Royal Devon University Healthcare NHS Foundation Trust

Inspection report

Royal Devon and Exeter Hospital (Wonford)
Barrack Road
Exeter
EX2 5DW
Tel: 01392402357
www.rdehospital.nhs.uk

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

The Royal Devon University Healthcare NHS Foundation Trust was established in April 2022 following the integration of Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust, combining resources and expertise to provide acute, community and specialist services across North Devon, Mid Devon East Devon and Exeter. Corporate and clinical services are in the process of being merged.

The trust provides services for 615,000 people across 2 acute hospitals, 17 community hospitals and a range of community, specialist and primary care services. Services cover more than 2000 square miles across Devon and some specialist services cover the whole of the peninsula. The trust has 15,000 staff.

We carried out a short notice announced focused inspection of medicine and surgery services at North Devon District Hospital and Royal Devon & Exeter (Wonford) site. We also carried out a comprehensive inspection of diagnostic services at both sites. We inspected medical care based on concerns and information we had received. We inspected surgery as the trust had 16 Never Events between March 2021 and November 2022. We previously inspected the Royal Devon and Exeter hospital in December 2017 also in response to concerns we had following a series of never events within surgery. We carried out this short notice announced comprehensive inspection for the diagnostic and imaging service as we had not previously inspected or rated diagnostic imaging as a stand-alone service at these locations.

Our well led inspection, planned for January 2023 was postponed due to pressures in the NHS. We completed the well led inspection on 3 and 4 May 2023. We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement. Use of Resources was not assessed during this inspection.

Our ratings for the core service inspection:

Our findings

For Medicine at both locations, we rated the service as requires improvement in safe and well-led. According to our methodology the remaining key questions were 'inspected not rated' due to using the focused inspection methodology. This meant that Royal Devon and Exeter (Wonford) site for medicine moved from good to requires improvement overall. North Devon District Hospital remained requires improvement for medicine overall. The remaining domains effective, responsive and caring reflect the historical ratings of the inspection carried out in 2019 for Royal Devon and Exeter (Wonford) and July 2021 for Northern Devon District Hospital.

For Surgery at both locations, we rated the service as requires improvement in safe and well-led. We only inspected the remaining key questions of responsive and effective which were 'inspected not rated' due to using the focused inspection methodology. This meant that Royal Devon and Exeter (Wonford) site for surgery moved from good to requires improvement overall. North Devon District Hospital also moved from good to requires improvement overall. The domains of effective, responsive and caring reflect the historical ratings of the inspection carried out in February 2016 for Royal Devon and Exeter (Wonford) and November 2014 for North Devon District Hospital.

For Diagnostic Imaging at both locations, we rated the service as good. This was good for the key questions of caring, responsive and well led, and requires improvement for the key question of safe. We inspected but did not rate the key question of effective which was in line with our current methodology.

Our rating for the well led inspection:

We rated the trust well led as requires improvement because:

- The trust and Devon were in a national oversight framework segment 4 due to financial performance and delivery against performance targets.
- The trust had a challenging financial position and a financial plan with a planned deficit of £28 million (2.8%). Although safety remained the highest priority within the organisation, we were told at times quality may be impacted.
- There had been an impact on the quality of data for audit while the electronic reporting system was embedding. The response to this had not been completed at pace.
- The trust needed to continue to address culture and work on equality, diversity, and inclusion within the organisation. As a newly integrated trust, culture and inclusivity was a key focus and the trust recognised there was work to be done to bring the cultures together and build a culture that is all inclusive. Staff satisfaction was mixed, however, improving the culture and staff satisfaction was seen as a priority.
- The trust had a high number of never events, these are serious incidents which are wholly preventable. The response time to never events lacked in pace and processes to implement actions and share widely lessons learned were not always effective.
- There were significant delays in investigating complaints and serious incidents.
- Community services were not well represented within the board service and performance measure.

However:

- Leaders had the experience, capacity, capability, and integrity to ensure the strategy can be delivered and risks to performance addressed. The leadership team were cohesive, patient centered and knowledgeable about the issues and priorities for the quality and sustainability of services and understood the challenges.

Our findings

- There was a clear statement of vision and values driven by quality and sustainability and translated into a realistic strategy. The strategy was aligned to local plans in the wider health and social care economy and services were planned to meet the needs of the local population.
- The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. Structures, processes, and systems of accountability were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.
- Safety remained a priority over performance. There were processes to manage current and future performance. There was an effective and comprehensive process to identify, understand, monitor, and address current and future risk. Performance issues were escalated to the appropriate committees and the board through clear structures and processes.
- The trust had undergone a digital transformation implementing an integrated electronic patient record system and making personal health information accessible to patients. The integrated electronic patient record system enables advancements in many aspects of patient care and service delivery across the trust. There were arrangements to ensure the confidentiality of identifiable data, records and data management systems, and information governance breaches were reported. There were arrangements to ensure data or notifications were submitted to external bodies as required.
- There was a collaborative relationship with system and external partners to share an understanding of challenges and the needs of the local population. Staff were engaged and involved. The trust included the patient voice to help shape and improve services.
- There was a focus on continuous learning and improvement at all levels of the organisation, including appropriate use of external accreditation and participation in research. There was knowledge of improvement methods and arrangements to support people to develop their ideas in a structured way. Internal and external reviews were used to identify learning and make improvements.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust Wide
The trust must ensure that:

- Information is up to date, accurate and properly analysed and this supports regular audits to assess, monitor and improve the quality and safety of services. The trust must continue to improve the use and functions of the electronic patient record system to capture meaningful data and complete audits, supported by the trust's planned roll out of staff training to support the systems functionality and capability. **Regulation 17(1)(2)(a)**

Our findings

- They have a stable financial position and systems and processes continue to ensure financial pressures are managed so they do not compromise the quality of care. **Regulation 17(1)(2)(a)**
- Their systems and processes support the oversight of and response to issues and risk in a timely way. The trust must consider how it can improve their pace in response to issues when they arise, for example the high number of never events and the electronic patient record system data issues. **Regulation 17(1)(2)(b)**

Surgery Core Service at Royal Devon & Exeter Hospital
The trust must ensure that:

- It continues addressing the high vacancy rates and high turnover rates for medical, nursing and health care assistant staff. Regulation 18(1)(2).
- Effective risk and governance systems are implemented which supports safe, quality care. The trust must ensure clinical audits are regularly carried out in the service to monitor service performance and staff compliance with the trust policies. Regulation 17(1)(2)(a)(b)(f).
- Processes to implement actions and share widely the lessons learned from all serious incidents, including never events, with all staff, and ensure action plans are implemented in a timely manner. Regulation 17(1)(2)(a)(b)

Surgery Core Service at North Devon District Hospital
The trust must ensure that:

- It continues to address the high vacancy rates and high turnover rates for medical, nursing and health care assistant staff. Regulation 18(1)(2).
- Staff complete patient documentation and risk assessments and ensure staff are competent in using the integrated electronic patient record system. Staff did not always complete nursing risk assessments on admission. Regulation 12 (a)(b).
- Effective risk and governance systems are implemented which supports safe, quality care. The trust must ensure clinical audits are regularly carried out in the service to monitor service performance and staff compliance with the trust policies. Regulation 17(1)(2)(a)(b)(f).
- Processes to implement and share widely the lessons learned from all serious incidents, including never events, with all staff, and ensure action plans are implemented in a timely manner. Regulation 17(1)(2)(a)(b)
- It maintains a complete and contemporaneous record in respect of each service user, which must be kept secure at all times, and only accessed by authorised people. There was a breach of confidentiality in the day surgery unit with patients details of operations displayed. Regulation 17 (2)(a)

Medical Care Core Service at Royal Devon & Exeter Hospital
The trust must ensure that:

- Staff complete patient documentation and risk assessments and ensure staff are competent in using the integrated electronic patient record system. Regulation 12 (a)(b).
- Medicines are stored securely, there is improved compliance on the medicine management audits and ensure medicine storage temperatures are monitored and recorded in line with trust requirements. Regulation 12(1)(2)(a)(b)(g).

Our findings

- Effective risk and governance systems are implemented which supports safe, quality care. Local audits are regularly carried out in the service to monitor service performance and staff compliance with the trust policies. Regulation 17(1)(2)(a)(b)(f).

Medical Care Core Service at North Devon District Hospital
The trust must ensure that:

- Staff complete patient documentation and risk assessments and ensure staff are competent in using the new integrated electronic patient record system. Regulation 12 (a)(b).
- Patients are provided with suitable equipment in the escalation areas to meet the needs of the patients, to include lockers and closer access to showers. Regulation 15 (1)(c).
- It reviews its standing operating procedures that relate to escalation areas and ensure the patients utilising these areas match the criterion stated in the standing operating procedure. Regulation 12 (a).
- Oxygen cylinders are handled and managed securely to minimise risks. Regulation 12(1)(2).
- Medicines are managed appropriately, there is improved compliance on the medicine management audits and ensure medicine storage temperatures are monitored and recorded in line with trust requirements. Regulation 12(1)(2) (a)(b)(g).
- Effective risk and governance systems are implemented which supports safe, quality care. Local audits are regularly carried out in the service to monitor service performance and staff compliance with the trust policies. Regulation 17(1)(2)(a)(b)(f).
- Temporary staff receive an adequate induction to the ward areas. Regulation 18 (2)(a).
- Patients receive regular consultant reviews. Regulation 12(1).
- It continues to address the high vacancy rates for medical, nursing and health care workers. Regulation 18(1)(2).

Diagnostic Imaging Service at Royal Devon and Exeter Hospital
The Trust must ensure that:

- Staff receive appropriate mandatory training and training records accurately reflect staff completion rates, and staff receive regular appraisals. Regulation 18 (2)(a)

Diagnostic Imaging Service at North Devon District Hospital
The Trust must ensure that:

- Staff receive appropriate mandatory training and training records accurately reflect staff completion rates, and staff receive regular appraisals. Regulation 18 (2)(a)
- There are governance processes to manage all aspects of safety and quality in the MRI department. This includes adequate cleaning, quality assurance and audit schedules and up to date protocols. Regulation 15(1)(e)
- All MRI staff are aware of The Medicines and Healthcare Products Regulatory Agency (MHRA) Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use (February 2021). Regulation 15(1)(e)
- The storage of all oxygen cylinders is safe and meets the Health Technical Memorandum for cylinder management. Regulation 12 (2)(g)

Action the trust SHOULD take to improve:

Our findings

Trust Wide

- Continue to address culture and work on equality, diversity, and inclusion within the organisation. Consider any training gaps for staff, particularly middle management and how they respond to discrimination and bullying. Review the support provided for neurodiverse staff. Review how staff can have protected time for roles such as inclusion champions and setting up and supporting staff networks.
- Review the guardian of safe working hours process to ensure it is effective and issues of compliance with safe working hours are reported and addressed.
- Confirm that all information is held on file and declarations signed annually to evidence fit and proper persons recruitment processes for executives and non-executives.
- Improve the visibility of executives and non-executives across all areas of the trust.
- Continue to address the backlog and delays with processing complaints at the eastern site.
- Continue to address delays with serious incident investigations to ensure learning is identified and action taken in a timely manner.
- Consider how executives can link with the executives at the mental health trust to help find solutions facing mental health provision.
- Consider the representation and reporting of community services within board papers and the integrated performance report.

