alleviate problems.

The play specialist team's philosophy was to remove as much trauma as possible from the child's visit to the hospital. In the anaesthetic room they took distractions such as toys and books. Although the area was not child friendly, the team went to great efforts to create a child friendly environment and a positive experience for the child and their parents. We saw a play specialist explaining to a child what would be happening before their surgery and showing them a needle and syringe. They accompanied a child to the anaesthetic room.

Play specialists worked closely with the clinical teams and provided an outreach service to other areas in the trust. The play specialists were popular with children, parents and staff and they encouraged children to think about the creative activities they could engage with. Play specialists aimed to see every child or young person once.

There was a large play room for the ward which was inviting and contained a range of toys and activities. Experienced play specialists assisted with child-led creative sessions. Dolls were used by the team to act out operating theatre procedures with real equipment ahead of anaesthesia.

There was colourful and age appropriate art work and information notice boards in all main areas. Pets as therapy (PAT) dogs visited the wards regularly.

Children who were well enough and were in hospital for more than five days received schooling from a local education provider in a dedicated school room. Medical staff identified children and young people who met the criteria for educational input. The school had one full time member of staff who was supported by staff based at a local medical tuition centre. When necessary, staff were rotated to ensure specialist teaching could take place. A key focus was on planning for education after discharge to allow early identification of those who would need bespoke provision or reasonable adjustment in their mainstream school.

There was a well-equipped school room with a TV, books, games and a computer. Children were taught in the school room, at the bedside or on the ward. School operated during term-time.

There was restricted access to mobile phones or social media on the ward as a result of young people contacting friends and encouraging them to come into hospital to seek mental health support.

Parking permits were provided for the family of every child during their stay in hospital.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Bed capacity fluctuated throughout the year. There were 19 beds in summer months, with an increase of 22 during winter pressures and a maximum of 25 beds if extra staffing was available.

There had been a 12.5% increase in attendance for younger children (0-4years).

The short stay paediatric assessment unit was situated in the children's ward and provided five beds and one treatment room for admission and observation for children and young people who were acutely unwell. Children and young people were assessed and treated in the assessment unit unless otherwise directed by the need for additional infection control measures or a requirement for resuscitation in the emergency department. From the short stay paediatric assessment unit, children might be admitted to the ward for ongoing treatment, discharged home the same day, or remained in the paediatric assessment unit for a longer observation period. This was to help the team determine if an admission was required.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. During the last 12 months there had been an increase in activity through the outpatient clinics and procedures. This was due to increased clinics being held to reduce waiting times and to accommodate more specialist visiting consultants allowing care to be given closer to home. Appointments were coordinated on the same day, where possible, to prevent multiple clinic visits.

The outpatient department was very busy during the time of our visit with general clinics running alongside visiting tertiary specialist clinics including renal, oncology and endocrine.

When children and young people had their appointments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

We spoke to parents who said they were satisfied with the speed of appointments and waiting times were kept to a minimum, and they were always informed if the clinics were running late.

Children and young people experiencing mental health issues were provided with care and treatment. Access to child and adolescent mental health services (CAMHS) were managed by the local NHS mental health trust. The CAMHS team assessed and reviewed children and young people on the children's ward and discussed the children and young people currently on the ward who either had mental health and / or social care conditions or issues. Children and young people with mental health issues were seen by the appropriate professional in a timely way and a plan for either discharge or further assessment was made.

The service was effective for those children and young people who did not require a tier 4 inpatient bed. However, there was a risk young people admitted with mental health issues would not receive appropriate and timely care and treatment. This was caused by a lack of level 4 tier beds locally and could result in a longer length of stay in an acute inpatient ward and a higher incidence of self-harm and potential harm to other patients, families and staff.

The admission of CAMHS patients on an acute paediatric ward was an area that had seen an increase in activity and dependency in the last year and the team were working closely with system partners to improve pathways for this group of children.

Staff planned children and young peoples' discharge carefully, particularly for those with complex

mental health and social care needs. Planning began as soon as possible after admission with representation from the multidisciplinary team and external agencies as required.

Bed occupancy

The trust reported no neonatal critical care beds at Torbay Hospital.

(Source: NHS England)

There was a quality improvement project based around the short stay paediatric assessment unit and the paediatric pathway to assess, define and diagnose the current issue. The pathway from the emergency department or a GP to the short stay paediatric assessment unit (SSPAU) aimed to improve the flow through the SSPAU and improve outcomes for children and young people. Work so far had concentrated on an analysis of demand, improving communication between the emergency department and GPs, identifying children and young people who could attend outpatient clinics instead of the SSPAU and setting up nurse led clinics in outpatient departments to reduce the footfall to the SSPAU.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Children, young people and their families knew how to complain or raise concerns. Parents knew how to make a complaint if they needed to and felt they could raise concerns with the clinical staff they met. Most parents told us if any issues arose, they would talk to the senior nurse available.

The service clearly displayed information about how to raise a concern in patient areas. Information about making complaints was available in all the areas we visited. Leaflets were available on all units and information could be accessed on the trust website with links about how to resolve concerns quickly and how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints. Staff were encouraged to try and resolve concerns as they arose. If concerns were raised verbally and resolved to the complainant's satisfaction, the complaints team did not need to be involved.

Staff were aware of complaints and any learning that had resulted. The staff were all aware of the complaints system within the trust and the service provided by the hospital's patient experience team. Staff were able to explain what they would do when concerns were raised by parents. They said they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the manager or the trust complaints' process.

Managers investigated complaints and identified themes. There were systems to monitor and improve the quality of care. During complaint investigations staff were required to provide comments, and when indicated, written statements. The feedback and engagement team (comprising of the complaints and Patient Advice and Liaison Service (PALS) also supported the trust in the delivery of the complaints investigation policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Every complaint and PALS concern was reviewed to identify the issues raised by the complainant to ensure learning and continuous improvement.

Trust level

From December 2018 to November 2019 the trust received 14 complaints in relation to children's services at the trust (4.8% of total complaints received by the trust). A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Assessment	5	35.7%
Treatment	4	28.6%
Referral	2	14.3%
Diagnosis	2	14.3%
Nutrition	1	7.1%
Total	**14**	**100.0%**

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

Number of compliments made to the trust

From December 2018 to November 2019 there was one compliment about children's services.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Managers had the right skills and abilities to run a service providing high quality and sustainable care. The clinical managers, consisting of a matron, consultants and ward managers were an experienced and strong team with a commitment to the children, young people and families who used the service, and to their staff and each other. It was an integrated and strong team with an emphasis on providing consistent and high-quality care.

The team were knowledgeable and passionate about the service and actively worked to improve delivery of care. They were visible and available to staff, and we heard about support for all members of staff on the wards.

There was an executive and a non-executive trust board member with responsibility for children and young people's services and they carried out safety walk rounds which provided opportunities to hear from staff first hand. The team said these individuals provided support and recognised the needs of the service.

Staff said managers were approachable and they felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed. The senior management team communicated with staff by email and face-to-face.

The unit managers and matron operated an 'open door' policy which staff were positive about. Staff were supported to develop their skills and competencies within their roles and with a view to

internal promotion. We received consistently positive feedback from staff who had a high regard and respect for their managers. One member of staff said their manager was “the heart of the unit and was always able to come up with an answer.” Another described their manager as “very loyal and will bend over backwards to help ... they make sure we know everything as a team. … I feel very supported.”

The leadership teams of medical and nursing staff clearly understood the challenges to delivering good quality care. They could identify areas where the department needed to improve and to make changes when things had gone wrong.

Managers encouraged learning and a culture of openness and transparency. They had an awareness that staff required different leadership styles and were flexible in their approach to the needs of their teams.

All staff we met said they felt valued and part of the team and were proud to work in the team. They said the children and young people’s service was a “fantastic place to work.” They felt supported by the senior management team, unit managers and their colleagues. One member of staff said, “people go beyond to step in to help and stay late or cover shifts.”

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

Child health spanned health services across acute and community services for children and young people from birth to when they transitioned into adult services. The service supported the care and treatment of children and young people from the point of admission in the hospital to discharge.

Staff were aware of the service priorities and the trust vision and mission. The vision for the trust was for children, young people, their families and carers to have a genuine voice in co-producing services, influencing strategic direction and holding the trust to account.

The trust’s objectives aimed to build a generation for Devon that was empowered, enabled, resilient and well. To achieve this the trust aimed to have services where children and parents felt understood, recognised the family as experts, made sure their voice was heard and saw the difference it made.

Staff showed they followed and incorporated the values when providing care and treatment to children and young people. For example, we observed good communication between staff, patients, their relatives and colleagues to promote effective care. Staff showed a positive attitude to their work and colleagues and provided personalised care and treatment.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The team was positive about their role and felt supported to deliver care to children and young people**.** All the staff we met said they felt valued, confident and proud of the care they provided for children and young people. The team told us they were proud of being able to make a difference and felt supported by the leadership team and their colleagues.

The team provided support to each other. It was clear their work was important to them and they felt passionate about their contribution to care and were committed to improving the health of children in the region. The team worked closely with the wider multidisciplinary teams.

Patients and their families were at the centre of the service. There was an emphasis on the importance of education and awareness for patients and their families. The team were working to raise the voice of the child and the profile of the paediatric service across the trust.

During our conversations with staff and observations on the ward it was clear staff had the children and young people and their parents at the centre of their work. They were passionate about services for children and young people and were dedicated to their roles and approached their work with flexibility. One member of staff said, “everyone helped and did their bit”, another said “we help out in the emergency department and colleagues from adult services always help us too.”

Managers said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality services to the children and young people. One member of staff told us, “I feel a valued member of the team … we all do the right thing and make a big difference.”

Staff were positive about working for the trust, although there had been times when they felt stretched and under pressure because of the volume of their work. Many staff had worked on the units for some time and were very proud of their length of service.

Staff felt listened to and were encouraged to make suggestions. One member of staff said, “someone will always listen and support you if you’ve got an idea,” another said, “I work with a fantastic team and everyone will move heaven and earth to help the patients and each other.”

Staff were aware of the whistleblowing policies and procedures and felt able to approach managers to raise any concerns or suggestions and were confident they would be listened to and action taken.

Managers encouraged learning and a culture of openness and transparency. Staff said they were encouraged to speak up and felt comfortable about raising any concerns. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian.

Staff were aware of the duty of candour legislation. 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. Staff were knowledgeable about reporting incidents and concerns.

There was an opportunity for staff to access support and debriefing when this was required. The trust also had a staff support/counselling service available to all staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The effectiveness of services was monitored through the trust integrated performance dataset. Performance was monitored through governance groups. A variety of data including risk,

incidents, complaints, concerns and compliments was reported through the governance group to the quality improvement group, the quality assurance committee and the board.

There was a clear governance structure driving change. Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework.

There was a clear performance management reporting structure with monthly child health quality safety audit and governance meetings looking at operational performance which fed into the executive performance reviews. Minutes from these meetings showed issues affecting the service were discussed and actions taken.

These included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training. We reviewed governance reports and minutes of meetings and saw the meetings were well attended.

The service had developed an audit programme to monitor and assess performance in line with national guidance and standards. The service participated in external and internal audit. Other audits were routinely completed, and results were monitored, and action plans devised to address concerns.

An extensive set of policies was readily available on the intranet and was supported by standard operating procedures and processes. There were monthly meetings to look at guidelines in date and those requiring ratification. This ensured staff were able to work according to best practice guidance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had systems for identifying risks and plans to eliminate or reduce them. The service maintained a local service level risk register which clearly identified individual risks and the action taken to mitigate the risks. At the time of our inspection there were nine risks identified on the risk register. The most significant risks, as evidenced on the local risk register included to the management of the demand for autism assessments from referral to assessment. The position was monitored at monthly meetings and action was being taken to address the risk by moving to a model where support was promoted first ahead of a diagnosis.

We looked at the health and safety risk assessment form for access to the treatment room on Louisa Cary ward with access through the medication preparation room. The hazards were outlined including the distraction of nurses undertaking drug calculations and drawing up medications for administration which could result in medication errors; contamination of equipment due to unknown infection; and potential for children to gain access to medications and sharps.

The existing control measures were also outlined, including to risk assess the level of urgency required and if the procedure could be safely undertaken in an alternative location, for example the treatment room in the short stay paediatric assessment unit or at a later time. All equipment was also stored in racks with clear plastic doors for visibility and reduction of contamination and all medication was kept in locked cupboards with key pad access. Children were also supervised at all times and access was restricted to essential users. Further action included signage on the door reminding staff not to distract colleagues when undertaking medication procedures and ensuring the door was kept closed at all times

The service monitored the effectiveness of care, treatment and performance. The service took part in national and local audits and evidence of improvements or trends were monitored. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.