Surgery Core Service at Royal Devon & Exeter Hospital

- The safe surgery and interventional procedures policy should be reviewed as part of the action plans, as stated in the never event investigation report.
- Action plans for never events should discuss the wider sharing of learning with staff across divisions and the whole trust.
- The trust should continue to work on waiting times from referral to treatment and arrangements to admit, treat and discharge patients, as they were not in line with national standards.
- The trust should continue to monitor and improve performance against national targets for elective and emergency surgery within specialties and for cancer patients.

Surgery Core Service at North Devon District Hospital

- North Devon District Hospital should be included in the safe surgery and interventional procedures policy which should be reviewed as part of the action plans, as stated in the never event investigation report.
- Action plans from patient safety incident investigations should discuss the wider sharing of learning with staff across the divisions and the whole trust.
- The trust should continue to monitor and improve performance against national targets for elective and emergency surgery within specialties and for cancer patients.
- The trust should continue to work on waiting times from referral to treatment and arrangements to admit, treat and discharge patients as they were not in line with national standards.

Our findings

- The division should have a more detailed risk register and update it regularly and ensure all leadership teams are fully engaged with the risk registers for their department.

Medicine Core Service at Royal Devon and Exeter Hospital

- The trust should ensure it continues to address the high vacancy rates and high turnover rates for medical, nursing and health care assistant staff. Regulation 12(1)(2); 18(1)(2).
- The trust should continue to work with system partners so patients can be discharged in a timely manner with suitable onward care.

Medicine Core Service at North Devon District Hospital

- The trust should continue to work with system partners so patients can be discharged in a timely manner with suitable onward care.

Diagnostic Imaging Service at Royal Devon and Exeter Hospital

- The trust should ensure specific training for people with learning disabilities and autism is incorporated into staff mandatory update training. Regulation 18 (2)(a)
- The trust should make sure that chairs are replaced when coverings are no longer intact.
- The trust should make sure there is a cleaning cycle in place for all linen curtains or replace them with disposable ones.
- The trust should consider the layout of the main waiting room to reduce the risk of patients hearing other patients' confidential information.
- The trust should ensure the radiopharmacy facility meets current standards as detailed in the Quality Assurance of Aseptic Preparation Services report (November 2022). Regulation 15(1)(c)
- The trust should consider reviewing the barrier system entry to the nuclear medicine department from the main radiology department.
- The trust should consider relocating medical photographer's studio due to its current proximity to the nuclear medicine department.
- The trust should ensure timely completion of the medical physics yearly quality assurance schedule for all pieces of equipment. Regulation 17 (2)(d)
- The trust should review the use of the room outside CT2 and CT3 currently used for cannulating to make sure patients' privacy and dignity is maintained.
- The trust should continue to make improvements to meet the 6 week national waiting list and reporting targets for all modalities.

Diagnostic Imaging Service at North Devon District Hospital

- The trust should ensure staff are aware of the need to complete specific training for people with learning disabilities and training. Regulation 18 (2)(a)
- The trust should ensure any additional emergency equipment, such as that in the MRI unit, is stored correctly, clearly identified and sealed. Regulation 12 (2)(b)

Our findings

- The trust should make sure Digi Locks are always locked to prevent unauthorised entry to staff only areas.
- The trust should ensure timely completion of the medical physics yearly quality assurance schedule for all pieces of equipment. Regulation 15 (10)(e)
- The trust should continue to make improvements to meet the 6 week national waiting list and reporting targets for all modalities.
- The trust should consider cross cover from other locations for some modalities, such as DXA Bone Density Scans, to build resilience into the service and reduce waiting times.

Is this organisation well-led?

The overall well led rating comes from the trust wide well led inspection which takes into account leadership at service level and the most senior level. This was the first inspection of the trust since it merged Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust. We rated it as requires improvement.

Leadership

Leaders had the experience, capacity, capability, and integrity to ensure the strategy can be delivered and risks to performance addressed. The leadership team were cohesive, patient centered and knowledgeable about the issues and priorities for the quality and sustainability of services and understood the challenges.

Leaders had the skills and abilities, experience, and capacity to manage the trust. The leadership team had a good mix of members, including those who had lots of experience within the national health service and other members who had experience of the private sector.

The board of directors, led by the chair of the trust included a cohesive and patient centred executive and non-executive director team, who we saw worked well together as a unitary board. The executive leadership team was led by the chief executive officer and included the deputy chief executive officer, chief medical officer, chief nursing officer, chief finance officer, chief operating officer and the chief people officer. The chair had been in post for one year after joining the trust on 1 April 2022. There were 7 non-executive directors, each with a specific area of responsibility. The non-executive directors had appropriate skills, a good range of backgrounds and offered challenge to the leadership team. There was a mix of skills within the board with awareness of the need for more diversity. The board held development days 4 times a year.

There was a system to monitor and assess whether the board of directors were deemed fit and proper to meet the fit and proper persons regulation requirements. We identified some gaps when reviewing executive and non-executive paper files, and the majority were easily rectified and information made available. However, two executives did not sign a fit and proper self-declaration for 2021 during the pandemic.

There were 31 seats on the council of governors, this included 22 public governors across three constituencies (eastern, northern, and southern), 7 staff governors and 2 appointed governors. The governors' duty is to hold the non-executive directors, individually and collectively, to account for the performance of the board of directors. We were told the governors bring a lot of energy, democratic voice and challenge to the trust and help to keep in touch with the community.

Our findings

Leaders were aware of the challenges the trust faced as a whole, including the system and political context. The leadership team were operating in a national oversight framework requiring mandated intensive support, they were 1 year post merger, dealing with issues arising because of the pandemic, as well as implementing a new trust wide patient electronic record system.

Leaders were sometimes visible and approachable for patients and staff. We heard positive comments about the chief executive being approachable and supportive. However, it was also commented on by a few staff about the lack of visibility of the chief executive and some junior doctors were not aware of the name of the chief medical officer. It was commented how prior to COVID the visibility of executives was much better, but since COVID visibility had reduced. At the time of the well led inspection, the non-executive directors did not conduct site visits of the hospitals, these had been paused during COVID, the trust was expecting this to be fully functioning again by June 2023 to allow non-executive directors to speak with people about what works and why, and how can things be made better.

The next level in the management structure was called the site leadership team. The team worked in triumvirates of site director of nursing, site medical director and site director of operations. There were leads at both the northern site (Barnstaple) and the eastern site (Exeter) who took responsibility for the site and each of these also led on trust wide areas. The triumvirate structure looked to be effective as it provided cross cover working arrangements allowing presence at both the northern and eastern sites and fostered good team working.

The trust had leadership development and training programmes available for staff. The leadership group within the trust is made up of the most senior 300 people across the trust. A talent review and succession plan were completed in November 2022 by the trust development group, this had not been completed as a full talent review for 3 years prior to this date due to the pandemic and would return to being reviewed annually. An executive director succession planning was completed in April 2021.

Vision and Strategy

There was a clear statement of vision and values driven by quality and sustainability and translated into a realistic strategy. The strategy was aligned to local plans in the wider health and social care economy and services were planned to meet the needs of the local population.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders clearly articulated the organisations vision and strategy and understood their role to achieve this, with strategic development being part of the deputy chief executive's role.

The new trust strategy was launched in Spring 2022, a 5-year strategy with a mission of "working together to help you stay healthy and to care for you expertly and compassionately when you are not". The strategy focussed on CARE objectives which included: **C**ollaboration and partnerships, **A** great place to work, **R**ecovering for the future and **E**xcellence and innovation in patient care. It also focussed on four core values: compassion, integrity, inclusion, and empowerment. We found patient experience was at the heart of the trust vision and strategy.

There were other separate but interlinked strategies including the patient experience 3-year strategy which was launched in 2022. A transformation strategy was launched to embed a quality improvement approach. At the time of our inspection the clinical strategy was being finalised to align with the peninsula. An inclusion strategy was also being developed.

Our findings

The trust and the Devon system was in a national oversight framework segment 4, due to financial performance and delivery against performance targets. The trust had an improvement plan focussed on elective care recovery (reducing waiting lists), improving patient flow (meeting urgent and emergency care standards and reducing non criteria to reside), delivering savings and productivity, finalising clinical strategy to align with the peninsula, getting maximum benefits from electronic patient record system, ensuring estate is fit for the future, divisional integration structures and clinical pathways, collaboration with system partners on service transformation, building leadership capacity and capability to deliver change. There was not a clear system plan and exit criteria agreed at a Devon system level at the time of our well led inspection.

The trust worked as a system partner offering mutual aid to neighbouring trusts. The mutual aid requests were increasing in frequency and it was recognised across Devon that greater collaboration would be needed to deliver clinical sustainability. The Nightingale Hospital run by the trust was repurposed as a system asset and is a Getting It Right First Time accredited surgical hub and community diagnostic centre.

The trust was strategically and operationally focussed, aligning a vision and day to day work to meet both todays and tomorrow's challenges. The trust had achieved a lot considering what was going on, they were 1 year post merger, had rolled out a digital system, had a recovery support programme, experienced challenges in the system and were post-COVID.

Culture

The trust needed to continue to address culture and work on equality, diversity, and inclusion within the organisation. As a newly integrated trust, culture and inclusivity was a key focus and the trust recognised there was work to be done to bring the cultures together and build a culture that is all inclusive. Leaders encouraged compassionate, inclusive, and supportive relationships among staff, so they felt respected, valued, and supported. Staff satisfaction was mixed, however, improving the culture and staff satisfaction was seen as a priority. There were processes to support staff and promote positive wellbeing.

The trust provided acute and community services and was 1 year post merging two trusts together to form the Royal Devon University Hospitals NHS Foundation Trust. It was recognised the cultures across the eastern and northern sites differed. A cultural assessment was completed for integration which set out the differences between the northern and eastern sites, identifying both had their positives which could be brought together into one culture.

Most staff felt respected, supported, and valued. Staff were positive and proud to work in the organisation. However, staff satisfaction was mixed, staff told us they felt tired and under pressure because of ongoing challenges and staffing vacancies, although all staff continued to focus on the needs of patients receiving care. The trust priorities included the workforce with targeted recruitment and retention, in particular medical recruitment in northern, and to learn from staff survey.

There were processes to support staff and promote positive wellbeing. However, it was identified appraisals were not always regularly completed. This had been recognised in the 2021 staff survey. Low appraisal rates were seen when we inspected diagnostic imaging and was attributed to ongoing workload pressures. Please see diagnostic imaging core service.

The trust was integrating services since the two trusts merged 1 year ago. They had a cultural road map and created one staff charter for the integrated trust. The trust still had work to do to ensure the northern site, eastern site and community services all felt belonging to the trust and there was an ongoing programme of integration. Some services

had integrated well, and other services were still finding their way but keen to make this work, whereas some services still did not feel truly integrated. For example, the northern site pharmacy team did not feel well integrated with the trust and were experiencing a shortage of staff impacting on their capacity and were running out of goodwill. The chief pharmacist was aware of these issues and trying to address these.

A cultural dashboard was reported on a quarterly basis to board, and this had been done since June 2022. The dashboard provided a summary of the latest pulse survey questions, latest agency and bank spend, latest vacancy rate and numbers by staff group, rolling 12-month absence and cases reported to freedom to speak up guardians.

The trust used the staff surveys and people pulse surveys to understand culture and wellbeing within the trust.

There were clear processes for speaking up within the trust and concerns were investigated sensitively and confidentially with lessons shared and acted on. Accountability for speaking up sat with the chief executive officer who delegated this to the director of governance. The trust had 2 freedom to speak up non-executive directors. There were 14 freedom to speak up guardians, with 1 a dedicated lead doing the role full time. Additionally, there were freedom to speak up champions. The lead guardian position was vacant and out for advert at the time of our inspection, this was a dedicated role which was currently embedding and developing within the trust to support further work for the trust's speaking up agenda. The trust had clearly defined processes for speaking up informally and whistleblowing. Twice a year freedom to speak up reports were presented to the board, via the governance committee, along with a high-level summary of whistleblowing cases.

Leaders understood they had more work to do for equality, diversity and inclusion, and their priorities, issues and risks in this area. Equality, diversity, and inclusion was felt to be fragmented across the trust and not joined up. The trust needed to work on equality, diversity, and inclusion within the organisation, but we saw a desire and focus to move this forward at executive and board level. Staff had chosen inclusion as a value for the trust. The trust was on a journey of changing the culture and looking at a no blame and restorative culture, and an inclusion strategy was being developed in coproduction with staff. Some managers had been able to access and complete inclusive leadership training. There were inclusion champions, however they did not have protected time for this role. A culture club was set up with a topic to discuss and people were encouraged to come along to talk about this, this was run by the people development team.

Staff we spoke with were aware the trust wanted do drive forward to be an inclusive place to work, however, whilst this had executive support there was still some work required for this to filter down to middle managers. We were told senior leaders promoted equality and diversity in daily work, however some staff groups felt there was a gap in middle management understanding of diversity and how to support staff when poor behaviour occurred. Managers were said not to know how to react to discrimination and bullying and it was felt middle management would benefit from further education or training. Some staff spoke of not getting promoted due to their race, although this was not reflected by Workforce Race Equality Standards data.

The trust had equality, diversity and inclusion embedded in its governance structure. The diversity and inclusion steering group had been established trust wide and held quarterly meetings. Membership included staff in key roles for diversity and inclusion, network representatives, executives and staff representing areas of the trust. Standard agenda items included staff, patient and community inclusion priorities and staff network feedback. This diversity and inclusion steering group reported to the people, workforce, planning and wellbeing committee and up to board.

Our findings

We were told equality, diversity and inclusion networks had been set up during covid and were now beginning to take off, this included the disability network, ethnic minority network and LGBTQ+ network. However, some staff said they did not have protected time to create useful networks. It was also commented how there was little support for neurodiverse staff. The trust informed us they had already recognised this and a neurodiversity staff network had been established and a task and finish group which was focused on accelerating neurodiversity inclusion.

Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standard (WDES) were mandatory reports which required board approval. The most recent report was the first report completed for the integrated trust, with data submission between 1st April 2022 and 31st March 2023, this was presented and approved by the board in May 2023. The WRES report noted an increased rate of recruitment of black and minority ethnic staff who reported more confidence in career progression. The data showed there were no black and minority ethnic staff who had entered a formal disciplinary process during the period reported. Concerns in the report included significantly low number of black and minority ethnic staff in the most senior manager group and the figures relating to bullying and harassment by senior managers and staff colleagues. The WDES report positive highlights included a reduction in staff feeling pressured to come to work, improvement in staff feeling valued, an increase in the number of staff reporting a disability, and improvements in adjustments being made. Concerns highlighted in the report related to bullying and harassment from senior managers and staff colleagues. The inclusion workplan would identify and monitor actions from these reports and present to board, at the time of our inspection this was being developed and triangulated with other data sources such as the staff survey. It was recognised that the report showed improvements in several areas but there continued to be a significant different in the experiences of Black and Minority Ethnic staff and staff with disabilities, compared to white staff and staff without disabilities, representing a risk to the trust.

Governance

The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. Structures, processes, and systems of accountability were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.

There were clear governance pathways within the trust which functioned well and interacted effectively with each other. The governance was the same for both acute and community. The governance committee was responsible for ensuring governance is embedded in the organisation and delivered safe, quality, and effective care.

Board subcommittees provided assurance to the board. For example, the audit committee, governance committee and finance and operational committee. We observed a governance meeting and reviewed a number of subcommittee papers which evidenced risk, issues and performance were effectively discussed and escalated to the board through the governance arrangements.

We observed a board meeting and found the chair effectively chaired the meeting and ensured people were able to comment and challenge constructively. There was trust and respect around the table and conversations appeared honest and authentic. The papers presented to board were clear and included appropriate level of detail, report authors articulated the key headlines and the board appeared familiar with the papers to ask relevant questions and identify issues which needed further and continued scrutiny.

Our findings

Divisional business and governance meetings were set up, which fed into the relevant committees and up to the board. There remained some differences between the eastern and northern sites and the trust was in the process of aligning governance for these areas and establishing common approaches. Some services were yet to be joined up in their approach, for example infection prevention control was still operating differently at the eastern and northern site and leads were keen to pull out best practice and align how this is delivered trust wide.

People we spoke with were clear of their roles and accountabilities within the trust's governance framework.

Management of risk, issues and performance

The trust and Devon were in a national oversight framework segment 4 due to financial performance and delivery against performance targets. The trust had a challenging financial position with a planned deficit of £28 million (2.8%). Although safety remained the highest priority within the organisation, we were told at times quality may be impacted. The response to identifying issues, for example never events and the electronic patient record data issues, was not always completed at pace. There were significant delays in investigating complaints and serious incidents. However, safety remained a priority over performance. There were processes to manage current and future performance. There was an effective process to identify, understand, monitor, and address current and future risk. Performance issues were escalated to the appropriate committees and the board through clear structures and processes. There were processes for clinical and internal audit, but data was not always available to support audit.

The trust and Devon were in a national oversight framework segment 4, due to financial performance and delivery against performance targets, this means they entered a recovery support programme and received intensive support from NHS England. The trust had a performance assurance framework for performance reporting, escalation and decision making. There was a clear structure of how this reporting worked.

The trust had a challenging financial position and a financial plan with a planned deficit of £28 million (2.8%). Some leaders told us finance did not compromise safety, although at times quality might be impacted. Safety remained a priority over performance and the executive and non-executive team were unified in this.

Leaders recognised the challenges they faced and their priorities to include:

- Reducing the number of patients with no criteria to reside to the 5% target.
- Returning to pre COVID productivity levels in theatres and clinics.
- Meeting access standards.
- Providing mutual aid to others while maintaining stability.
- Leadership capacity with the trust and the system.
- Ensuring get the best data out of the electronic patient record system to ensure robust snapshot and trend report.
- Delivery of savings in 2023/24 and savings based on doing the right thing and delivering better value with continued focus on quality and safety.
- Maintain wellbeing, supply and retention of people.

There was an effective and comprehensive process to identify, understand, monitor, and address current and future risk. There was a process for identifying risks and recording these at department, divisional or trust level dependent on the

threshold. There was a governance review twice a year for the risk register and the corporate risk register went to board annually with the board assurance framework. The board assurance framework was reviewed quarterly with individual risks allocated to subcommittees of the board for monthly review. The risk register was used to identify priorities for audit, and the programme of work for subcommittees, and to help maintain a strategic view.

There was an open and transparent approach to risks, concerns, and issues and these were consistent across the senior leadership team. The top 3 risks aligned to the board assurance framework included workforce, urgent and emergency care, and patient flow. The board assurance framework, bringing together in one place all the relevant information on the risks to the board's strategic objectives, was presented to the board of directors for review on a quarterly basis. The most recent review was in April 2023 with 11 strategic risks and clearly described the risk to meeting the trust's strategic aims. The corporate risk register in April 2023 was presented to board and had been reduced to 26 corporate risks.

The chief operating officer, chief nurse and chief medical officer worked well together to achieve clinical standards to manage risks, issues, and performance.

There were internal and audit processes to manage risk, issues, and performance. There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. Internal audit was overseen by the audit committee. Clinical audit was overseen by the clinical effectiveness committee. However, some clinical audits had been stood down during the pandemic and the implementation of the electronic patient reporting system or data was not available to support audit. Please see information management section and medical care and surgery core services.

The trust had a high number of never events, these are serious incidents which are wholly preventable. The response time to never events lacked in pace and processes to implement actions and share widely lessons learned were not always effective. Never events were recognised by leaders as increasing and attributed to the theme of tiredness and pressure of staff, which was a symptom of pressure the hospitals were under, however there had been no significant impact to patients. The trust was resolving this, lessons had been learnt and there were now established processes to support improvements and learning. Please see surgery core service for more information.

There had been a significant backlog of complaints, particularly for the Eastern site. For example, in March 2023, 88% of complaints were received and acknowledged within 3 days, but 64% were overdue on the 45-day response target and 23 complaints were still unresolved after more than 6 months. However, the trust was clear of their position on complaints and provided a weekly report, this ensured everyone was aware of the stages of the complaint and had a plan to manage. Regular complaints huddles with the divisions across both sites were used to review complex cases and provide support. The complaints position was reported regularly to board along with main themes which included communication, waiting times and values and behaviors. Focused work continued across both sites to reduce the volume of overdue complaints and progressing early resolution of complaints in line with best practice. The trust was aligning the complaints policies and process for the northern and eastern sites. The trust was an early adopter for the new NHS complaints standards, launched in April 2023, aiming to make the complaints process quicker, simpler, and more streamlined.

Serious incident investigations were significantly delayed. At the eastern site there was not the capacity to complete investigations. The trust was planning to roll out a central investigation team in August 2023 with an aim to improve this. Delays in investigation meant learning was not identified and actions taken in a timely manner.

Our findings

The trust had processes, in line with national requirements, to review the care of patients who had died in the trust's care. This included identifying cases where there are clinical concerns about care given or where the death could be described as unexpected. Standard judgement reviews were completed, and mortality and morbidity meetings were held at specialty or divisional level. Mortality outliers were identified and investigated.

The guardian of safe working hours approach wasn't effective and needed resolving. This role ensures issues of compliance with doctors safe working hours are addressed. There had been no guardian of safe working hours at the northern site since December 2022, a new appointment had been made to start in May 2023. Quarterly reports were still being produced but these were data driven. Exception reporting was low and at the northern site there was evidence some surgeons did not encourage surgical junior doctors to exception report, however this had been addressed.

The mental health lead was committed to having good outcomes for patients and aware of the issues facing the service in relation to mental health. The trust would benefit from being encouraged to find ways for executives to be more engaged with executives in the mental health trust and find solutions together on the problems facing mental health provision locally.

Information Management

The trust had undergone a digital transformation implementing an integrated electronic patient record system and making personal health information accessible to patients. Service performance measures were reported and monitored, however, there had been an impact on the quality of data and availability of audit while the electronic reporting system was embedding. Community services were not well represented in performance measures. There were arrangements to ensure the confidentiality of identifiable data, records and data management systems, and information governance breaches were reported. There were arrangements to ensure data or notifications were submitted to external bodies as required.

The trust had undergone a big digital transformation, implementing the integrated electronic patient record (EPR) system. This comprehensive EPR system was implemented at the eastern site in October 2020 and later rolled out at the northern site in July 2022. This system enables advancements in many aspects of safe patient care and service delivery across the trust, with the ability to share patient information quickly and securely for safer and more efficient care and enable access to real time data. Patient information is available and legible, can be used by simultaneous users and is a fundamental enabler for cross site working. The trust was recognised nationally in this area, being the first in the UK to go live with an integrated EPR across acute and community services and providing patients with a single integrated patient record, accessible by primary care. The trust was trialling virtual ward rounds using the EPR system, where a consultant can be based on one site and juniors and patients on another site. Patients were able to access their healthcare information through a patient portal which enables management of individual health and quick and convenient access to medical information.