There was a trust major incident plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the trust major incident plan and how to access this.

There were local contingency plans for the children's ward and the special care baby unit if there were significant capacity and staffing issues, and problems with equipment. Actions were described for staff to follow and escalate depending on the status of the situation.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had access to information they required to provide good patient care. All staff had access to the trust's intranet which contained all the information and guidance for staff to carry out their duties. Staff we spoke with were familiar with the trust intranet and knew where to find the information they needed.

Staff had access to information about patients to ensure they had sufficient and up-to-date knowledge to provide safe care and treatment. Staff used electronic systems to manage patient information such as referrals to the specialist care teams and to gain access to information about results of investigations such as blood tests.

The medical teams said there was good and quick access to test results and diagnostic and screening tests. Patient confidential and personal information was held securely.

Information to deliver effective care was available to relevant staff in a timely and accessible way. There was a range of documentation on the paediatric wards, the outpatient department and the SCBU and this was easily accessible. Patient paper notes were prepped for elective admissions and clinics and staff confirmed they were available in good time.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Children, young people and their families and/or carers were actively encouraged to take part in the NHS Friends and Family Test. Completion rates had improved slightly since the last inspection in 2016 and rates varied between 12% and 15%f or the period from July to November 2019 with the majority saying they would be extremely likely to recommend the service. The service recognised the challenges of engaging with young people to obtain feedback and continued to develop the use of information technology.

The Friends and Family Test was supplemented by the patient engagement network interviews which provided real time feedback on experience. Feedback from patient surveys was regularly discussed at governance meetings.

The trust participated in the CQC Children and Young People's Survey 2018. Children and young people were asked to answer questions about different aspects of their care and treatment. Based on their responses a score out of ten for each question was allocated and showed most results about the same as other trusts. Questions were divided into issues relating to safety, effectiveness, caring, responsiveness and well led. The trust performed about the same as most other trusts in England in all categories. Details of the results have been included above in relevant sections of the report.

There were effective systems to engage with staff. There were regular meetings to discuss and share information and provide feedback. Minutes were taken of each meeting and emailed to all staff and paper copies placed in staff rooms to ensure those who could not attend had access to the information.

Staff told us they felt engaged, informed and up to date with what was happening within the wider trust. Information was shared through different forums. These included unit meetings. newsletters, communication book, WhatsApp (for short cover, training updates), verbally, formal meetings and education boards in staff rooms.

Staff said they were encouraged to speak up and voice their suggestions and solutions.

There were informal processes supporting staff to highlight quality and safety concerns. The chair led a "See Something / Say Something" initiative and held regular open-door surgeries across the trust. The chair and chief executive held staff engagement sessions open to all where issues could be raised and discussed. A 'Just Ask' web page provided a mechanism for staff to raise concerns anonymously.

Staff had access to health and wellbeing services. There were reflective debrief sessions and counselling services were available through the occupational health service.

Staff wellbeing was supported through interventions including; informal executive walkouts/visits to teams, monthly trust talk, Schwartz rounds, weekly chief executive vlog, staff bulletin and the recent publication of a 'Healthy Futures' magazine.

Other initiatives included health and wellbeing awareness weeks, staff Olympics and staff hero awards/ceremonies. There were also paediatric awards for training and achievement (PAFTAs), and every area of the service had been nominated. A consultant had been awarded a super hero award for supporting and supervising junior doctors. Staff and parents could nominate staff for super hero awards.

Staff engaged in fund raising events for the ward, for example, sponsored a static bike ride and car washing and organised parties for children and young people, for example, a princess and superhero party.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a culture of innovation and improvement across the service. There was an emphasis for continuous, evidence-based improvement for improved health and better care.

Staff told us they were always keen to learn and develop the service. Innovation and improvement were encouraged with a positive approach to achieving best practice. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care to ensure the delivery of high-quality care for children, young people and their families. Staff and managers felt there was scope and a willingness amongst the team to develop services through training and research and by learning from when things went well and when they went wrong.

There were a number of examples of innovations. These included:

- A quality improvement project based around the short stay paediatric unit (SSPAU) and the paediatric pathway to assess, define and diagnose the current issue. The project encouraged team ownership of issues with an emphasis on small scale test of change and building up to solutions and design. As a result of the project there had been improved pathways for receipt of blood results and reduction in rework, such as ensuring a senior review, which was indicating a reduction in waiting times within SSPAU. The team were continuing to monitor the test of change.
- A parent ran a support group for parents of babies on the special care baby unit to share experiences of specialist baby care, informing, guiding and coaching them to bond closely as a family and manage the ongoing health and developmental concerns they might share. Feedback from parents attending the group was overwhelmingly positive, with 100% of parents finding the group helpful, and recommending it to others.
- Collaborative working between the special care baby unit and maternity through thermal regulation to prevent admission. Data showed a reduction in admission to the special care baby unit.

Community inpatients services

Facts and data about this service

Information about the sites and teams, which offer services for inpatients at this trust, is shown below:

Location / site name	Team/ward/satellite name	Number of inpatient beds
Brixham Hospital	Brixham inpatients	16
Dawlish Hospital	Dawlish inpatients	16
Newton Abbot Hospital	Newton Abbot inpatients	60
Totnes Hospital	Totnes inpatients	16

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

The trust provided the following information about their community services for inpatients.

Torbay and South Devon NHS Foundation Trust (TSDFT) has five inpatient wards within four community hospitals providing a total of 112 beds. Dawlish and Totnes have 16 medical/rehabilitation beds, Brixham has 16 medical/rehabilitation beds plus four intermediate care beds. Newton Abbot hospital has two wards of 30 beds each, one is medical/rehabilitation the other is medical plus stroke and neuro rehabilitation. The admission criteria allows for a wide range of patients to be either transferred from secondary care or directly admitted from the community preventing an admission into an acute setting.

Inpatient areas have embedded the principles of the SAFER model into their patient planning and utilise a multi-disciplinary team (MDT) approach to managing discharge and maintaining patient flow through the system. A greater level of integration within each locality between the wards and the community teams is helping to develop greater understanding and management of patients within the community who access inpatient services.

Recruitment challenges remain, particularly in relation to registered nurses. A number of initiatives are in place to support recruitment including rotational posts, return to practice nurses amongst others.

(Source: CHS Routine Provider Information Request (RPIR) – Context CHS tab)

Percentage of patients that are children

From December 2018 to November 2019, no patients attending community inpatient services within the last 12 months were identified as being a child aged 17 years or under.

(Source: Routine Provider Information Request (RPIR) Universal – Children)

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

Trust level

The trust set a target of 85% for completion of mandatory training for all courses except for information governance, which had a trust target of 95%. All training performance at the trust was reported on a rolling month by month basis.

The compliance for mandatory training modules from December 2018 to November 2019 was 92% at trust level for qualified nursing staff in community inpatients. Of the eight training modules provided seven achieved compliance and one failed to reach the trust target.

No training modules scored below 75%.

The compliance for mandatory training modules from December 2018 to November 2019 was 84% at trust level for qualified allied health professional staff in community inpatients. Of the training modules provided three achieved compliance and five failed to reach the trust target.

No training modules scored below 75%.

Brixham Hospital community inpatients department

The compliance for mandatory training modules from December 2018 to November 2019 was 89% for qualified nursing staff in community inpatients at Brixham Hospital. Of the training modules provided four achieved compliance and four failed to reach the trust target.

One module failed to score above 75% as outlined below.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance <75 %	Trust Target Met	Compliance change when compared to previous year
Moving and handling	10	7	70%	✗	↓

No qualified allied health professional staff were reported at this site.

Newton Abbot Hospital inpatients department

The compliance for mandatory training modules from December 2018 to November 2019 was 91% for qualified nursing staff in community inpatients at Newton Abbot Hospital. Of the training modules provided six achieved compliance and two failed to reach the trust target.

No training modules scored below 75%.

The compliance for mandatory training modules from December 2018 to November 2019 was 84% for qualified allied health professional staff in community inpatients at Newton Abbot Hospital. Of the training modules provided three achieved compliance and five failed to reach the trust target.

No training modules scored below 75%.

Totnes Hospital community inpatients department

The compliance for mandatory training modules December 2018 to November 2019 was 99% for qualified nursing staff in community inpatients at Totnes Hospital. Of the training modules provided all achieved compliance.

No qualified allied health professional staff were reported at this site.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During the inspection we were shown evidence of managers having booked staff on to relevant training courses to ensure all staff were compliant with mandatory training.

Community nursing staff were also required to complete adult immediate life support resuscitation training and reported 94% compliance.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

The trust sets the following targets for the safeguarding courses for which medical, nursing and qualified allied health professional staff are eligible.

- 90% for safeguarding levels 1
- 80% for safeguarding level 2 and 3

The tables below include PREVENT training as a safeguarding course, which had a trust target of 85%. PREVENT works to stop individuals from getting involved or supporting terrorism or extremist activity.

All training performance at the trust is reported on a rolling month by month basis.

Trust level

The compliance for safeguarding training modules from December 2018 to November 2019 was 91% at trust level for qualified nursing staff in community inpatients. Of the training modules provided four achieved compliance and one failed to reach the trust target.

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	55	55	100%	✓	→
Basic Prevent Awareness	55	53	96%	✓	↑
Safeguarding Adults (Level 2)	55	51	93%	✓	↑
Safeguarding Children (Level 2)	55	44	80%	✓	↑
Safeguarding Adults (Level 3)	14	11	79%	✗	↑

The compliance for safeguarding training modules from December 2018 to November 2019 was 100% at trust level for qualified allied health professional staff in community inpatients.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children (Level 2)	4	4	100%	✓	↑
Safeguarding Adults (Level 1)	4	4	100%	✓	→
Basic Prevent Awareness	4	4	100%	✓	↑
Safeguarding Adults (Level 2)	4	4	100%	✓	→
Safeguarding Adults (Level 3)	3	3	100%	✓	→

Brixham Hospital community inpatients department

The compliance for safeguarding training modules from December 2018 to November 2019 was 88% for qualified nursing staff in community inpatients at Brixham Hospital. Of the training modules provided three achieved compliance and two failed to reach the trust target.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Basic Prevent Awareness	10	10	100%	✓	→
Safeguarding Adults (Level 1)	10	10	100%	✓	→
Safeguarding Adults (Level 2)	10	9	90%	✓	↑
Safeguarding Children (Level 2)	10	7	70%	✗	↓
Safeguarding Adults (Level 3)	2	1	50%	✗	→

No qualified allied health professional staff were reported at this site.

Newton Abbot Hospital community inpatients department

The compliance for safeguarding training modules from December 2018 to November 2019 was 89% for qualified nursing staff in community inpatients at Newton Abbot Hospital. Of the training modules provided three achieved compliance and two failed to reach the trust target.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	32	32	100%	✓	→
Basic Prevent Awareness	32	30	94%	✓	↑
Safeguarding Adults (Level 2)	32	29	91%	✓	↑
Safeguarding Children (Level 2)	32	24	75%	✗	↑
Safeguarding Adults (Level 3)	7	5	71%	✗	↑

The compliance for safeguarding training modules from December 2018 to November 2019 was 100% for qualified allied health professional staff in community inpatients at Newton Abbot Hospital.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children (Level 2)	4	4	100%	✓	↑
Safeguarding Adults (Level 1)	4	4	100%	✓	→
Basic Prevent Awareness	4	4	100%	✓	↑
Safeguarding Adults (Level 2)	4	4	100%	✓	→
Safeguarding Adults (Level 3)	3	3	100%	✓	→

Totnes Hospital community inpatients department

The compliance for safeguarding training modules from December 2018 to November 2019 was 100% for qualified nursing staff in community inpatients at Totnes Hospital.

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children (Level 2)	13	13	100%	✓	→
Safeguarding Adults (Level 1)	13	13	100%	✓	→
Basic Prevent Awareness	13	13	100%	✓	→
Safeguarding Adults (Level 2)	13	13	100%	✓	→
Safeguarding Adults (Level 3)	5	5	100%	✓	→

No qualified allied health professional staff were reported at this site.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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 have their own guidelines as to 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.

Community inpatient services made no safeguarding referrals for adults or children between December 2018 and November 2019.

Community adult inpatient services had a comprehensive safeguarding training programme for staff. This was provided as a combination of on-line and classroom-based training. Staff we spoke to also told us they had completed the safeguarding training applicable to their role. Staff at most of the wards we inspected spoke confidently about identifying and managing complex safeguarding issues. Although staff at Totnes Hospital were able to recognise abuse, their knowledge was not comprehensive. The trust had a designated safeguarding lead. We observed a good example of how staff at Brixham hospital had ensured a patient was safeguarded from ongoing concerns.

(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff maintained the cleanliness of equipment and premises to a high standard. In most of the wards we visited, the design, maintenance and use of facilities, premises and equipment kept people safe.

Staff used equipment and control measures to protect patients, themselves and others from infection. Infection prevention and control formed part of the trust's mandatory training and staff we spoke with at the time of inspection were compliant with infection control training. Across all the services we visited, staff washed their hands with soap and water or sanitised their hands before and after contact with patients. All staff had access to personal protective equipment such as aprons and gloves and used them appropriately. Staff complied with the trusts policy and national guidance about being bare below the elbow when providing care.

Most of the wards we visited had appropriate systems in place to manage substances hazardous to health. However, on Dart ward at Totnes Hospital we saw the doors to the sluice rooms were not locked and could be easily accessed by patients. Hazardous chemicals had been left on the work tops and not placed in designated locked cabinets inside the sluice room.

Cleaning at Dawlish Hospital was managed by a contracted external company. It was run by the hotel services of the trust at Totnes Hospital. There had been an incident this year following an episode of norovirus on the ward where a patient had been re-infected as the hotel services did not have enough staff to facilitate a deep clean. Staff had put measures in place to prevent similar incidents from occurring.

Staff collected safety information through audits such as hand washing and infection control and used this information to improve safety. Managers shared results with staff teams through team meetings and email communication. The figures the trust provided us with for the period December 2018 to November 2019 showed that all wards except Totnes Hospital showed less than 75% compliance with infection control training. This was below the trust target, however managers told us that staff had enrolled on this training since.

All clinical areas we visited were visibly clean and tidy and gel dispensers and hand washing facilities were available. Treatment rooms had waste disposal bins for non-clinical and clinical waste and sharps containers were not overfilled. Arrangements were made for hazardous and non-hazardous material to be segregated and disposed of safely.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The trust had processes and systems in place that ensured people always received equipment in a timely fashion. Mobility equipment, home adaptation equipment and pressure-relieving equipment was supplied through third party suppliers, who were responsible for servicing and delivering equipment to patients at home. Managers told us that if a patient required specific equipment such as bariatric hoists, some wards had access to a limited range of equipment and extra equipment could be ordered in prior to the patient admission. However, on Teign ward and Brixham ward there was equipment lined up against the walls in the communal walkways. This meant that equipment was a potential hazard and falls risk to patients, carers and staff. Teign ward did not have access to a storage room to safely store equipment. On Brixham ward there were rooms on the ward where equipment could be stored safely but had not been on the day of inspection.

Managers told us they worked closely with the Intermediate Care and Re-enablement teams which had an equipment store with a range of essential transfer equipment including basic wheelchairs, commodes, and toilet aides and provided cover seven days week. During our inspection we found that staff we spoke to knew how to obtain equipment out of hours and at weekends.

During the inspection we visited several premises and clinics and checked a range of consumable items. All items that were checked were correctly stored and within date. We also checked resuscitation bags at various locations within the trust. These were all sealed and tagged. The resuscitation bags and oxygen bags all had their contents recorded and a weekly check was carried out by staff.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Comprehensive risk assessments were carried out for people who used the services and risk management plans were developed in line with national guidance. These were assessed, monitored and managed appropriately. On referral into the service, a qualified nurse completed a full handover over the phone with the referring service. This assessment was completed using the SBAR approach (Situation, Background, Assessment, Recommendation) which was used for all patients. Once the patient had arrived onto the ward, they were seen by the medical and therapy team within 24 hours to complete a more detailed assessment of their current care needs and rehabilitation goals.

Staff used appropriate guidance and tools to assess patients. We saw the use of the SBAR approach which was used for all patient assessments together with the NEWS2 tool. This is a national early warning score to improve the detection and response to clinical deterioration in adult patients and was a key element of patient safety and improving patient outcome. We saw records included a range of assessments to encompass a broad range of patients' health. This included a Malnutrition Universal Screening Tool (MUST) assessment, risk stratification, any referrals, psychiatric and mental health assessment, Waterlow chart score for assessing the risk of acquiring a pressure ulcer, bowels, mobility, and resuscitation status. Staff at Dawlish Hospital used a track and trigger system to monitor patients and pick up early warning signs of the deteriorating patient.

Ward teams discussed and reviewed patients through a daily ward board meeting and had handovers three times a day. This meeting was a platform whereby members of the multi-disciplinary team met and discussed the care, process and plans for every patient. We observed two ward board meetings which were held every morning. These meetings included discussions about expected discharge dates, falls risks, patients that required manual handling with a minimum of two staff, therapy progress, medication and prescription and a care plan review.

Staff were attentive to the risk of pressure ulcers. Staff assessed skin integrity using the 'SSKIN Bundle.' This included assessing patients skin several times a day and encouraged staff to photograph and document any areas of concern for monitoring. Staff worked closely with the tissue viability and leg ulcer services to ensure effective treatment. We saw that staff ensured patients at risk of pressure ulcers had appropriate equipment in place to prevent patients developing sores.

Staff had sufficient access to diagnostic services, such as X-ray and pathology. Ward staff were trained to do electrocardiograms, venepuncture, cannulation and catheters. This meant that patients were not transferred to an acute hospital unnecessarily.

Staffing

Safer staffing levels

Staff fill rates compare the proportion of planned hours worked by staff (Nursing, Midwifery and Care Staff) to actual hours worked by staff (day and night). Trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Therefore, an average 70% fill rate in January 2016 for nursing staff during the day means; in January 70% of the planned working hours for daytime nursing staff were actually 'filled'.

Details of staff fill rates within community inpatient services for registered nurses and care staff from February 2019 to January 2020 for each site are published on the trust website, however they are not provided here as they are formatted in a hard-coded monthly PDF format which cannot be easily recreated for the whole year.

The challenges of staff recruitment and turnover in community health inpatient service had been recognised by the trust and local management teams. In Brixham Hospital, qualified nurse recruitment was at the top of their local risk register as they had 4.5 full time equivalent vacancies for registered nurses. The provider monitored safer staffing levels and managers submitted monthly safer staffing reports. The service was actively advertising these posts and senior leadership was exploring ways of increasing awareness of nursing opportunities amongst the community. For example, senior leaders had recently attended 'career fairs' at universities.

Dawlish Hospital had 3.8 full time equivalent vacancies for registered nurses. These vacancies were being managed by using bank nursing staff. Where these could not be filled by registered nurses, shifts were filled by a band four assistant practitioner. The manager told us they have sufficient autonomy to increase numbers based on the acuity of the ward. However, as they were unable to use agency healthcare assistants and only bank, sometimes these extra shifts went unfilled. Totnes Hospital did not have the same recruitment difficulties, with one registered nurse vacancy. Staff across all sites told us that there had been increases to the acuity of their patient group. Although there were enough staff to meet the basic needs of the patients, staff told us there was less time to spend with patients doing rehabilitation work and supporting families with the existing staffing numbers as the levels of the patients' basic need had increased.

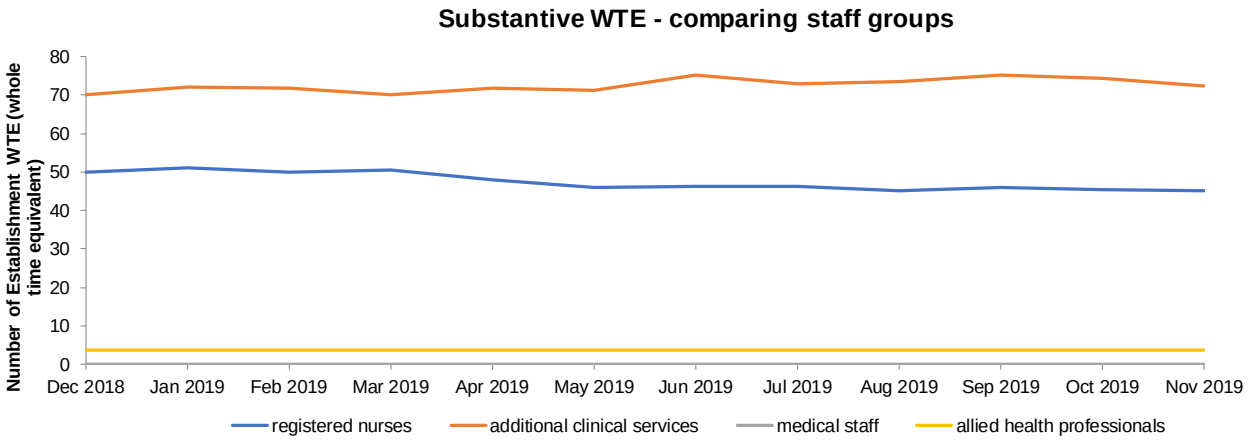
Templar ward had no vacancies for qualified nurses. Teign ward had three vacancies. All three had been recruited to, with new recruits due to start imminently. Healthcare assistant vacancies remained low across the service.

Managers ensured that all volunteers had appropriate background checks and received the same mandatory training as substantive members of staff.

Annual staffing metrics (Remove charts and tables before publication)

Trust level

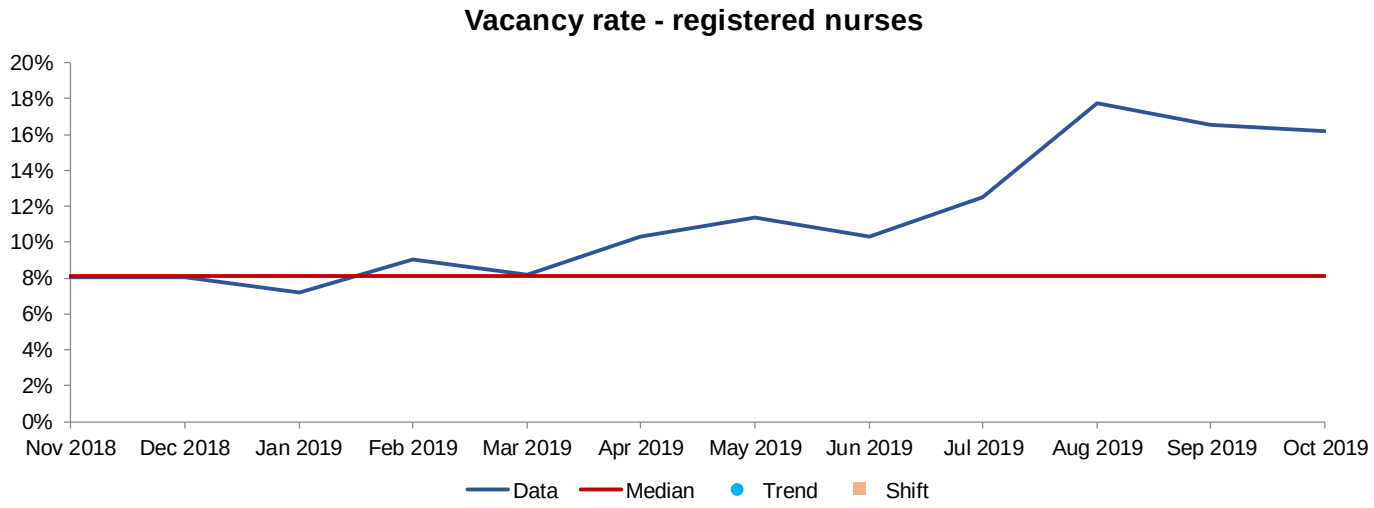
From November 2018 to October 2019, the comparison of staff groups in post WTE in community inpatients services is shown in the chart below.