The trust had worked to align reporting for both sites for uniformity across the organisation. The hospital sites remained split so the board could see how each hospital was performing. The trust board papers included integrated performance reports which presented performance against targets with summary information provided. However, it was recognised by the trust the community services were not fully represented in the integrated performance report and steps were being taken to improve the reporting metrics and visibility.

The implementation of the electronic patient record had impacted on the ability to provide accurate, valid, reliable, and timely data both internally and externally. Service performance measures were reported and monitored however there had been an impact on the quality of data and availability of audit while the electronic reporting system was

embedding. Some metrics and data had not been available for inclusion in integrated performance reports due to the implementation. The trust lacked in pace in resolving some of these data issues. The trust had not used a data warehouse and it had been recommended they needed to urgently put this in place. Services were not always able to challenge and improve performance in the absence of data and audits while the EPR was embedding. For example, our review of surgery and medical care core services found full oversight of the services was difficult where audits had been stood down during the pandemic and unavailable due to the implementation of the EPR system. This limited information on how the service was performing and where improvements were needed, and service leaders and staff reflected how the ward to board assurance information had been lost. Please see Medical Care and Surgery core service well led sections later in the report.

It was reflected by leaders the implementation of the EPR system is a 5-year journey and improvements were still needed to use it to its full potential. The trust recognised there were further training needs for staff to support the use of the EPR system to be able to use its full potential and training was being rolled out in summer 2023. The trust reflected how the COVID pandemic did not allow for the support and training, which was planned, when the EPR system was rolled out at the eastern site. Utilising refresher trainer aims to help maximise user proficiency and the use of real time reporting functionality. The trust planned to embed the use of real time reporting tools, at ward and department level, to monitor and improve quality and safety and develop retrospective reporting dashboards for key quality and safety nursing metrics.

The chief medical officer was the trust's senior information risk officer, who is accountable and responsible for information risk across the trust and ensure everyone is aware of their personal responsibility to exercise good judgement and to safeguard and share information appropriately. There were arrangements to ensure the confidentiality of identifiable data, records and data managements systems, and information governance breaches were reported. We were told there had been 1300 information governance issues flagged through the trust's incident reporting system in the 9 months before our well led inspection. There were 14 information governance breaches between May 2022 and May 2023 that were reportable to the information commissioner's office (ICO), no further action was taken by the ICO in response to these.

There were arrangements to ensure data or notifications were submitted to external bodies as required.

Engagement

There was a collaborative relationship with system and external partners to share an understanding of challenges and the needs of the local population. Staff were engaged and involved. The trust included the patient voice to help shape and improve services.

Leaders engaged externally with patients, the public and local organisations to plan and shape services. The trust worked collaboratively with system partners and with stakeholders about performance.

The communications, engagement and marketing strategy was developed to reflect the status as a newly merged foundation trust covering a large geography.

Plans and priorities were influenced by staff, governors and the public. Staff were engaged in the production of the trust strategy and in identifying the trust values.

Our findings

Staff feedback was measured through the annual staff survey and the people pulse survey which runs monthly. Outcomes of these were reported through the people, workforce planning and wellbeing committee and onwards to the board via the governance committee. The trust 15,000 staff and was the largest employer in Devon.

There were 5,941 staff who took part in the NHS staff survey in 2021. The staff survey results for 2021, from the previous trusts Royal Devon and Exeter NHS Foundation Trust (RDE) and Northern Devon Healthcare NHS Trust (NDHT) showed 5,941 people took part, this was a 48.5% response rate which was in line with the national average. The survey results had deteriorated from previous year's results which the trust put down to merger and post covid issues. When comparing to national average RDE scores were positively above average for 9 elements/themes and NDHT all 9 elements/themes were above average. Trust wide, divisional and departmental specific action plans were developed in response to the staff survey and reported to board.

The NHS staff survey results for 2022 were presented to board in March 2023 and this was the first time the survey had been completed for the newly formed trust. There was a significant decline noted in response rate, which was reported as 37% which was considerably under the national average for similar trusts. The scores remained above both national and regional averages, but initial analysis identified greater decline across the northern site while the eastern site remained relatively stable. Except for one area, looking at staff development and appraisals, which was considerably below average. A full action plan was planned to be taken to July board.

The trust included the patient voice to help shape and improve services. A patient or carer story was at every board meeting for the past year to bring the voice and patients to the forefront of conversations. The trust had a patient experience committee, chaired by a non-executive director, which included representation from healthwatch, maternity voice partnership and the council of governors.

Learning, continuous improvement and innovation

There was a focus on continuous learning and improvement at all levels of the organisation, including appropriate use of external accreditation and participation in research. There was knowledge of improvement methods and arrangements to support people to develop their ideas in a structured way. Internal and external reviews were used to identify learning and make improvements.

People in the organisation were passionate about quality improvement and implementing change. The quality improvement leads were an enthusiastic team, but it was early days in their strategy. They had the tools for making improvements. The trust had a transformation team to help to coach people to transform their ideas into reality and this was well supported by the board. Helping to support people to harness ideas and develop them in a structured way.

The trust had external accreditation where relevant and participated in research independently and in conjunction with other services.

Internal and external reviews were used to identify learning and make improvements and were evidenced in presentation to the board.

The trust had several areas where they could demonstrate innovation. The trust shared examples of areas where they wanted to celebrate their innovation and the impact this has had:

- NHS Nightingale Hospital in Exeter is a location run by the trust but providing services to the community of Devon. This includes the South West Ambulatory Orthopaedic Centre which is a getting it right first time (GIRFT) accredited

surgical hub providing day case healthcare and supporting elective recovery across Devon. It has the highest day case conversion rate of any surgical facility in the UK. The Nightingale also provides a centre of excellence for eyes implementing swim lanes and a surgicube modular surgical environment to support rapid succession of surgeries with minimal risk of contamination and high patient comfort. The Nightingale is also an offsite community diagnostic centre currently delivering the highest volume of CT scans and MRI scans of any offsite facility in the UK.

- Introducing an online home blood testing service which won a health service journal award for clinical innovation. People can undertake home blood testing for early detection of health conditions and focus on prevention rather than treatment of diseases.
- Launch of a digital patient portal, empowering patients to have 24/7 access to their health information.
- Acute hospital at home (virtual ward) programme, supporting 30-40 patients a day, where patients can receive the care they need from their own home either preventing avoidable admissions into hospital or supporting early discharge out of hospital.
- A world first national genetic testing service for acutely ill children was launched by the trust in collaboration with the local university.
- Research and development and being awarded a National Institute for Health and Research Care Research Biomedical Medical Centre to help translate scientific discoveries into tangible benefits for patients and to accelerate development of better precision healthcare. The trust run a chief nurse research fellow programme, which has been running since 2020, for non-medical professionals to develop knowledge and skills in research and undertake projects.
- Patient flow improvements by developing a direct referral pathway for patients from the local ambulance trust stack into the trust's urgent community response service, to help prevent avoidable admissions.
- Expanding the safeguarding approach to encompass and support staff suffering from domestic violence. Appointment of independent domestic violence advisors available to support both staff and patients. The safeguarding team also provide outreach into places where people are at risk of exploitation.
- One Northern Devon's High Flow Programme, in co-production with the local community developing a new approach to support high intensive users of multiple public services across Northern Devon. Reducing the need for multiple appointments/admissions with different providers and support patients' physical and mental health recovery.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ May 2023	Good ➔➔ May 2023	Outstanding ➔➔ May 2023	Good ➔➔ May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↓ May 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Devon & Exeter Hospital (Wonford)	Requires Improvement ↔ May 2023	Good ↔ May 2023	Outstanding ↔ May 2023	Good ↔ May 2023	Good ↓ May 2023	Good ↔ May 2023
Tiverton District Hospital	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Honiton Hospital	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
The Oak Centre, Hawkins House (Exeter SARC)	No action Jun 2021	No action Jun 2021	No action Jun 2021	No action Jun 2021	No action Mar 2022	Good May 2017
Mardon Neuro-rehabilitation Centre	Good Apr 2019	Good Apr 2019	Outstanding Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
North Devon District Hospital	Requires Improvement ↔ May 2023	Requires Improvement ↔ May 2023	Good ↓ May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↔ May 2023	Requires Improvement ↔ May 2023
Overall trust	Requires Improvement ↔ May 2023	Good ↔ May 2023	Outstanding ↔ May 2023	Good ↔ May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↓ May 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Royal Devon & Exeter Hospital (Wonford)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ May 2023	Good →← May 2023	Good →← May 2023	Good →← May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↓ May 2023
Services for children & young people	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Critical care	Good Feb 2016	Good Feb 2016	Outstanding Feb 2016	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016
End of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Maternity and gynaecology	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Surgery	Requires Improvement May 2023	Good May 2023	Good May 2023	Good May 2023	Requires Improvement May 2023	Requires Improvement ↓ May 2023
Urgent and emergency services	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016
Outpatients	Good Apr 2019	Not rated	Good Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019
Diagnostic imaging	Requires Improvement May 2023	Not rated	Good May 2023	Good May 2023	Good May 2023	Good May 2023
Overall	Requires Improvement →← May 2023	Good →← May 2023	Outstanding →← May 2023	Good →← May 2023	Good ↓ May 2023	Good →← May 2023

Rating for Tiverton District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
People with long term conditions	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Families, children and young people	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Older people	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Working age people (including those recently retired and students)	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
People experiencing poor mental health (including people with dementia)	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
People whose circumstances may make them vulnerable	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Overall	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Rating for Honiton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Overall	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Rating for The Oak Centre, Hawkins House (Exeter SARC)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	No action Jun 2021	No action Jun 2021	No action Jun 2021	No action Jun 2021	No action Mar 2022	Good May 2017

Rating for Mardon Neuro-rehabilitation Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Rehabilitation services	Good Apr 2019	Good Apr 2019	Outstanding Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Overall	Good Apr 2019	Good Apr 2019	Outstanding Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Rating for North Devon District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← May 2023	Requires Improvement →← May 2023	Outstanding →← May 2023	Good →← May 2023	Requires Improvement →← May 2023	Requires Improvement →← May 2023
Services for children & young people	Good Nov 2014	Good Nov 2014	Good Nov 2014	Good Nov 2014	Good Nov 2014	Good Nov 2014
Critical care	Good Nov 2014	Good Nov 2014	Good Nov 2014	Requires improvement Nov 2014	Good Nov 2014	Good Nov 2014
End of life care	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Surgery	Requires Improvement ↓ May 2023	Good →← May 2023	Good →← May 2023	Requires Improvement →← May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↓ May 2023
Urgent and emergency services	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Maternity	Requires improvement Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019
Outpatients	Good Sep 2019	Not rated	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019
Diagnostic imaging	Requires Improvement May 2023	Not rated	Good May 2023	Good May 2023	Good May 2023	Good May 2023
Overall	Requires Improvement →← May 2023	Requires Improvement →← May 2023	Good ↓ May 2023	Requires Improvement ↓ May 2023	Requires Improvement →← May 2023	Requires Improvement →← May 2023

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community end of life care	Requires improvement Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
Community health services for adults	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

North Devon District Hospital

Raleigh Park
Barnstaple
EX31 4JB
Tel: 01271322577
www.northdevonhealth.nhs.uk

Description of this hospital

Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust is part of the Royal Devon University Healthcare NHS Foundation Trust which was established in April 2022. Stretching across Northern, Eastern and Mid Devon, the trust has a workforce of over 15,000 staff, making it the largest employer in Devon. The trust provides services for more than 615,000 people, covers more than 2,000 square miles across Devon. Some of the trusts specialist services cover the whole of the peninsula, extending as far as Cornwall and the Isles of Scilly.