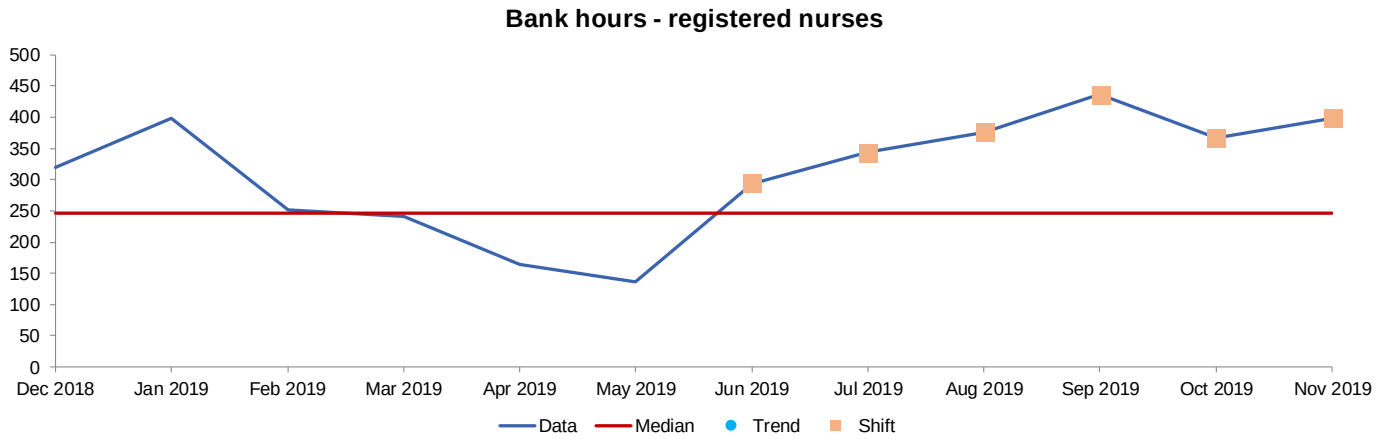
	Community inpatients annual staffing metrics (November 2018 to October 2019)						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	149	10%	13%	5.1%			
Qualified nurses	55	11%	17%	4.7%	3,729 (5%)	4,782 (7%)	202 (<1%)
Nursing assistants	84	8%	12%	5.9%	25,913 (22%)	0(0%)	2,980 (2%)
Medical staff	0	N/A	N/A	N/A			
Allied Health Professionals	6	13%	0%	0.9%			

Trend analysis is only presented below for nursing staff due to the small numbers of allied health professionals within this core service. Nursing staffing rates within community inpatients at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and agency use.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.



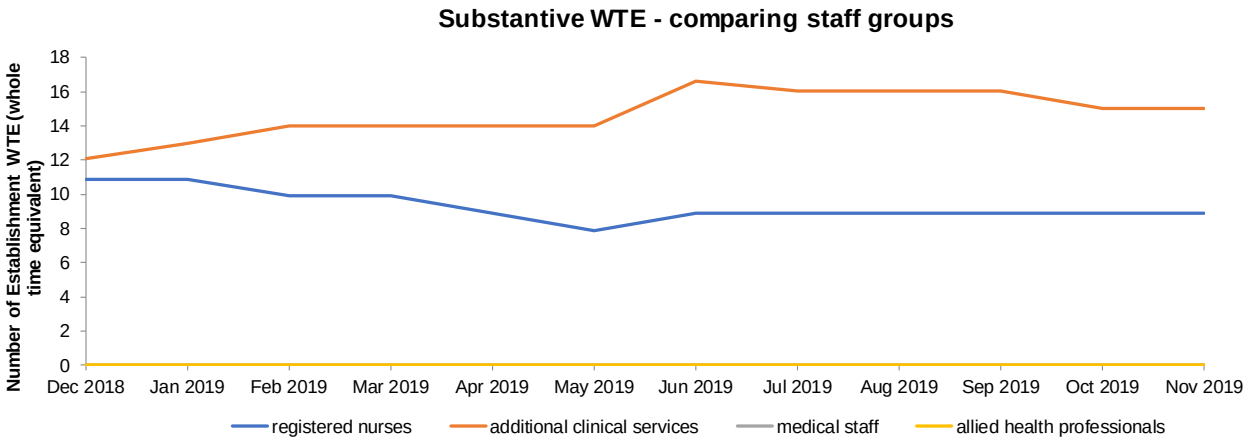
Monthly vacancy rates over the last 12 months for registered nurses were not stable and may be subject to ongoing change.



Monthly bank use over the last 12 months for registered nurses show an upward shift from June 2019 to November 2019. This could be an indicator of change.

Brixham Hospital

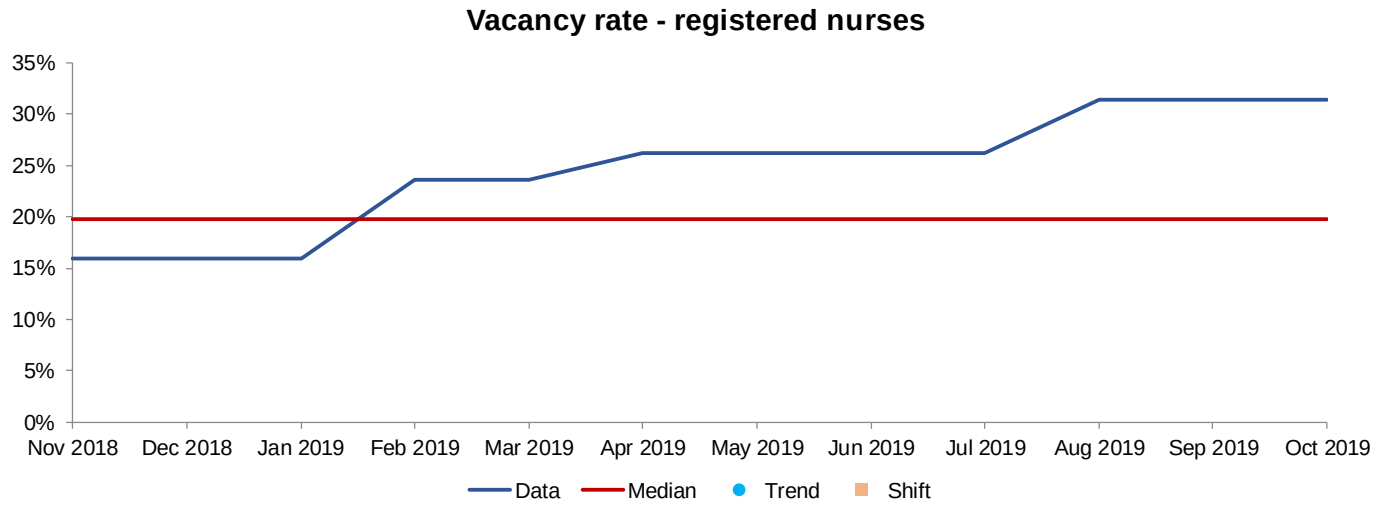
From November 2018 to October 2019, the comparison of staff groups in post WTE in community inpatients services at Brixham Hospital is shown in the chart below.



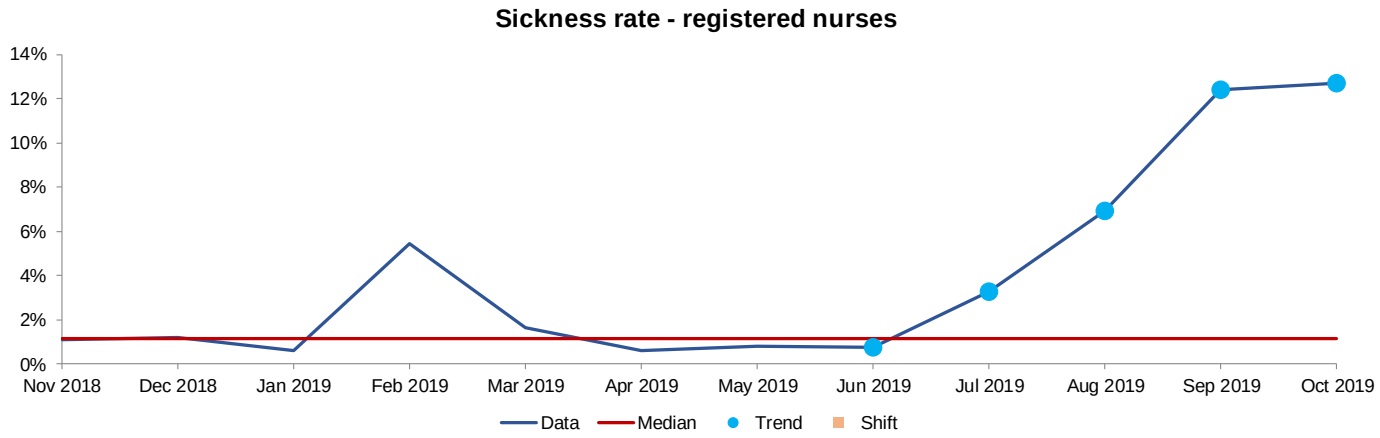
	Community inpatients annual staffing metrics (November 2018 to October 2019)						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	35	17%	9%	4.9%			
Qualified nurses	13	24%	22%	3.8%	1,676 (11%)	1,678 (11%)	054 (<1%)
Additional clinical services	20	15%	4%	6.8%	6,200 (24%)	0(0%)	831 (3%)
Medical staff	0	N/A	N/A	N/A			
Allied Health Professionals	0	N/A	N/A	N/A			

Nursing staffing rates within community inpatients at Brixham Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency use.

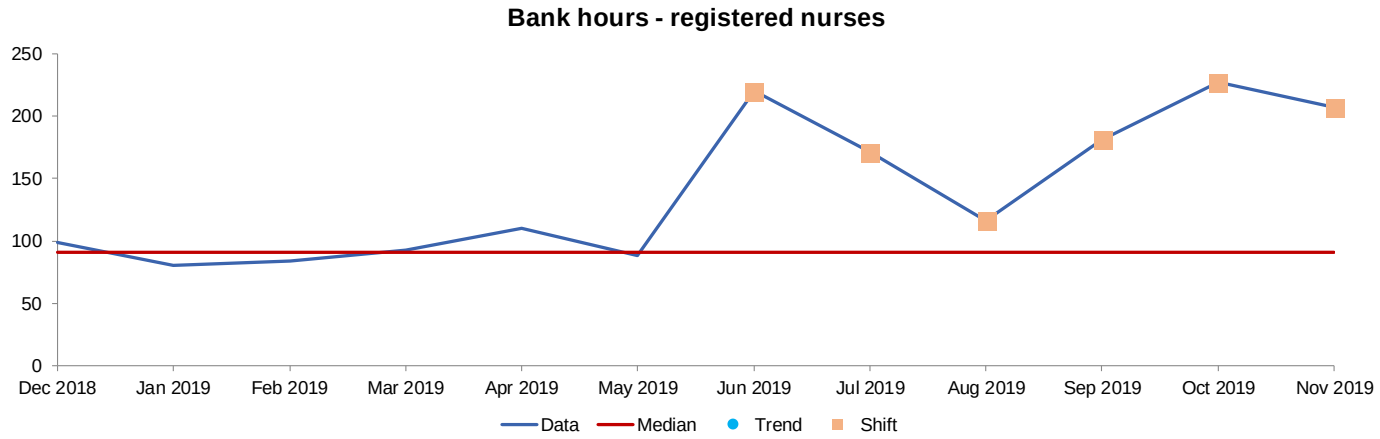
The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.



Monthly vacancy rates over the last 12 months for registered nurses were not stable and may be subject to ongoing change.



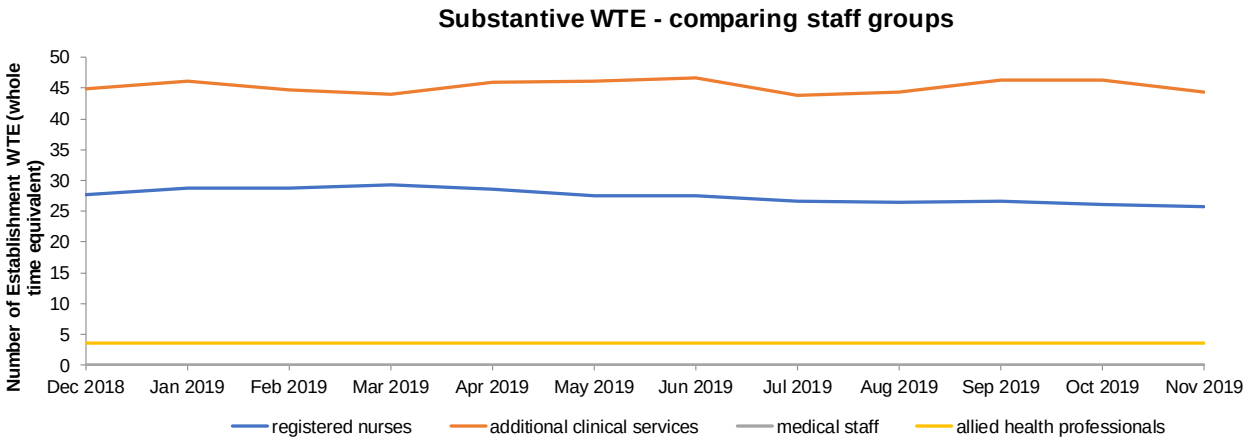
Monthly sickness rates over the last 12 months for registered nurses show an upward trend from June 2019 to October 2019. This could be an indicator of deterioration.



Monthly bank use over the last 12 months for registered nurses show an upward shift from June 2019 to November 2019. This could be an indicator of change.

Newton Abbott Hospital

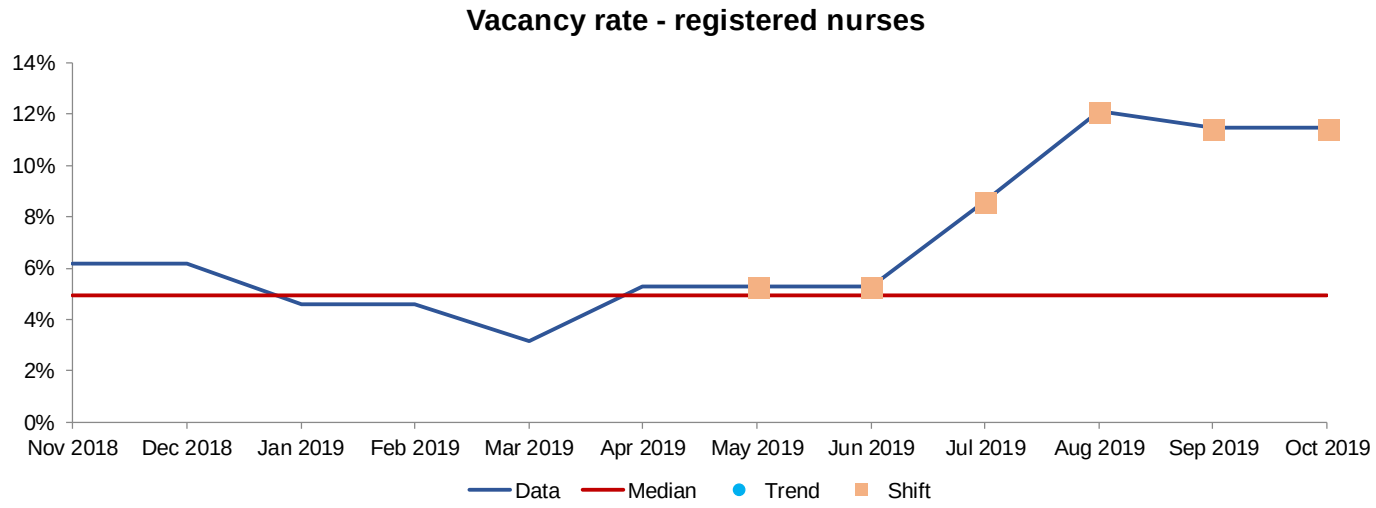
From November 2018 to October 2019, the comparison of staff groups in post WTE in community inpatients at Newton Abbott Hospital is shown in the chart below.



	Community inpatients annual staffing metrics (November 2018 to October 2019)						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	89	8%	14%	5.4%			
Qualified nurses	30	7%	17%	6.1%	1,613 (4%)	2,242 (6%)	106 (<1%)
Additional clinical services	51	7%	14%	5.3%	13,857 (19%)	0 (0%)	1,683 (2%)
Medical staff	0	N/A	N/A	N/A			
Allied Health Professionals	6	13%	0%	0.9%			

Nursing staffing rates within community inpatients at Newton Abbott Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use and agency use.

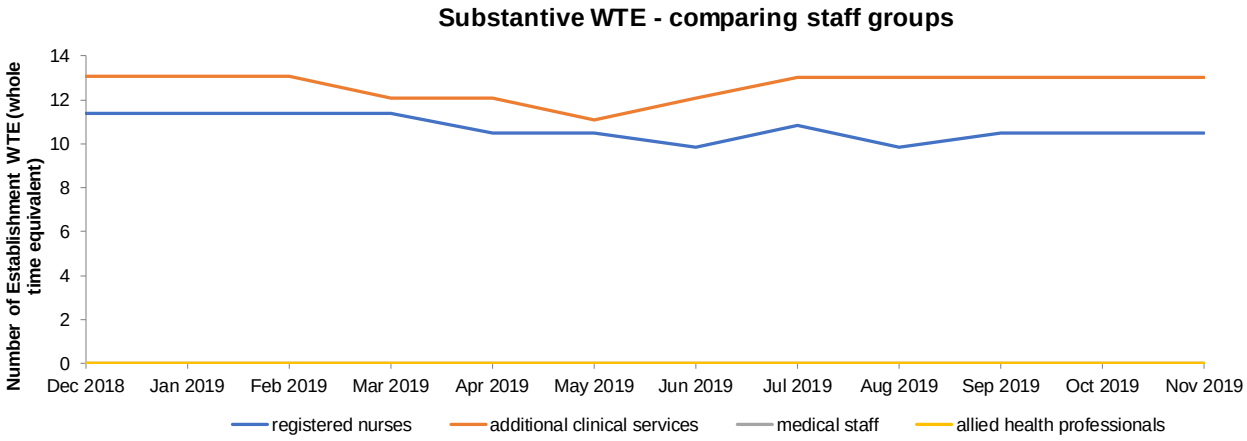
The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.



Monthly vacancy rates over the last 12 months for registered nurses show an upward shift from May 2019 to October 2019. This could be an indicator of change.

Totnes Hospital

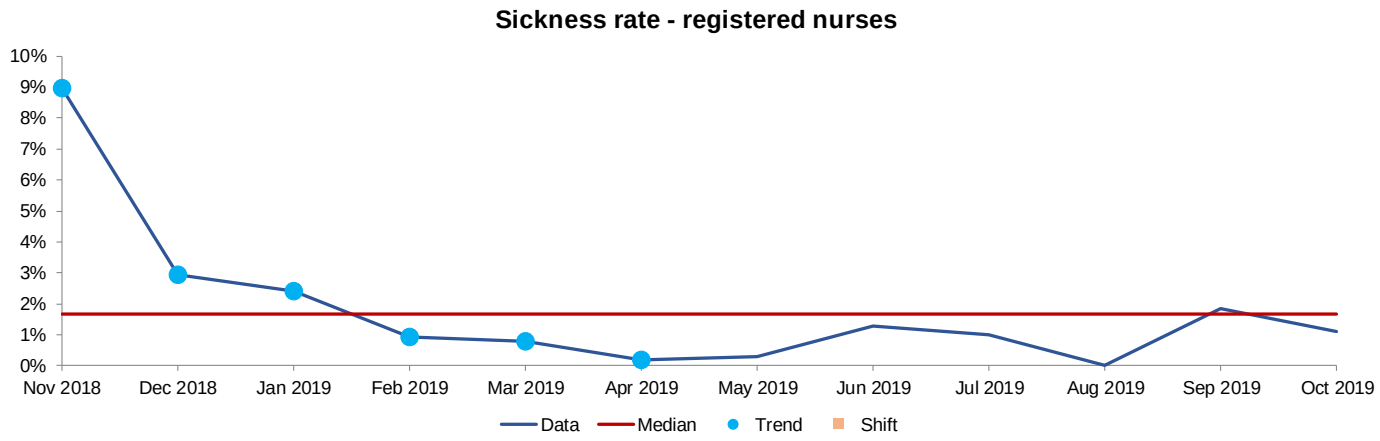
From November 2018 to October 2019, the comparison of staff groups in post WTE in community inpatients at Totnes Hospital is shown in the chart below.



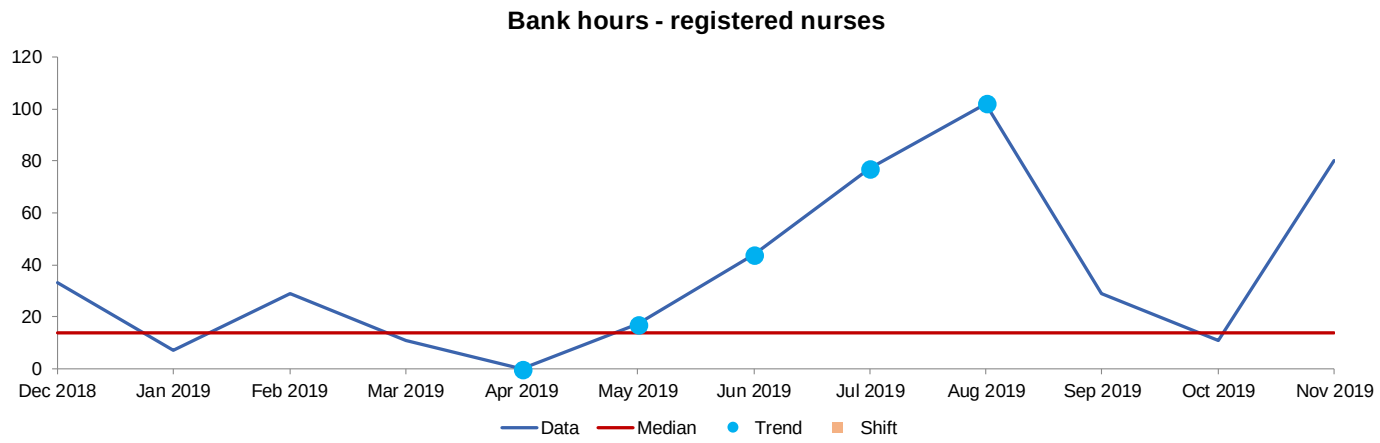
	Community inpatients annual staffing metrics (November 2018 to October 2019)						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	25	5%	14%	4.6%			
Qualified nurses	12	8%	11%	1.9%	440 (3%)	862 (5%)	042 (<1%)
Additional clinical services	13	2%	16%	7.1%	5,856 (27%)	000 (0%)	466 (2%)
Medical staff	0	N/A	N/A	N/A			
Allied Health Professionals	0	N/A	N/A	N/A			

Nursing staffing rates within community inpatients at Totnes Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and agency use.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.



Monthly sickness rates over the last 12 months for registered nurses show a downward trend from November 2018 to April 2019. This could be an indicator of improvement.



Monthly bank use over the last 12 months for registered nurses show an upward trend from April 2019 to August 2019. This could be an indicator of change.

(Source: Universal Routine Provider Information Request (RPIR) Staffing data P16 – P21)

Suspensions and supervisions

During the reporting period from December 2018 to November 2019, community inpatient services reported that there were no cases where staff have been either suspended or placed under supervision.
(Source: Universal Routine Provider Information Request (RPIR) – Suspensions or Supervised tab)

Quality of records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. We reviewed 30 patients' care records which were complete and managed in a way that kept people safe. We found that the nursing and therapy care plans were detailed, patient centred and goal oriented. We saw that records across the service had clearly stated reasons for admission and diagnosis. Information was updated after each ward round and notes were comprehensive. All care plans we saw across the service were detailed, patient centred and goal oriented. Patients notes included a NEWS2 sheet, MUST sheet, care plan and drug administration record. Records contained specific care plans pertaining to a patients' individual needs, such as pain management, communication, breathing, infection, hydration and nutrition. However, in Brixham, two out of six records did not contain clear rationales for clinical decisions, such as stopping a fluid chart.

Staff used a paper notes system, with medical notes stored in a locked office and daily notes stored in patient's bays. Staff told us this system worked well and the trust was exploring options for an electronic recording system. However, at times we had difficulty reading the handwriting of staff in these records. This meant that a patient's care could be compromised if important information was not legible by all staff.

The trust's resuscitation policy stated that the overall responsibility for making a do not attempt cardiopulmonary resuscitation (DNACPR) decision rests with the senior medical clinician. In most of the care records we reviewed which contained these forms, they were completed accurately and there was evidence of a review by the patient's consultant. However, two out of six records we saw on Templar ward contained inaccurate DNACPR Resuscitation forms. We brought this to the

attention of the ward manager during the inspection who assured us these forms would be re-visited as a matter of urgency.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Pharmacists attended the ward weekly and nurses managed the stock in clinic rooms. Medicines were prescribed by a doctor on all the wards. Pharmacy supply came from the acute hospital and was available 24 hours a day. Pharmacists completed audits of prescription charts and discussed the outcome of audits with ward staff.

Medicines were well organised and stored appropriately in locked rooms, only accessible by designated clinicians. Controlled drugs were stored securely, and stock was monitored in line with national guidance. Staff monitored fridge and room temperatures to ensure medication was stored within their recommended temperature range. However, on Brixham ward we saw fridge temperatures were documented above the recommended range, on two consecutive days in the month prior to the inspection. There was no evidence to suggest that staff had followed the trusts' protocol of rechecking the temperature after one hour. This meant that medication in the fridge may have lost its efficacy or need to be discarded. We brought this to the attention of the ward manager who assured us they check the safe range for medications stored in the fridge and discard them if necessary.

Staff had to be assessed as competent in the safe administration of medicine and there were a range of training courses available for staff to develop those competences. Staff recorded administration of medicines in line with the trust policy. Staff followed current national practice to check patients had the correct medicines. We saw evidence that staff administered medicines safely to patients. We checked records and noted that nursing staff checked patients International Normalised Ratio (INR) regularly and adjusted their warfarin medication in line with practice recommendations.