North Devon District Hospital is the trust's district general hospital in Barnstaple, offering emergency and urgent care for people in North Devon and the surrounding areas. This includes an emergency department, intensive care unit, women and children's services, diagnostics, outpatient clinics and specialist services.

The medical care service includes 9 wards delivering, specialist and general medical services. The combined medical admissions for the trust was 71,958 from March 2021 to Feb 2022.

The surgical service includes 4 surgical wards and 9 operating theatres. The general surgical team encompasses a full range of emergency and elective inpatient and day case surgery.

The diagnostic imaging department currently includes general X-rays, Fluoroscopy and Interventional procedures, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Ultrasound, Mammography and Dual Energy X-ray Absorptiometry (DXA scans). For the purposes of this report, the different types of examinations taken will be referred to as modalities. In the12 months up until 12 December 2022, the service had performed a total of 102,142 examinations across all modalities. This included 17,485 CT scans, 7434 MRI scans and 54,818 plain film x-rays

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Assessing and responding to patient risk

There were gaps and incomplete documentation and risk assessments for most patients, this meant staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This included recording physical observations; for example, blood pressure, pulse and respirations. This information was recorded and stored electronically and calculated the national early warning score (NEWS2). NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis, in hospitals in England. Staff told us they knew when they had to call for a medical review. Due to the implementation of a new integrated electronic patient record system, NEWS2 audits had not been undertaken since June 2022. We were told NEWS2 audits were planned to recommence in early 2023. Previous audits of NEWS2 charts showed that staff escalated patients for doctor review appropriately. The trust looked at incident reports where there had been a possible delay in either escalating or in responding to a deteriorating patient to ensure that any learning was identified.

There was a protocol for the management of sepsis. There was a designated pathway for suspected sepsis on the integrated electronic patient record which took staff through the required actions and escalations.

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool, and did not review this regularly. Staff were required to complete risk assessments for patients using nationally recognised tools. These included, falls assessments, nutrition and hydration assessments and pressure care assessments. We reviewed 23 patient records. Out of the 23 records reviewed,12 out of 23 falls assessments were not fully completed and 17 out of the 23 malnutrition universal screening tool charts were incomplete. We could not be assured that risks to patients were understood and managed effectively. The trust was aware that staff were not completing risk assessment documentation and said this was due to the implementation of the new integrated electronic patient record system. Post inspection we were told the leadership team were working with the Integrated Patient Record system supplier and clinical informatics team to optimise the existing risk assessment functionality to include additional system prompts and workflow improvements for relevant staff. We were told this work would be completed by June 2023.

We saw an example of a high-risk patient not having had their risk assessments completed. This patient had been on the ward for 9 days and a nurse told us they had not been eating or drinking much. Despite this, the patient had no MUST or fluid risk assessments completed, no care plans documenting the plan to manage this patient or any food or fluid charts completed to monitor any improvements or deterioration in their fluid and nutritional intake. We told the nurse in charge who reviewed the patient immediately.

The number of falls varied from month to month in the service. The number of falls across the medical service between January 2022 and October 2022, ranged at the highest between 61 falls in July 2022 to the lowest number of falls of 29 in September 2022. During this period only 5 falls were rated as moderate or above harm. Patients at high risk of falls were cared for in a bay near to the nurse's station which was in line of sight to all clinicians at the station. A system of bay tagging was also in operation, where one member of staff had to be in the bay at all times. Staff said that if a patient required one to one supervision this was not always achieved. The service was unable to provide us with any falls audits completed within the past 12 months. As these audits were not undertaken, we could not be assured themes and trends were being tracked and that the wards had targeted areas for improvement or conversely good practice was shared with other wards.

Due to pressures on capacity and bed availability, some patients were cared for in escalation areas. The service had implemented standing operating procedures (SOP) for staff to follow with criterion for the type of patient that could use the escalation areas. For example, there was a SOP for pre-emptive boarding (see access and flow section), a SOP for patients admitted to day surgery as well as a SOP for medical outliers. Staff in escalation areas told us they did not believe the SOPs were followed in terms of the criterion of patients that were supposed to reside in these areas. Staff shared they did not feel they had the necessary skill set to look after some of the more acutely unwell patients. We saw one example of a patient who had a prolonged stay of 10 days in an escalation area and raised this with the Trust. The Trust has since changed its standing operating procedure to ensure patients are reviewed if their stay in an escalation area exceeds 72 hours.

At times, staff knew about and dealt with any specific risk issues. We saw an example where a patient had a speech and language swallowing advice sign on the door of their room to inform staff of specific requirements for this patient. The information identified the food and fluid requirements for this patient to ensure their safety when swallowing.

The service had 24-hour access to mental health liaison and specialist mental health support.

Nurse staffing

The service was heavily reliant on a bank and agency workforce and there was a high rate of sickness amongst nursing staff. Managers regularly reviewed and adjusted staffing levels and skill mix when able and through the safe care process held twice daily.

The service had high vacancy rates for registered nurses. It should be noted that at the time of the inspection there was a national shortage of nursing staff and health care assistants. The service overall needed 291.88 full time equivalent registered nurses, however, they actually had 235.64 full time equivalent registered nurses available. This equated to a 19.27% vacancy rate for registered nurses. However, data for October 2022 indicated the fill rates for shifts for nursing and health care assistant staff were consistently above 80% for registered nurses and 77% for health care assistants during the day and 89% for registered nurses and 80% for health care assistants at night. This meant most shifts were considered safely staffed if not at the planned numbers. Wards we visited showed the planned number of nurses versus the actual number of nurses and healthcare assistants available to cover shifts on the wards. Most wards we visited during the inspection were down one registered nurse or a healthcare professional on most shifts that day. This meant patients sometimes had to wait longer to receive food and personal care.

The service had high rates of bank and agency nurses used on the wards. For example, Tarka Respiratory ward, in the month of October, had 49% of its staff who were temporary staff. This was the highest use of temporary staff on a ward. It should be noted that Roborough Ward was under the leadership of Tarka Ward and as such had 8 escalation beds

which is why agency staff were necessary. The lowest was MAU (including Alex Ward) at 30.2%, which is still significantly high. The trust was running recruitment fairs and concentrating on employing more health care assistants and international nurses. The high level of agency nurses makes it difficult to ensure there were staff with the right skill mix and competencies on every ward.

The service had high sickness rates. Medicine wards in particular suffered from high sickness rates. These included Victoria Ward which for the year was at 13.3%. Staples Stroke Unit had sickness rates of 10.3%. The trusts annual target for sickness was 3.5%. In September 2022, 22% of all sickness related to stress and anxiety.

Managers used bank and agency staff that were familiar with the service however we were not assured there was an effective induction process for bank and agency staff that were new to some wards. Senior nurse staff on wards were unable to provide an induction process check list which could prove staff had completed an induction process and what information was shared at induction. In terms of navigating the new integrated electronic patient record system, agency staff were provided with a 45 minute tutorial. We found most permanent staff we spoke with were unsure of how to navigate the new integrated electronic patient record system. These staff were using the system daily (see records).

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 but sometimes struggled to fill shifts. The service used a national tool to support with the calculation of nursing requirements. Acuity of patients was recorded twice daily through the national tool which was used in the staffing meetings. In order to ensure patient safety, staff moved from ward to ward to cover the gaps. One member of staff told us it was “daunting to have to go and work on a ward which was unfamiliar.”

Medical staffing

The service did not have enough consultant staff to ensure regular review of medical patients. The service was heavily reliant on a locum workforce.

The service did not have enough full time equivalent consultant staff. There were 9 whole time equivalent substantive medical consultants in post, against a historical planned establishment of 18 whole time equivalent medical consultants. There was a strong reliance on locum cover within the medicine division. This accounted for 60% of the medical workforce. When locum, eastern staff and agency staff were counted in the numbers the service was short 17.88 programmed activity or a four hour block of time. We were told the trust had a stable base of locum consultants who were familiar with the trust and its processes. However, it was sometimes difficult for the trust to fill shifts for example during the Christmas period as the trust had no control on when locums were able to take holidays. The locum workforce was expensive and the lack of substantive staff meant that service development, management and governance was difficult.

The areas where medical staffing was affecting the service provision had been escalated to the corporate risk register. Examples of this were the insufficient capacity within the cardiology department to meet demand and concerns around endoscopy consultant cover. All risk register items were reviewed regularly and there were action plans to mitigate risks. The safety and risk committee of October 2022 highlighted the deteriorating position around consultant ward rounds for weekends and weekdays despite the short term mitigations that had been put in place. Data showed patients were not being reviewed on many of the medical wards during the period January 2022 to October 2022. For example, data averaged across this period for Staples Ward and Fortescue showed consultant review to be less than once a week. It is

generally expected that consultant led ward rounds are carried out 2 to 3 times a week, with junior team members endeavouring to see all the patients every day. There had been no material improvement in consultant cover since our last inspection in July 2021. Nationally there is a shortage of consultants and the trust has been trying to attract candidates to its vacancies for a substantial period of time.

There was insufficient junior doctor capacity to meet the demands of the service. This risk was recorded on the risk register. We were told this impacted on patient safety as there were sometimes insufficient junior doctors to provide out of hours cover. The lack of substantive consultant workforce limits the amount of supervision and clinical education available for the junior doctor workforce which has led to the Deanery withdrawing posts from the service in acute medicine and healthcare for older person. Despite this, junior doctors we spoke with told us they felt supported and mostly felt their workload was manageable. There was also an on call rota of consultants for junior doctors to contact if they needed support. The trust was working to increase the baseline establishment rate for the number of junior doctors required for the northern site.

Records

Patient records were not always completed fully. Records were stored securely and available to all staff providing care.

The trust had a new integrated electronic patient record system which was introduced in July 2022. Staff told us the system had “made a difference and made things more accessible but was still being embedded.” Some staff told us there were so many alerts it was easy to “get blind to it.” Staff felt more could be done to better support the introduction of the integrated patient record system. They felt they needed to better understand how to navigate the system when working and using the system live. Staff suggested they would appreciate more learning if it was carried out by a clinical person who was competent in using the system rather than a non clinical person. Most staff agreed the system had brought in benefits in terms of monitoring a patient and the ability to have colleagues review and input into a care plan.

Not all staff could access documents stored on the integrated electronic patient record system easily. It was clear from observation during the inspection, that many staff were struggling to use the new patient record system. During the inspection we asked members of staff to show us documents and records on the integrated electronic patient record system. Staff were unable to navigate the system and at times were unable to locate documents we asked to view. This lack of clarity and confusion was impacting on patients in terms of care planning and creating stress for the already stretched workforce who were highly reliant on agency and bank staff.

Patient notes were not always comprehensive but were stored securely. The system stored notes in chronological order and all were named, timed and dated automatically at each entry. However, the majority of risk assessments and care plans were not completed. Access to patient records was restricted by clinical role and grade. This meant staff only saw patient information appropriate to the role and care they were providing. The electronic patient record was password protected.