In preparation for discharge from hospital, staff worked with patients and families to support them with self-management of their medication in the community. Staff provided patients and carers with a medicines prompt sheet on discharge.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Managers ensured that actions from patient safety alerts were implemented and monitored. The largest category of incidents were patient falls. Dawlish and Newton Abbot Hospitals had implemented a number of strategies to reduce the number of patient falls, which was reflected in the number of falls for the past 12 months.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. We saw examples of changes that had been made following learning from incidents. Staff at Brixham Hospital had introduced 'I can' boards following an incident where bank staff had

overestimated a patient's immobility. The board is placed above patients' beds and provides a single sentence detailing what support a patient needs for transferring and mobilising. Staff fed back that this initiative had been useful, particularly when bank and agency staff were working shifts.

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 December 2018 to November 2019, the trust reported no never events for community inpatient services.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in community inpatient services, which met the reporting criteria set by NHS England from December 2018 to October 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	11	78.6%
Pressure ulcer meeting SI criteria	3	21.4%
Total	14	100.0%

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From December 2018 to November 2019, trust staff within community inpatient services reported 13 serious incidents.

Of these, none involved the unexpected death of a patient. The most common types of serious incidents are in the below table

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	10	76.9%
Pressure ulcer meeting SI criteria	3	23.1%
Total	13	100.0%

(Source: Universal Routine Provider Information Request (RPIR) – Serious Incidents tab)

Prevention of Future Death Reports

The Chief Coroner's Office publishes the local Coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local Coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports sent to Torbay and South Devon NHS Foundation Trust.

(Source: Universal Routine Provider Information Request (RPIR) – Prevention of future death reports)

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

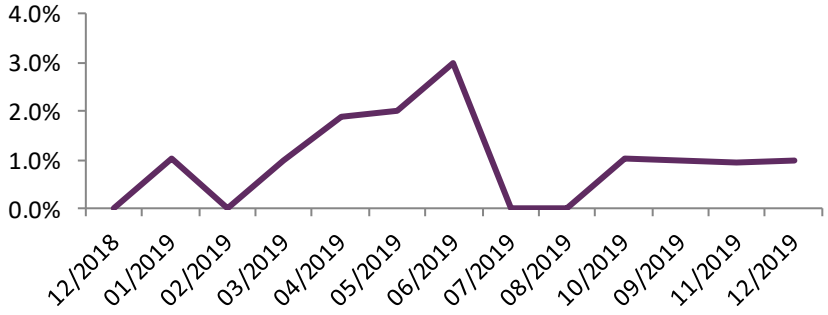
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Trust level

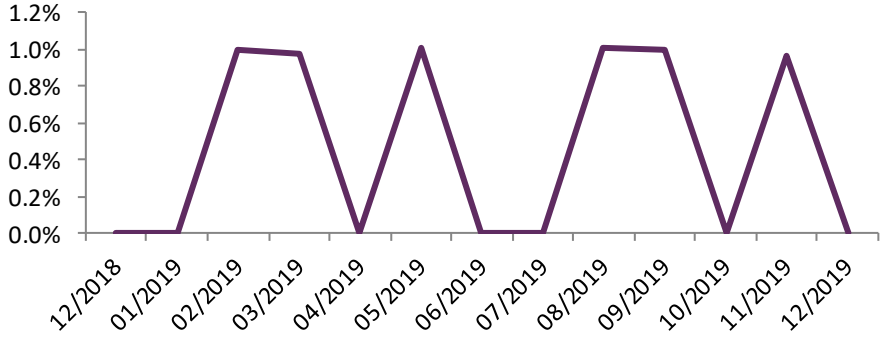
From January 2018 to January 2019 the trust reported 13 new pressure ulcers, six falls with harm and seven new catheter urinary tract infections within all community inpatients wards.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Torbay and South Devon NHS Foundation Trust – All community Inpatients wards.

Total Pressure ulcers (13)

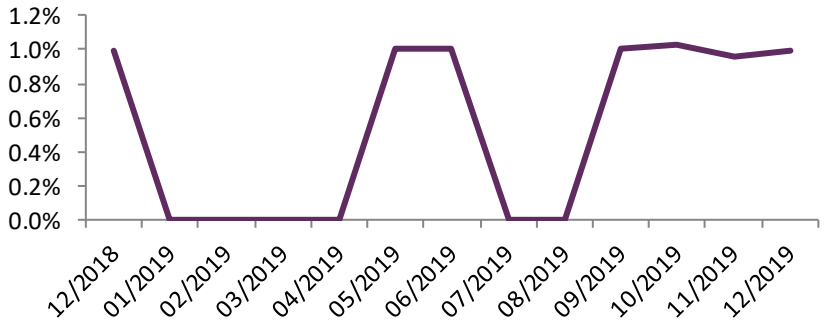


Total Falls (6)



Total CUTIs

(7)



(Source: NHS Safety Thermometer: https://www.safetythermometer.nhs.uk/index.php/classic-thermometer)

The safety thermometer is a measurement tool for improvement that focuses on the most commonly occurring harms in healthcare, for example, pressure ulcers, falls and complicated urinary tract infections (CUTI).

Staff collected data to enable wards, teams and the trust to understand the particular harms at their organisation, measure improvement over time and connect frontline teams to the issues of harm, enabling immediate improvements to patient care.

The wards collected safety thermometer data monthly to carry out these checks. In addition, managers completed audits of care and reviewed incident forms to identify any ongoing trends or concerns. Staff explained how the service had completed initiatives around fall prevention help them to identify the time, place and possible reason for a patient's fall. This enabled staff to identify trends in patient's falls. Staff and managers were able to use this data to respond to the trend in falls and made staff more available for patients around the identified times or places. For example, on Templar ward we saw a healthcare assistant had been employed, who was supernumerary to ward staffing to increase staff presence in communal areas. Teign ward were piloting a doctor led post-falls review to fully encompass contributing factors, including medication.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Each ward had access to link nurse specialists, this included specialist teams for continence, wound management, manual handling, risk and infection control. Each ward had leaders for different specialisms who could access training and attend meetings to ensure they had up to date knowledge in these areas. We saw evidence of leaders sharing this information with their colleagues via information boards on the wards.

Staff across the service used the SAFER patient flow bundle. This is a practical tool used to reduce delays for patients in adult inpatient wards. We observed a SAFER meeting on Templar ward and saw staff were following the five elements of best practise.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Patient's nutrition and hydration needs were assessed and met. Patient's food and fluid intake was assessed on admission and reviewed regularly thereafter. Staff used the malnutrition universal screening tool (MUST) for all patients and we saw that these were completed in full and necessary action taken when issues were identified.

Speech and language therapists (SALT) could be accessed easily and regularly visited the wards to review patients. SALT team members provided support to people who had speech, language, communication or swallowing difficulties. Patients who experienced difficulties in any of these areas had comprehensive risk assessments and care plans in place. Teign ward had a dedicated SALT worker, which meant patients receiving neuro-rehabilitation received close and regular review.

Patients had access to hot and cold drinks throughout the day and night. All wards we visited had water coolers to prompt patients to rehydrate. In addition to this, Brixham ward had a range of snack and beverages available for patients and carers.

Pain relief

Most staff assessed and monitored patients regularly to see if they were in pain. Staff used a pain assessment tool and were responsive to patient needs. Staff used a pain scale which allowed them to assess pain for noncommunicative patients. We saw evidence of staff discussing pain with patients and taking action to reduce this. Nursing staff discussed pain assessment tool results with doctors who would review the patient and pain relief medications. However, on Brixham ward we saw two records where pain management had not been identified when it was clearly an issue in the documentation of care notes. This meant that patients may not have received adequate pain relief to maintain their comfort.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. Managers monitored outcomes through national and local audits. Managers completed audits of care and reviewed incident forms to identify any trends or concerns and where improvements could be made. Wards we visited displayed information on notice boards at the entrance to wards. These showed performance information such as safety thermometer results and friends and family tests. Information was reviewed during team meetings and handovers.

Audits – changes to working practices

The trust have participated in no clinical audits in relation to this core service as part of their Clinical Audit Programme.

(Source: Universal Routine Provider Information Request (RPIR) – Audits tab)

Staff collected information about service delivery through local audits. These included handwashing and infection control, medicines management, pharmacy audits of prescription charts, appraisal rates, supervision compliance, staff sickness and training compliance. Ward managers shared results with staff teams in team meetings and by email communication. Ward staff created effective actions plans to respond to the findings and outcomes of audits.

Competent staff

Clinical Supervision

The trust provided the following information about their clinical supervision process:

Clinical Supervision is carried out in a manner of formats across the trust, dependent on roles and responsibilities.

The Trust has a robust policy to support staff and managers to meet the requirement with supporting paperwork. There are clinical supervisors and coaches available for staff to access as needed through the trust intranet site. Supervision can be sourced through groups, peers, individuals, debriefs, action learning sets or through ward meetings etc.

Records are held by the individuals and supervisors on their personal files. Compliance is tracked in a variety of ways; some areas track compliance with a database with dates only when supervision was undertaken, others allow staff to be responsible and take ownership. Records are kept in paper and/or electronic format.

(Source: CHS Routine Provider Information Request (RPIR) – Clin Supervision tab)

There were no systems in place to ensure that staff received regular clinical supervision. Therapy staff across the service had received practice supervision and staff we spoke with felt well supported by their line managers. It is important that staff receive clinical supervision because it provides staff with time to reflect on and discuss the care they deliver, which is strongly associated with improved performance and patient care. However, nursing staff told us they were receiving ad-hoc supervision but not regular practice supervision or line management supervision. The trust supervision policy was for staff to receive supervision once every 12 weeks. Managers had recorded supervision sessions in different ways, and it was difficult to see how often staff had been supervised. On Teign ward, there were no records of any supervision for nursing staff. This meant that we were not assured that staff providing care and treatment for medical and neuro rehabilitation had received supervision from their manager.

Appraisal rates

From December 2018 to November 2019, 83.8% of required staff in community inpatient services received an appraisal compared to the trust target of 90%. This compares to an appraisal rate of 84.3% in the previous year.

The breakdown by staff group can be seen in the table below:

Community inpatients total

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and ancillary	1	1	100.0%	90.0%	Yes
Additional clinical services	61	52	85.2%	90.0%	No
Nursing and midwifery registered	46	39	84.8%	90.0%	No
Administrative and clerical	5	4	80.0%	90.0%	No
Allied health professionals	4	2	50.0%	90.0%	No
Total	**117**	**98**	**83.8%**	**90.0%**	**No**

Brixham Hospital

From December 2018 to November 2019, 72.0% of required staff at Brixham Hospital received an appraisal compared to the trust target of 90%. This compares to an appraisal rate of 96.3% in the previous year.

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional clinical services	12	9	75.0%	90.0%	No
Administrative and clerical	4	3	75.0%	90.0%	No
Nursing and midwifery registered	9	6	66.7%	90.0%	No
Brixham Hospital	**25**	**18**	**72.0%**	**90.0%**	**No**

Newton Abbot Hospital

From December 2018 to November 2019, 88.2% of required staff at Newton Abbot Hospital received an appraisal compared to the trust target of 90%. This compares to an appraisal rate of 77.1% in the previous year.

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and ancillary	1	1	100.0%	90.0%	Yes
Administrative and clerical	1	1	100.0%	90.0%	Yes
Nursing and midwifery registered	25	23	92.0%	90.0%	Yes
Additional clinical services	37	33	89.2%	90.0%	No
Allied health professionals	4	2	50.0%	90.0%	No
Total	**68**	**60**	**88.2%**	**90.0%**	**No**

Totnes Hospital

From December 2018 to November 2019, 83.3% of required staff at Newton Abbot Hospital received an appraisal compared to the trust target of 90%. This compares to an appraisal rate of 91.7% in the previous year.

Staff group	December 2018 to November 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Nursing and midwifery registered	12	10	83.3%	90.0%	No
Additional clinical services	12	10	83.3%	90.0%	No
Total	**24**	**20**	**83.3%**	**90.0%**	**No**

(Source: Universal Routine Provider Information Request (RPIR) – Appraisals tab)

Managers completed appraisals with staff which related to work performance. Staff had personal development plans which they reviewed with their managers. Learning needs of staff were developed as part of their appraisal. Staff told us that the trust and wards provided a good learning environment and staff were overwhelmingly positive about learning opportunities. Staff could access bespoke training courses in specific areas, dementia or end of life care. Extended educational opportunities were also available to staff such as non-medical prescribing training and a care certificate in neurobehavior management. We saw examples of nurses from within the trust delivering training to ward staff. For example, psychiatric nurses had delivered training on mental health awareness and how to support patients with mental health disorders. Staff could access leadership opportunities and nursing assistants were supported to access nursing associate and registered nurse training.