When patients transferred to a new team, there were no delays in staff accessing their records. Nursing, and medical notes could be accessed electronically on every ward.

Medicines

Staff followed some systems and processes to prescribe and administer medicines safely. However there were instances where medicines were not stored and monitored according to trust policies.

Medical care (including older people's care)

We checked the storage of medicines, fluids and gases on the medical wards. We found these were not always stored safely and securely.

Fridge temperatures that stored medicines were not always checked daily and logged in line with trust policies.

We were told pharmacy staff were not always available at weekends. This impacted on patient flow out of the hospital as patients could not be discharged without medications. The trust had tried to mitigate the impact of this by providing prescriptions that could be fulfilled by the community pharmacies or by having common take out packs available. There was 24 hour pharmacy support either on site or on-call out of hours.

Patient medications were sometimes not available on discharge but were sent on after the patient was discharged. The medications were sent using a third party. We are unable to establish the impact on the patients from this practice for example of delays in patients receiving pain medication because this process had not been audited. We have received information from social care agencies that this has negatively affected patients.

The trust had carried out an audit of the medical wards between June to November 2022. This showed there were areas which required improvement. In particular regarding the recording of expiry dates on open bottles of liquid medication and topical remedies and ensuring that patient lockers only contained items labelled for the patient.

Staff mostly completed medicines records accurately and kept them up-to-date.

Is the service effective?

Requires Improvement 

The service was previously rated requires improvement. We did inspect aspects of effective but did not rate the service according to our current focused methodology.

Nutrition and hydration

Staff did not always know if patients had enough food and drink to meet their needs and improve their health as it was not recorded.

A nationally recognised screening tool was used to monitor patients at risk of malnutrition, however this was not always completed. The service used the malnutrition universal screening tool (MUST). Of the 23 MUST charts we reviewed, 17 had not been completed. The completion of the MUST tool helps to inform onward care planning therefore we could not be assured that patients nutrition and hydration care plans were individualised for optimal care.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. We saw examples where dieticians and speech and language therapists had been requested to review patients. It was unclear with the lack of risk assessment and care planning how the decision to refer patients to these clinicians had been made.

Medical care (including older people's care)

Staff said they made sure patients had enough to eat and drink, despite low staffing levels.. Drinks rounds occurred on the wards. Patients were offered a choice of drinks and we saw staff check to see if each patient had any individual requirements prior to giving them their drink. Water jugs were easily accessible for patients. Red trays were used for patients who needed additional support at mealtimes. Staff said that due to staff shortages some patients had longer to wait in order to be assisted with their food and drink.

Mealtime co-ordinators were allocated on a daily basis to oversee mealtimes and support patients when required. We observed ward staff also coming to support patients at mealtimes so they could eat their food in a timely manner and when it was warm.

We were not assured fluid and nutrition charts were always completed. Staff told us these were completed after mealtime had ended. During our inspection, we did not observe any charts being completed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a numerical scoring system to understand the severity of patient's pain. We saw this was consistently recorded on the NEWS2.

Patients received pain relief soon after requesting it. We observed staff discussing pain with patients during medicine rounds and taking prompt action to manage those with pain.

Staff prescribed, administered and recorded pain relief accurately.

Is the service caring?

Outstanding ☆ ➔➔

The service was previously rated outstanding. We did inspect aspects of caring but did not rate the service according to our current focused methodology.

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 made sure patients and those close to them understood their care and treatment. One relative told us "I have been involved all the way through. Nurses have updated me daily and I have been involved in conversations with doctors about discharge too."

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. One relative told us, the service for their loved one had been "excellent, the people are lovely and the care has been marvellous." They told us it had been easy to provide written feedback about this.

Medical care (including older people's care)

Patients gave positive feedback about the service. On wards we observed boards which contained feedback from patients who were expressing their gratitude to the wonderful staff who had looked after them during their stay. In the friends and family patient survey for May 2022 the feedback was positive. A patient on Alex ward stated “Health issues aside, my experience on Alexandra Ward has been fantastic. Everyone has been friendly, polite and made my stay a very comfortable one. I am amazed at how staff can achieve this in such a busy and demanding atmosphere and I am full of admiration for them”

Is the service responsive?

Good 

The service was previously rated good. We did inspect aspects of responsive but did not rate the service according to our current focused methodology.

Access and flow

Patients could access the service when they needed it but did not always receive the right care promptly due to pressures on services and bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages.

The number of medical fit for discharge patients waiting for an onward package of care was large. As at November 2022 this number was 61. These patients did not have a medical reason for remaining in hospital. The lack of onward community and social care packages is a national problem which presently remains unsolved. Despite being medically fit to be discharged these patients still require care and attention from medical and nursing staff. Long hospital stays could be linked to negative outcomes such as a decline in physical ability as well as an increased risk of picking up a hospital-acquired infection for frail elderly people. In November 2022 the average length of stay for a medical patient was 12.78 days. In 2021 in the UK the average length of stay was 6.2 days. We were told by staff that sometimes up to 30% of its bed base was utilised by patients who no longer needed specialist hospital care.

The trust used an established tool to identify the capacity of wards and assessment units at any point in time. The trust tried to use these tools to best meet the needs of patients. The trust had been consistently over 94% bed occupancy since January 2022, with bed occupancy peaking at 98% in September 2022. This made flow throughout the hospital difficult to manage. The National Institute for Health and Care Excellence Guideline 94 depicts 85% bed occupancy being recognised in literature as the ideal occupancy rate and states “high levels of bed occupancy may affect patient care as directing patients to the bed most suitable for their care is less likely to be possible”.

There were medical patients on non-medical wards. Due to pressures on capacity and bed availability, some patients were cared for on a medical ward or in an escalation area which did not specialise in their medical condition. For example, only 40% of stroke patients were treated on the stroke unit in August 2022. Junior doctors told us it was difficult to review and manage stroke outlier patients. However, there were systems to ensure outlier patients had access to the correct medical specialities and in the main we were told these worked. We found that in escalation areas medical patients did not always have suitable facilities. For example, the day surgery unit was used for one patient for a total of 10 days. This unit lacked facilities for washing and lockers to store personal belongings. Patients using this facility had to walk down a corridor and use the facilities at another ward. We spoke to the patient who stayed in this

area and they stated they were uncomfortable accessing the facilities in the different ward. There were standing operating procedures that outlined the criterion for patients that were moved to escalation areas. However, staff we spoke with said the criterion was not always followed and patients who were unsuitable for these areas were sometimes admitted. Since our inspection the trust has reviewed the criterion for these escalation areas.

The hospital monitored the demand on its service. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. The service had been at OPEL level 3 and 4 for the last 6 months. Level 4 is the highest OPEL level and means the trust is at high pressure. Each day bed meetings took place to review the flow of patients through the hospital. Those meetings were attended by bed managers and ward nurses.

The trust had launched a new model of pre-emptive boarding to improve flow through the medical service in the hospital. Pre-emptive boarding was when patients were moved to a hospital ward when it was known other patients in that ward were due to be discharged that day. This model had only been used 3 times this year and we were told this was a “last resort when all other options to improve flow had been exhausted.”

Managers monitored waiting times and made sure patients were assessed to access services when needed and received treatment in clinical priority order. Consultant led referral to treatment waiting times were not always being met and patients were not always treated within the 18 week window. Most NHS trusts are struggling to meet these targets as a result of the impact of the pandemic. Trust wide data for the month of August 2022 Source: NHS England Consultant led referral to treatment times indicated that the trust was struggling to meet targets in Neurology, Respiratory and Ophthalmology, however were performing well for the elderly medicine service. Dermatology was only seeing 2 week wait and 104 week patients due to delays in processing patients as a result of the implementation of the new electronic patient record. Dermatology had been experiencing a significant increase in 2 week wait referrals (waiting time for suspected cancer), averaging 210 each week in comparison to last year’s average of 170. This came at a time when the number of medical workforce had decreased.

We were not assured all patients were being seen within 12 hours of admission or 14 hours of arrival to hospital. This information was accessible on individual patient records however the service was unable to run a report to produce this management information as a collective for the patients that had been admitted. The service had requested that this information is made available, however we have not been told when this will be able to be accessed

The medical services had a same day emergency centre however this was often used as an inpatient area for medical patients and had been for the past year. The purpose of the same day emergency centre was to take patients from the emergency department, community and GP referrals, and treat them the same day thus avoiding admission into the trust. Whilst it was difficult when the service was pressured to resist using this area for inpatients some trusts have tried to ringfence this facility in order to avoid further admissions. The trust is currently planning to build a new space for the same day emergency centre to enable this service to run as intended.

Despite the lack of onward care packages, managers and staff started planning each patient’s discharge as early as possible. Each ward had a discharge coordinator who linked up with hospital staff to make sure referral letters and care packages were set up in readiness for patients to be discharged. They also made transport arrangements for patients who needed it and communicated these arrangements with patients. We saw a board had been set up to provide information to ward staff about what arrangements had been completed and what was outstanding, so it was visible to all ward staff. There was a new discharge lounge which had been open since 24th October 2022 staffed by 1 Band 6

Medical care (including older people's care)

Registered Nurse and 2 health care assistants. It was open Monday to Friday 9-5pm and was averaging 3 patient discharges per day. This was a safe place for patients to wait for their transport and meant wards were able to free up a bed space for the next patient at an earlier time in the day. The trust monitored any complaints relating to discharge to identify any themes or trends.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders in post had the skills and abilities to run the service however some service areas had suffered from a lack of personnel in leadership positions.

There had been a lack of leadership and service development in some service areas in the medicine division such as cardiology. However, staff said that this had been partly mitigated by support from the eastern site, where eastern site leaders had also taken on leadership roles for the northern site. Staff we spoke with said that the heavy reliance on a locum workforce on the northern site had resulted in a lack of service development in some medical areas.

Staff we spoke with said they felt supported by their leadership teams and they understood the challenges to quality and could identify the actions needed to address them.

There was a lead for mental health within the department.

Culture

Staff morale was low but staff focused on the needs of patients receiving care. The service provided opportunities for career development.

Staff told us morale was low. Staff explained they were passionate about the work they carried out however, working with too few staff was stressful and led to low job satisfaction. Due to low staff numbers, staff had to work in wards which they were unfamiliar and this also negatively impacted morale. Senior nursing staff we spoke with discussed the impact on staff morale mainly caused by staff shortages. They explained they understood staff were concerned about being moved to areas they were not familiar with.

Despite morale being low, staff felt supported, respected and valued. Several staff we spoke with had worked for the trust for several years. We were told, there were “good interpersonal relationships and that the service was a great place to work.” We were told “because the hospital was small, this allowed a good cultural experience.” Staff told us they valued how hands on their seniors were in working on the wards to cover staffing shortages.

There was a strong emphasis on the safety and well-being of staff. Matrons understood the need to be visible and support staff. Matrons were carrying out “tea with matron” sessions on different wards to give the staff the opportunity to meet with them and to raise concerns or issues. This session gave staff the opportunity to feel heard and supported.

Medical care (including older people's care)

There were cooperative, supportive and appreciative relationships among staff. Staff told us they felt supported by their colleagues and worked as teams to deliver care. We saw that staff were kind and compassionate towards patients and supportive of each other.

Governance

The introduction of a new integrated electronic patient record system and capacity challenges had adversely impacted on effective governance processes. However, 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.

There was a governance structure, but challenges with the new integrated electronic patient record system and having full oversight of the service was difficult. Several audits had been stood down during the pandemic and were currently unavailable due to the implementation of the new electronic reporting system in July 2022. There were monthly governance meetings looking at operational performance, however again due to the implementation of the integrated electronic patient record system and capacity challenges, these meetings had been cancelled in June, August and October. With the lack of audit information and the lack of governance meetings, we were not assured that leaders had effective oversight of the different ward areas. However, staff at all levels were clear about their responsibilities, roles and accountability within the governance framework.

The trust shared how the implementation of the integrated electronic patient record (EPR) has enabled advancements in many aspects of safe patient care and service delivery across the trust. The trust is recognised nationally in this area being the first in the UK to go live with an integrated EPR across acute and community services and providing patients with a single integrated patient record, accessible by primary care. This enables patient information to be shared quickly and securely. The trust was aware of improvements which needed to be made to the EPR system and had a work plan to optimise functionality, provide further end user training and refine governance.

Management of risk, issues and performance

There was a lack of intelligence reporting which impacted on the ability of teams to plan and provide assurance on service delivery. Leaders had plans to cope with unexpected events.

There was a lack of intelligence reporting which impacted on the ability of teams to plan and provide assurance on service delivery. The programme of clinical and internal audit to monitor quality, and systems to identify where action should be taken had stopped prior to the introduction of the integrated electronic patient record system. Following the inspection, we requested data around different audits and found the trust were unable to provide the data around NEWS2 audits, the number of patients seen by a consultant within 12 hours, safe care compliance data, falls audits or medical record audits. Most of these audits had not been completed within the past 12 months. Staff were manually trying to validate data to ensure there was some oversight. The governance meeting minutes from September 2022 also highlighted the challenges with the integrated electronic patient record system and extracting data. No further information was provided as to how this issue was being managed.

There were local arrangements for identifying, recording and managing risks and issues. There were 7 risks on the medical risk register. Each risk had a risk score, a risk owner and contained the date at which the risk needed to be reviewed. Once risks were elevated to the corporate risk register they no longer appeared on the local risk register.

Medical care (including older people's care)

Teams were trying to overcome the challenges around accessing quality and performance data. For example, the falls team validated each fall every month and summarised these in a report. This was then used to monitor falls rates over time. This method was time consuming for teams to continually keep up to date with.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected disruption to staffing or systems. On the day of our inspection, there was due to be an outage of the integrated electronic patient record on the night shift for all staff. The matrons were able to clearly discuss the mitigation of any risks involved with this outage and the actions they were taking.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe stayed the same. We rated it as requires improvement.

Assessing and responding to patient risk

Staff did not always complete or update risk assessments for each patient to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool, and did not review this regularly. We reviewed 3 sets of electronic notes. We found risk assessments for falls assessments and nutrition and hydration were not completed in 2 out of 3 records. Therefore, the trust could not be assured the risk to patients were recorded, understood or managed effectively. This was partly due to the introduction of a new integrated electronic patient record system 6 months previously. We found staff could not easily find risk assessments on the system. Post inspection we were told the leadership team were working with the Integrated Patient Record system supplier and clinical informatics team to optimise the existing risk assessment functionality to include additional system prompts and workflow improvements for relevant staff. We were told this work would be completed by June 2023.

Staff were aware of specific risk issues around venous thromboembolism (VTE) (a serious but preventable condition that happens when blood clots form in deep veins in the legs). However, the trust had not completed any regular audits on VTE assessment as they were unable to retrieve the data from the new integrated electronic patient record system. A spot audit had been completed on October 2022 of 181 patients across 8 adult inpatient wards for medicine and surgery. This showed, on the acute surgical admission ward, of 29 patients, 15 had a completed VTE assessment but 6 did not. This meant patients who may have required intervention to prevent against VTE may not have received this.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS 2) framework was used. Vital observation scores were flagged up on the electronic patient record system. There were good systems for escalation and good outreach support for critical care. There was an escalation policy for patients with presumed or confirmed sepsis who required immediate review and we found staff were aware of sepsis protocols. The NEWS 2 system was also used in theatres to monitor patients post-operatively.

The service complied with the 5 steps to safer surgery, World Health Organisation (WHO) surgical checklist including marking of the surgical site. In theatres, we observed 4 WHO surgical checklists completed to a high standard. However, the integrated electronic patient record system did not allow for clear auditing of this process to measure its completeness and effectiveness.

In theatres there was a protocol in cases of life-threatening/major haemorrhage which had recently been revised. They reflected the range of surgery undertaken and the geographical isolation of the location. There was at least one member of recovery staff who was trained and certified to an appropriate level in life support and an anaesthetist available to support patients if they became unwell. However, staff we spoke with did not have an awareness of the trusts' safe surgery and interventional procedures policy to guide best practice.

Surgery

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 was provided onsite by the local mental health trust.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes, handovers and safety briefings/huddles included all necessary key information to keep patients safe. This included the wards, from theatre to recovery and recovery to ward staff. However, in the day surgery unit, the electronic patient display contained inappropriate information or operations for all the patients. Operations were listed for all the patients. For example, a patient was going to theatre for a gynaecological procedure which was named. This was highly personal information that should not be available for everyone to see. When brought to the attention of the management, it was removed.

Nurse staffing

The service did not always have enough nursing and support staff with the right 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.

Within surgery, the service did not always have enough nursing and support staff to keep patients safe. The registered nursing vacancy was 18% which meant there were 35 whole time equivalent (wte) registered nurse (RN) posts vacant across North Devon hospital and 9.5 wte healthcare assistants' vacancies. Data provided by the trust showed most of the RN vacancies were on the emergency surgery ward (56%) and an orthopaedic trauma ward (46%).

The number of nurses, healthcare assistants and theatre staff did not always match the planned numbers. Staff told us they covered vacant shifts, staff were redeployed from other more well-staffed wards, covered by bank or agency staff. This maintained safety and supported skill mix within the surgical division. The ward manager could adjust staffing levels daily according to the needs of patients. Managers made sure all bank and agency staff had a full induction and understood the service. On wards and in theatres managers used bank and agency staff, they requested staff familiar with the service or block booked staff to ensure continuity of care.. There was an established process to escalate staffing shortages.

Medical staffing

The service did not always have enough medical staff with the right qualification\s, 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 did not always have enough medical staff to keep patients safe. There were more than 11 whole time equivalent (wte) medical vacancies in the surgical division. This included 3 wte in general surgery, 3 wte in Anaesthetics, 2 wte in Urology and 2 wte in Ophthalmology. The trust was actively recruiting to fill these positions. However, these vacancies were not reflected on the divisional risk register.

Despite the medical vacancies, the service usually had a reasonable skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Junior medical staff we spoke with felt consultants were supportive and approachable. No concerns were expressed to us about difficulties in contacting or obtaining consultant input. There was a Consultant Physician on duty daily whose role was to review and manage medical outlier patients on the surgical wards.

Incidents

Surgery

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them including serious incidents. Staff raised concerns and reported incidents and near misses in line with trust policy.

Within surgery, the provider had 5 never events (patient safety incidents that are wholly preventable where guidance or safety recommendations providing strong systemic protective barriers available at a national level and have been implemented by healthcare providers) between December 2021 and July 2022. Of these never events, 2 were wrong site administration of an anaesthetic block, 2 wrong site surgery and 1 wrong eye injected. Of the 5 incident investigations, only 3 reports had been completed with action plans. The remaining 2 reports relate to Dermatology which is under the trust's medicine division.

We found leaders did not always understand fully the root cause of some never events occurring at the trust. The trust did not have an effective method of implementing actions and sharing widely the lessons learned for serious incidents and never events with all staff within the division or across the whole trust. Oversight and monitoring of actions plans were not as effective as it could have been.

We reviewed the 3 completed never event investigation reports. Human factors training was not mentioned in any report or action plan despite it being a significant factor. Human factors was the framework used as the investigation technique in 1 investigation. However, no human factors training for staff has yet been mentioned in action plans.

Managers did not always share learning about never events with their staff or across the trust. We found action plans discussed the sharing of learning with staff involved in the incident but not across the sites. Staff we spoke to were unable to discuss learning across the trust, division or hospital. Staff we spoke with had not participated in, and learned from, reviews and investigations by other services and organisations. Medical staff talked about the openness and honesty at all levels within the organisation in response to incidents. They understood the importance about learning from patient safety incidents especially never events. Several members of the medical staff were concerned the learning from the never events that occurred was not being shared widely enough but felt this would be addressed by appointment of a new patient safety lead across all trust sites. The trust held a never event webinar and a recording was sent to all ward staff and clinical teams for learning. We saw a poster displayed on a ward highlighting the number of never events.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff did not meet to discuss the feedback and look at improvements to patient care. Staff we spoke to were not always aware of outcomes and learning from investigations including serious incidents and never events. The iBulletin was only produced by staff at the Royal Devon and Exeter hospital site however post inspection this has now become a joint production document from March 2023. Medical staff were aware of the never events on site but had limited knowledge of those which occurred at the Royal Devon and Exeter hospital. On one ward we saw a staff newsletter sharing learning about a fall causing a fracture, although staff told us they often did not have time to read newsletters.

There was evidence changes had been made as a result of investigations. For example, 'stop before you block' posters were evident in theatres. We observed staff following this protocol properly. Packs for nerve blocks could not be opened until safety checks were completed and confirmed by second person.

Surgery

Is the service effective?

Good 

The service was previously rated good. We did inspect aspects of effective but did not rate the service according to our current focused methodology.

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 not yet been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits and submitted data for surgical site infections (SSIs). The hospital participated in national audits such as the national joint registry, national hip fracture database, national oesophagus gastric cancer audit, adult cataract surgery audit, national prostate cancer audit and the national bowel cancer audit. Most of the audits were continuous ongoing data collections.

The results of surveillance for SSIs showed a mixed picture. However, the figures were skewed for total hip replacements due to fewer operations being performed compared to normal. This was a result of lower than predicted surgical availability of beds due to winter pressures, capacity and flow in the hospital.

Managers worked to minimise the number of surgical patients on non-surgical wards. There were good arrangements for surgical staff to review any surgical patients on non-surgical wards and medical staff to review medical outlying patients on surgical wards. Some orthopaedic beds were ringfenced to control infection risk. This meant there were no other types of medical or surgical patients on the elective orthopaedic ward. On 30 November 2022, there were 22 medical outlying patients on surgical wards.

There were medical staffing rotas to manage the provision of emergency surgery, particularly at night, weekends and public holidays.

Outcomes for patients were not always positive and did not always meet expectations, such as national standards. The surgical division was under pressure with long waiting lists which were increasing. The managers actively monitored all 62 day and 104-week waits and had a plan to clear these by the end of December 2022 with an additional 10 lists being provided before Christmas. All 2-week wait referrals are now on the new integrated electronic patient record system and were being booked at 2-weeks.

Managers and staff were unable to carry out the programme of repeated audits to check improvement over time due to issues with the new integrated electronic patient record system. This meant managers could not use information from the audits to improve care and treatment (see well led domain). This included any audits for the ‘stop before you block’ which originated from the wrong site block never events. However, work was ongoing to remedy this.