Managers on all wards ensured that regular team meetings took place to ensure staff received feedback on ward progress and performance. Managers also used informal meetings and one to one meetings to gather and provide feedback from and to staff.

Multidisciplinary working and coordinated care pathways

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. Patients received care and treatment from a range of health care professionals which included doctors, occupational therapists, physiotherapists, registered nurses, nursing assistants, pharmacists, social workers, and speech and language therapists. All members of the multidisciplinary team attended weekly meetings and daily goal setting and safety briefings. We observed multidisciplinary meetings and noted these to be collaborative, with patient's and carers thoughts and preferences being considered. Nursing and medical staff told us they assessed patients' needs holistically and worked with patients to identify goals and interventions to work towards recovery. The wards completed a daily ward board round where the staff team discussed daily goals with patients.

All staff told us that they worked well as a team and patients agreed with this. There was a whole team approach to assessing the range of patients' needs, setting individual goals and providing patient-centred care. There were some nursing staff vacancies on Brixham ward, but staff had collaboratively made an immense effort to maintain a high standard of care.

The wards had social workers and discharge coordinators who supported the team by identifying potential discharge accommodation and packages of care. Where the team could not meet patient needs on discharge, referrals were made to other specialist departments. This included in-reach end-of-life and mental health liaison teams.

Staff had good links with services within the trust that could provide specific support and guidance on delivering patient care. For example, we saw an example of a patient's community Parkinson's nurse visiting them on the ward and providing vital information to staff about the patients baseline health and how to manage the patient's symptoms.

Staff worked closely with link workers from the community mental health teams and the local authority safeguarding teams. Staff at Dawlish Hospital worked alongside a partnership agency who provided volunteers who supported patients to get back into their own homes quicker. Volunteers completed tasks such as arranging removal of furniture to allow for delivery of hospital equipment, which would normally delay discharge.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed patient's health and wellbeing on admission which included smoking status and level of alcohol consumption. A dietician was available to attend the wards and provide health promotion in relation to obesity. We saw that staff across the service supported patients to engage in exercise therapy or gym sessions. All the wards had access to a gym facility that met the needs of the client group.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that mental capacity act training including deprivation of liberty safeguards is delivered as part of the corporate and clinical induction for all new staff. No training data for these courses was provided to CQC as part of the Provider Information Request.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Deprivation of Liberty Safeguards

From December 2018 to November 2019 the trust reported that 108 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority, 21 of which were pertinent to community inpatients services. None of the DoLS applications made were emergency ones.

From December 2018 to November 2019 CQC received no direct notifications from Torbay and South Devon NHS Foundation Trust.

Number of standard DOLS applications

Site / ward name	Number of applications made	Number of applications approved
Brixham Hospital	3	0
Dawlish Hospital	0	0
Newton Abbot Hospital – Teign ward	11	0
Newton Abbot Hospital – Templar ward	0	0
Totnes Hospital	7	0
Total	21	0

(Source: Universal Routine Provider Information Request (RPIR) – DoLS tab)

The trust had a policy on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). Staff received basic training in the MCA and followed policy and procedures when patients were unable to consent to decisions about their care. Managers made sure that assessments of capacity were completed by the most appropriate team members for the related decision. Staff organised and documented best interests' decisions where patients lacked capacity. Staff ensured patient, carers and families were involved in best interest's decision making. However, we did not see any evidence of advocacy being offered to patients who lacked the capacity to make specific important decisions such as where they will live. None of the wards had information leaflets for advocacy on display and we did not see any examples of patients being offered it. Advocates are mainly instructed to represent people where there is no one independent of services (usually family or friends) to represent the person.

Patients' capacity to consent to treatment was recorded in their records and on their care and treatment plans.

Is the service caring?

Compassionate care

The sites which provide community inpatient services for the trust were compared to other sites of the same type and the scores they received for privacy, dignity and wellbeing were found to be about the same as the England average.

(Source: NHS Digital)

All of the patients we spoke with told us staff treated them with respect, kindness and maintained their dignity. Staff provided emotional support to patients, families and carers to minimise their distress. Staff took time to listen to patients and were responsive to their needs. Patients felt safe on the wards and told us that staff maintained their privacy when providing personal care and

discussing their treatment. Staff used curtains to maintain privacy in bay areas and used bathrooms, where possible to provide personal care.

Staff attempted to take account of patient's individual needs but there was a lack of understanding amongst staff about patients' personal, cultural and religious needs. Although staff had completed mandatory training on equality and diversity, they showed little understanding of how different protected characteristics may be supported. This meant that we were not assured that a patient's needs were being fully assessed and met. However, we saw that staff were responsive when they had identified a patient need, such as gluten free meals.

Patients told us that staff were supportive and worked hard to help them achieve their goals and become more independent.

We observed staff assessing and discussing patients' psychological health, discomfort levels and pain in a compassionate and timely way. Patients told us that staff were interested in their wellbeing and responsive to their needs.

Staff completed a daily assessment of patients' psychological and general wellbeing and recorded these on the daily progress notes. Staff were perceptive to changes in patients' presentation and discussed changes in team meetings.

All wards had tableware that was appropriate for patients with dementia. Staff had completed 'This is me' documents for people with dementia and used these to provide person centred care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff assessed and understood the impact that a patient's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.

Managers ensured carers were supported and encouraged to visit patients. Visiting hours were open, although some mealtimes were protected to ensure patients food and fluid intake was adequate. The wards had day rooms where patients could spend time with family. Carers and family members could access drink making facilities on the ward.

A chaplain visited the wards regularly and staff told us patient could request visits from religious leaders from their faith. Staff on Teign ward gave us an example of a Greek Orthodox patient receiving daily visits from her chaplain, which were facilitated in a quiet room.

Staff were perceptive to changes in patients mental state and organised assessments in response to this. During the ward board round on Templar ward we saw clinicians were considerate of patients' emotional health and referrals were made to the mental health team when appropriate.

We observed strong multi-disciplinary team working which supported patients and empowered them to manage their own health and maximise their independence. Most of patients we spoke with understood their care plan and felt involved with goal setting and discharge planning.

Staff responded quickly to nurse alarms and calls for help.

Managers liaised with community services to provide support. Volunteers from a partnership agency visited the wards once to twice weekly to provide services such as befriending, filling in forms, pet therapy and memory cafes. Brixham ward patients had access to two places at a day centre opposite the hospital to support patients with social stimulation. Staff told us that this facility had been most beneficial for patients who had been at the hospital for longer than two weeks.

Patients were supported to access alternative therapies where requested. We were given examples of patients receiving reflexology on Teign ward.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff used different techniques to communicate with patients to ensure they understood their care and treatment. This included using pictures and accessing interpreters. We saw evidence of staff accessing support from specialists in the community to support a patient with learning difficulties.

Patients were aware of the goals of their treatment and felt supported to achieve these. On Brixham ward, we observed staff exploring all possible avenues and safely discharging a patient home, as they wanted to be home for their final days.

Carers felt listened to and respected. On Brixham ward we saw that visiting times which had been changed to opening visiting in response to patient and carer requests.

Patients and carers had information available to them about a variety of topics that might benefit them. For example, on all the wards we saw leaflet stands holding information for specific diagnoses, safeguarding, healthy eating, voluntary services available locally and the complaints procedure. On Teign ward we saw specific information for different aspects of a patient's life that could be affected after a stroke. This included leaflets containing information for communication problems, visual problems and fatigue associated with a stroke were available in communal areas.

Patients could use their mobile phones and other electronic devices.

Is the service responsive?

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service worked well with the local acute hospital and GPs to ensure smooth care pathways from acute services and the community. Referrals from the local acute hospital were triaged and assessed by the ward team before admission. Local GPs referred patients directly to the ward and ward staff assessed the referrals. Admission criteria included a need for rehabilitation and identifiable goals of admission. The ward teams ensured patients were medically fit before admission for rehabilitation. Managers signposted patients to alternative services if their needs could not be met by the wards. For example, managers signposted patients from the community to acute services for investigation if the medical cause for their rehabilitation need had not been investigated.

The trust and managers were able to advise us how they worked with commissioners of care and external providers such as care homes and other voluntary agencies to plan and develop services to meet the needs of local people. For example, volunteers supported mealtimes and Totnes and Newton Abbot Hospitals had a regular visiting 'Pets as Therapy' dog. Volunteers from a partnership agency had raised money for Templar ward and donated a Reminiscence Interactive Therapy Activities (RITA) computer. RITA is an evidence-based digital therapy system which allows patients to apps, games and other leisure activities as part of their hospital stay. Patients

whose first language was not English could also use RITA as it was programmed in many languages.

We saw that medical cover on the wards was extended to include Saturday mornings. This meant that patients admitted on Friday did not have to wait until Monday to have a medical assessment. On Brixham ward we saw that administration staff were also extended to Saturday mornings in response to feedback from staff that they were spending less time with patients due to clerical duties.

Ward moves

The trust was asked to list ward moves for a non-clinical reason during the last 12 months. For example, if a patient has to move wards several times because there is no room in the speciality ward they should be on.

Ward managers confirmed that they did not move patients for non-clinical reasons and therefore there had been no ward moves during the last 12 months.

(Source: Universal Routine Provider Information Request (RPIR) Universal – Ward moves tab)

Moves at night

The trust were asked to list ward moves between 22:00 and 08:00am for each core service for the most recent 12 months

From December 2018 to November 2019, the trust reported that there were no moves at night for community health inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) Universal – Moves at night tab)

Mixed sex breaches

Mixed sex breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. Whilst these are specifically for mental health providers the same definitions apply to community health services and acute providers from a CQC perspective. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children's and adolescent units. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children's unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

The trust reported that between December 2018 to November 2019 there were no mixed sex breaches within community inpatients services.

(Source: Universal Routine Provider Information Request (RPIR) –Mixed sex tab)

Meeting the needs of people in vulnerable circumstances

Staff engaged with and were responsive to patients in vulnerable circumstances. There was access to specialist link nurses and teams, from within the organisation and external providers, such as Parkinson's nurses, tissue viability nurses and a mental health liaison team. Staff engaged with the relevant specialist link nurses and teams to improve the care provided. For example, Brixham ward staff had liaised with a patient's regular consultant to discuss treatment options, as some medications and therapy had a potential to affect the patient's underlying condition.

Staff did not engage patients in stimulation outside of their therapy sessions. Although wards had books, televisions and games, there was no specific occupation provided for patients. This meant that patients were not receiving stimulation outside of their therapy sessions. The trust provided some online training for dementia but there was no face to face training available and it was not mandatory training.

Staff collaborated with workers from other teams involved in patients care, such as mental health teams and social workers, throughout decision making and discharge planning.

Managers could access interpretation services and we were given some examples of patients who had been supported by an interpreter. Speech and language therapists and staff developed techniques and methods to communicate with patients who could not communicate, such as using pictures and writing things down.

The trust had ensured that the wards were accessible and contained the necessary equipment to provide care for patients in wheelchairs or with mobility issues. All wards had wide walkways and wheelchair accessible toileting and bathing facilities.

The organisation met patients' religious needs and patients could request visits from religious leaders of their choice. Each ward was visited by a chaplain weekly to speak with patients about their religious needs and how they could be met during their hospital admission.

(Source: NHS Digital)

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly.

The service did not have specific admission criteria as it worked on the basis that they provided beds to whoever need them in order to support the local community. Staff told us the wards accepted adults over the age of 18 who required rehabilitation and were fit enough to partake in therapy. Staff at Dawlish Hospital had continued to support patients in their own homes after discharge, where possible, to enable patients to leave hospital when there was a delay in receiving social care in the community.

Referrals from the local acute service were triaged by senior staff and placed on a list for assessment which was accessible to the acute team and the trust's staff. Managers told us that waiting lists were non-existent and wards had capacity to accept patients within 24hours of referral. GPs referred directly to the wards and there were no waiting lists for patients to be admitted from the community. On Teign ward, the trust had an agreement to reserve one bed for GP referrals from the community. During the inspection the wards had admitted all patients within two days.

When patients were referred from another ward, staff ensured they were transferred with their medication, medication charts and relevant information such as treatment escalation plans. The ward doctors reviewed and transferred this information to the trust's documents when completing admission paperwork for patients.

All the wards had good access to medical cover. Newton Abbott, Brixham and Dawlish Hospitals benefited from a GP on site who provided cover from 9am to 5pm on weekdays, but also did a ward round on a Saturday to ensure Friday evening admissions were not left all weekend. Totnes Hospital had a guaranteed medic on site for two hours per day. Outside of hours the service utilised the county-wide on call doctor service. A specialist stroke doctor visited Teign ward once a week to complete a full ward round with staff to ensure patients were receiving specific care and support that maximised their rehabilitation potential. Teign ward also had a full time occupational

therapy consultant to develop and recommend a programme of occupational therapy and rehabilitation.

Accessibility

The largest ethnic minority group within the trust catchment area is Other Asian with 0.39% of the population.

	Ethnic minority group	**Percentage of catchment population (if known)**
First largest	Other Asian	0.39%
Second largest	White and Asian	0.34%
Third largest	White and Black Caribbean	0.34%
Fourth largest	Indian	0.31%

(Source: Universal Routine Provider Information Request – Accessibility tab)

Bed occupancy

The trust provided information regarding average bed occupancies from December 2018 to November 2019.

A breakdown of bed occupancy levels in November 2019 by site for community health inpatient services is below:

Site	**Ward**	**Bed occupancy in November 2019**
Brixham Hospital	Brixham	97%
Dawlish Hospital	Dawlish	97%
Newton Abbot Hospital	Templar	99%
Newton Abbot Hospital	Teign	98%
Totnes Hospital	Dart	97%

(Source: Community Routine Provider Information Request (RPIR) Community – Bed occ & LOS tab)

Average length of stay data

The trust provided information for average length of stay from December 2018 to November 2019.

A breakdown of average length of stay by the for community health inpatient services below:

Location	**Ward**	**Average length of stay**
Brixham Hospital	Brixham	14
Dawlish Hospital	Dawlish	12
Newton Abbot Hospital	Templar	16
Newton Abbot Hospital	Teign	14
Totnes Hospital	Dart	10

Note: The averages in the table are calculated based on monthly averages provided by the trust so may not be representative of actual amounts.

(Source: Community Routine Provider Information Request (RPIR) Community CHS7 – Bed occupancy and length of stay tab)

Referrals

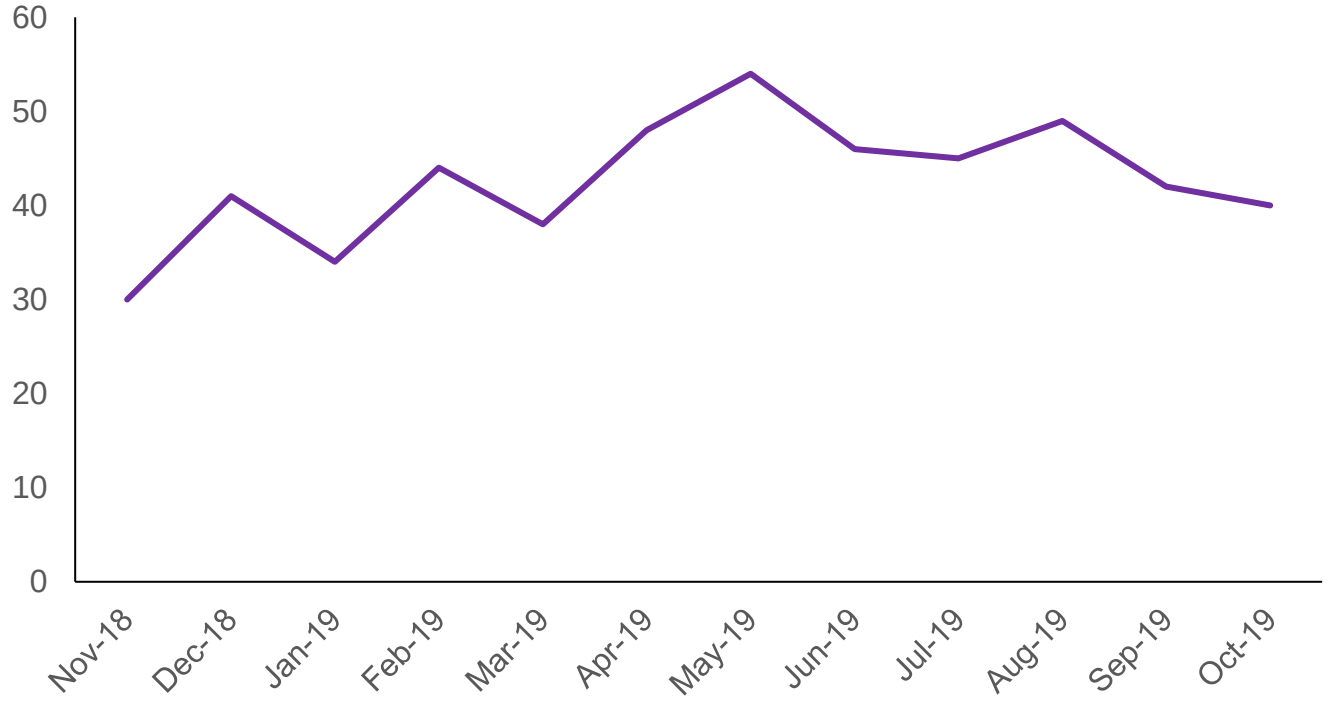
No referrals were made by community inpatients services.

(Source: CHS Routine Provider Information Request – Referrals tab)

Delayed discharges

From November 2018 to October 2019, there were 511 delayed discharges in community health inpatient services. This amounts to 17.2% of the total discharges in this core service.

Delayed discharge trends from November 2018 to October 2019 at Torbay and South Devon NHS Trust



A breakdown of delayed discharges by location / ward for community health inpatient services is shown below:

Location or ward	Total Discharges	Total Delayed Discharges	% Delayed Discharges
Totnes Hospital	438	107	24.4%
Newton Abbot Hospital – Templar ward	755	153	20.3%
Brixham Hospital	523	90	17.2%
Dawlish Hospital	610	91	14.9%
Newton Abbot Hospital – Teign ward	650	70	10.8%
Total	2,976	511	17.2%

(Source: Universal Routine Provider Information Request (RPIR) Universal – DTOC tab)

The multidisciplinary team discussed discharge planning and needs throughout admission and liaised with ward teams, patients, families and external providers from the outset to prevent and reduce delays in discharge. The wards had dedicated discharge facilitators who worked closely

with social workers to identify suitable packages of care and liaised with outside agencies to support timely discharge. Managers raised concerns about the local area's availability of care packages and residential services as a reason for delayed discharges.

The wards had regular multidisciplinary team meetings and daily board ward rounds which focused on patient needs, goals of admission and goals of the day to work towards discharge. The daily meetings were used to identify patients progress towards discharge.

Staff across the service had managed to keep the average length of stay low. The average length of stay for all wards was 16 days or less.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients and carers were aware of how to make a complaint and felt comfortable to do so. Leaflets and information were displayed on the wards which explained how patients could complain.

The wards dealt with concerns and complaints appropriately. Formal complaints were reviewed by the central complaints team. They were investigated by managers and lessons learned from the outcomes of complaints were fed back to staff. Staff received feedback through emails, bulletins and team meetings.

The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with all staff. We saw examples of staff learning from incidents that had resulted in improvement in care. Staff on Templar ward provided an example of learning from a complaint when a patients' medication changes not been explained on discharge. Managers had implemented a new system where doctors had to complete discharge summaries before the patient left the hospital. This meant that all changes were given to the patient verbally and in a written format prior to discharge.

Complaints

Trust level

From December 2018 to November 2019 the trust received eight complaints about community inpatient services (2.7% of total complaints received by the trust). The trust took an average of 66.4 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

A breakdown of complaints by subject and site is shown below:

Community Inpatients Total – Breakdown by type of complaint

Type of complaint	Number of complaints	Percentage of total
Discharge	3	37.5%
Treatment	2	25.0%
Care	2	25.0%
Assessment	1	12.5%
Total	8	100.0%

Community Inpatients Total – Breakdown by location

Type of complaint	Number of complaints	Percentage of total
Newton Abbot Hospital	4	50.0%
Brixham Hospital	2	25.0%
Dawlish Hospital	1	12.5%
Totnes Hospital Ward	1	12.5%
Total	8	100.0%

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

Managers could not identify reasons for delays in responding to complaints, as this was completed by the complaints team.

Compliments

Trust level

From December 2018 to November 2019 the trust received two compliments for community inpatient services, both at Teignmouth Hospital. The two compliments received accounted for less than 1% of all compliments received by the trust as a whole.

We saw staff had received 'thank you' cards from patients and carers. These contained comments that showed patients were complimentary of the staff and the service they received.

(Source: Universal Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Managers reported on a number of key performance indicators to monitor performance of the ward. These included staffing, budget, readmission rates and delayed discharges.

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. Staff spoke positively about their ward managers and locality senior managers. Staff described an open culture where they could raise concerns without fear of repercussions and managers worked to solve problems.

Managers had the skills, experience and knowledge to undertake their roles effectively. Managers had the opportunity to undertake leadership training.

Staff and managers were aware of who the trust board members and senior members of the trust were. Staff told us that members of the senior leadership team had visited the wards on festive bank holidays to show their support for staff and patients.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. Staff we spoke with knew where to view the vision and strategy and agreed with it.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Morale amongst staff was good and staff felt supported through challenging times on the ward, such as when staffing levels were low.

The trust had processes and procedures to ensure staff met the duty of candour. Training was included in the corporate induction and further training was available for senior staff.

Staff had been given autonomy to improve the delivery of services, once suggestions were agreed by senior leadership. For example, on Brixham ward the GP had agreement to pay for a taxi to safely transport blood samples to the local acute hospital on a Sunday. This meant that the results could be tested on Monday and results returned to the ward sooner. Patients could then be discharged up to a day earlier.

Staff told us there was a ‘no blame’ culture, and all incident investigations were approached in terms of how to learn and improve practice. Staff knew how to whistle blow and where to access the whistleblowing policy. Staff told us that the trust ‘Freedom to speak up guardian’ had visited the wards recently and they felt confident to make contact.

There was an emphasis on development and staff were encouraged to engage in training and personal development opportunities.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust provided a governance framework through meetings at team and management level.

There were systems in place to ensure monitoring of the services provided was undertaken and appropriate action taken to make improvements. The information gathered was used to monitor and manage quality and performance.

Matrons and managers attended the monthly local managers meetings and ward performance reviews. Ward managers created reports on key performance indicators and developed action plans to meet any areas of concern. Data to inform key performance indicators were collected for infection control, audits, appraisals, supervision sickness, training and admission data

collection. However, we were told by managers that the online system did not capture all mandatory training for nurses. This meant that managers had to collate this data separately through a different system.

Staff undertook audits at ward level in a number of areas such as medicines management, infection control and hand hygiene. Ward staff created effective action plans to respond to audit outcomes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had a risk register and each ward had a local ward-based risk register. Managers and staff were able to submit items to the risk register for approval. Dawlish had one item on the risk register, which was the recruitment of registered nurses. Totnes Hospital had three items; availability of staff parking, the hospital lift and staffing amongst hotel services. The lift was due to be replaced by the trust by the end of March 2020.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and managing expected and unexpected events. The trust had contingency plans for when service could be disrupted, such as through adverse weather. Throughout the inspection we saw examples of contingency plans for the COVID-19 pandemic. We also observed staff adhering to guidance provided by Public Health England, such as asking all staff and visitors to wash their hands on entering the wards.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to enough computers in the community hospitals to undertake their roles. Computer systems were secure, and staff had individual access passwords. Electronic systems were used by ward staff for recording of incidents, completing some aspects of mandatory training and accessing email. Although care records were paper based at the time of inspection, staff told us these were working well and were easily accessible. Managers had access to information that told them about the individual unit's performance. For example, incidents, supervision and training data.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust engaged well with patients, staff and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Managers attended locality meetings between other agencies such as the council, acute trust and GPs.

The trust completed staff surveys and made improvements based on these results. We saw ward managers had encouraged staff to feedback about various aspects of the service. On Teign ward we saw staff had asked to increase the number of comfortable chairs for patients to sit out in, and

this had been agreed by management. Patients and carers were encouraged to participate in surveys, including the family and friends test. However, staff at Dawlish Hospital told us they had collected friends and family feedback but had not received feedback from the trust team.

The trust engaged with local volunteer services and charities which had led to volunteers visiting the wards to provide befriending services on the ward and following patients' discharge.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research

The service had engaged staff in falls prevention work. We saw initiatives had been implemented across the service to reduce the number of falls. This included daily falls tracking calendars and increasing staff presence. The most recent addition to this work was the piloting of a yellow sticker on drug charts. The sticker was to highlight 'risk of falls' patients to prompt prescribing doctors to give extra consideration when making medication choices. This was in response to a patient who experienced falls after they had been taken off antidepressant medication.

Leadership service encouraged staff to develop and promoted their personal and professional development. For example, the manager of Teign ward had been supported to complete a master's degree module in dementia and all managers had been completed a leadership course.

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby 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 that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust reported no relevant accreditations for community inpatients services.

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