Surgery

Managers and staff worked to make sure patients did not stay longer than they needed to and started planning each patient's discharge as early as possible. A multidisciplinary daily board round was held on the wards from Monday to Friday to discuss progress of patients and discharge arrangements. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Managers worked to keep the number of cancelled appointments, treatments and operations to a minimum despite issues with capacity and flow through the hospital. The service monitored and managed elective waiting times closely for each surgical speciality. The hospital acknowledged the backlog of elective patients waiting for surgery and was committed to reduce the number of patients waiting 104 weeks to zero by the end of March 2023. There were weekly patient tracking meetings to directly support and oversee the waiting list and delivery of waiting times.

When patients had their appointments/treatments/operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. However, this was not always within national targets and guidance including patients who had already waited over 104 weeks. Between August and October 2022, a total of 95 elective patients had their surgery cancelled. This included 20 ophthalmology patients and 19 urology patients. Reasons for cancellation included no inpatient bed available and the theatre lists overran, with 1 patient cancelling themself.

The trust was working towards anaesthesia clinical services accreditation. Volunteers were working on 140 of the standards, 3 have been achieved and 14 are yet to be started.

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 patients. There was a good training programme for junior surgical doctors, nurse practitioners and anaesthetic staff with monitoring of competencies. Staff told us they felt properly trained and supported. All medical staff had annual appraisals and there were governance and reporting systems to ensure consultant's scope of practice was within their training and competency.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us the trust was making development available for all grades of staff with funding for training and education relevant to their place of work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified poor staff performance promptly and supported staff to improve.

Is the service caring?

Good

The focused inspection did not look at this domain.

Surgery

Is the service responsive?

Requires Improvement 

The service was previously rated requires improvement. We did inspect aspects of responsive but did not rate the service according to our current focused methodology.

Access and flow

People could access the service but not always when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times and made sure patients could access services, but treatment was not always within agreed timeframes and national targets. One of the biggest contributing factors of not meeting timeframes and national targets was the COVID-19 pandemic. For example, orthopaedic surgery stopped operating for 6 months which caused a backlog, along with available theatre capacity. The growth in trauma demand meant reducing elective capacity and theatre infrastructure had not kept pace with this.

From August to October 2022, 108 patients had their surgery cancelled. Reasons for cancellation included lack of anaesthetic cover, patient unfit for surgery or testing positive for COVID 19 and lack of an inpatient bed. During October 2022, the trust made efforts to reduce the use of the Day Surgery Unit for emergency escalation beds, this led to an increase in day case activity. Highest clinical priority patients and long waiting patients continued to be monitored weekly through the Patient Tracking Meeting. At the beginning of November 2022, 18 patients were waiting more than 104 weeks for surgery with the expectation this would reduce to 8 by the end of November 2022. This was an improvement since May 2022 when the figure was 39.

As a result of transitioning to a new integrated electronic patient record system, there was a reported drop in 2-week cancer wait performance since August 2022. This impacted on the 2-week wait performance to confirm diagnosis within 28-days. Actions to support these services were monitored as part of the Trust's Cancer Recovery Action Plan.

Diagnosis breaches for colorectal cancer significantly increased as a result of challenges with the lack of availability of a medical consultant and a clinical nurse specialist. Access to endoscopy for colonoscopy diagnosis was also an issue. A newly appointed Patient Navigator started in post September 2022 to provide dedicated support in tracking and escalating pathway delays in colorectal cancer.

The hospital was undertaking 'waiting list initiative' surgery on Saturdays to help the recovery of elective orthopaedic services.

Performance against the cancer 2 week wait standard was 63.5% in October 2022, an improvement on the September figure but did not meet the national target of 93%. In October 2022 there was a slight increase in patients seen from September 2022. Provisional data currently showed a further improvement in November 2022. Performance for breast patients improved by in October with a projection of 83.2% of patients seen for November 2022.

Performance of the 31-day cancer target to treatment standard, (cancer patients receive their first treatment within a month of a decision to treat following diagnosis) was currently decreasing and below the expectation of 95% at 94.3% in

Surgery

October 2022 with a current prediction of 79.5% in November 2022. At the time of inspection there was 6-8 week wait for new breast patients with theatre capacity being expressed as a challenge. The average wait in some specialties (breast/ urology and lower gastro-intestinal) for surgery was 5 weeks. Urology had a significant number of patients waiting, approximately 30. To mitigate this long wait, we saw how the team reviewed the clinical priority of patients to ensure those who need to be treated urgently were prioritised.

Performance of the 62-day standard for GP referral to cancer treatment target was below the expectation of 85% it was reported at 64.2% in September, 73.9% in October 2022 and for November was currently at 61.49%. Colorectal performance was challenged with 33.33% performance in October 2022 and currently 8% in November. This was due to lack of capacity throughout the care pathway including availability of access to diagnostic tests (endoscopy), reporting of diagnostics (radiology), outpatient and theatre capacity.

The aim for all fractured neck of femur patients was to undergo surgery within 36 hours of admission. From the latest data available, August to October 2022 an average of 73.7% of medically fit patients underwent surgery within 36 hours and September 2022 at 90.0%

Managers worked to keep the number of cancelled appointments, treatments and operations to a minimum despite issues with capacity and flow through the hospital. The service monitored and managed elective waiting times closely for each surgical speciality. The patient flow team and clinical site managers had oversight of cancellations. The hospital acknowledged the backlog of elective patients waiting for surgery and was committed to reduce the number of patients waiting 104 weeks to zero by the end of March 2023. There were weekly patient tracking meetings to directly support and oversee the waiting list and delivery of cancer waiting times.

Managers and staff worked to make sure patients did not stay longer than they needed to and started planning each patient's discharge as early as possible. A multidisciplinary daily board round was held on the wards from Monday to Friday to discuss progress of patients and discharge arrangements. Managers and staff started planning each patient's discharge as early as possible. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Clinical site managers had oversight of where patients were admitted. They worked to minimise the number of surgical patients on non-surgical wards. There were good arrangements for surgical staff to review any surgical patients on non-surgical wards and medical staff to review medical outlying patients on surgical wards. Some orthopaedic beds were ringfenced to control infection risk. This meant there were no other types of medical or surgical patients on the elective orthopaedic ward. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

There were good consultant and junior cover arrangements through medical staffing rotas to manage the provision of emergency surgery, particularly at night, weekends and public holidays.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Surgery

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.

Leaders at all levels had the knowledge or experience and felt well supported to run the service. They understood the challenges to quality and sustainability and could identify the actions needed to address them. Staff told us leaders at all levels were visible and approachable and a matron was based on each ward. Leadership and management courses were available for staff.

Leaders told us they were very proud of the teamwork and strength of how hard staff worked to do the job and the strong leadership teams. Also, the dedication teams had shown throughout COVID-19 pandemic and the commitment they had provided, despite the circumstances, especially as staffing had been, and continued to be, in a difficult and challenged position.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service generally had an open culture where patients, their families and staff could raise concerns without fear.

Most staff felt supported, respected and valued. Medical staff said the culture encouraged openness and honesty at all levels within the organisation. Most staff we spoke with, at all levels, felt supported, respected, valued for their work and empowered to speak up.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Learning and action taken as a result of concerns raised had improved. Staff felt positive and proud to work in the organisation. Leaders expressed their admiration for staff to change and adapt during recent challenges. Staff told us they felt empowered to raise concerns

Governance

Leaders operated governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities but did not always discuss and learn from the performance of the service.

There was a clear governance structure and system of accountability to support the delivery of care with surgical governance meetings held monthly but did not always discuss and learn from the performance of the service. In response to the large number of patient safety never events across both locations, the provider commissioned a never events task and finish group led by the trust's chief nurse and chief medical officer. The group was formed with the purpose of reviewing actions taken to date to mitigate the risk of further never events occurring and what additional actions could be taken to further reduce the risk of re-occurrence. The group had formulated a never event improvement plan which identified issues, actions required, a timeframe for achievement and a monthly update report to the safety and risk committee. The trust was also seeking external support from NHSE/I for a review of relevant systems/processes/ culture to add an objective assessment to the trusts' insight.

The provider had recently appointed a new associate for quality and safety and a cross trust lead for patient safety. However, we found leaders did not always understand fully the root cause of some never events occurring at the trust. Human factors was used as an investigation method in an investigation report however, human factors training was not

mentioned in the action plan or the never event improvement plan. Trust wide human factors training was part of the induction process for new staff and was incorporated into the mandatory fire safety training which was completed on a three yearly basis. In addition, there were simulation sessions for junior doctors in training, incorporating human factors training. This is also provided for specific staff groups.

At the safety and risk meeting in October 2022, the trust acknowledged they were not sufficiently assured that all the steps taken, to minimise the amount of never events, were being taken. Whilst individual investigations were completed, the trust recognised the need to join up the learning and communicate this between all trust locations.

There was a programme of clinical and internal audit to monitor quality and operational processes, but it did not monitor performance closely enough. We saw evidence of 5 steps to safer surgery audits and a stop before you block audit recorded and reported up through the governance system. However, there were challenges with the new integrated electronic patient record system as full oversight of the service provided was difficult. Some audits had been postponed during the pandemic and results were currently unavailable due to the implementation of the new integrated electronic patient record system since October 2020. This did not give sufficient oversight of performance and how to improve.

The trust shared how the implementation of the integrated electronic patient record (EPR) has enabled advancements in many aspects of safe patient care and service delivery across the trust. The trust is recognised nationally in this area being the first in the UK to go live with an integrated EPR across acute and community services and providing patients with a single integrated patient record, accessible by primary care. This enables patient information to be shared quickly and securely. The trust was aware of improvements which needed to be made to the EPR system and had a work plan to optimise functionality, provide further end user training and refine governance.

The initial benchmarking work for Local Safety Standards for Invasive Procedures (LocSSIP) has begun in North Devon hospital. Further work was ongoing for safety checklists and their application, as despite there being the functionality on the new integrated electronic patient record system, further assurance was required on whether staff were using this when they should. This was being monitored through the safety and risk committee.

Medical and nursing staff at junior levels told us they were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and did not identify actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams did not always use systems to manage performance effectively. They were not always able to identify and escalate relevant risks and issues or identify actions to reduce their impact. The trust had a performance assurance framework process to look at key quality risk and performance information and this also provided an opportunity for the division to escalate. In addition, performance was monitored by the Trust Delivery Group and Operations Board, and through to the Board. However, the service had implemented a new integrated electronic patient record system in July 2022. Since then, there had been a lack of clinical audits carried out. Clinical audits highlight any good or poor performance in different ward areas. For example, there had been no MUST audits since the start of the pandemic. This meant there was a gap in the governance process as it was difficult to celebrate or drive improvement in areas when there was no information on how the service was performing.

Surgery

The surgical risk register did not reflect the true picture of risk actions across the division. The risk register was incomplete with no action owner, action due date, actions to be taken or completion date recorded. Staffing was noted as a risk but only on 2 wards. The 2 wards with the highest registered nurse vacancies were not mentioned.

The theatre leadership team were not able to tell us what was on their risk register. They knew they could search for risks on the incident reporting system and had to update their risks as requested by the clinical risk lead.

There was a clinical governance group responsible for reviewing surgical procedures and developing new local safety standards for invasive procedures.

Diagnostic imaging

Good

Is the service safe?

Requires Improvement

We have not previously inspected diagnostic imaging as a single service. We rated safe as requires improvement

Mandatory training

The service provided mandatory update training in key skills to all staff but data showed this was not always completed or training records did not provide an accurate view.

Staff received statutory and mandatory update training. However, compliance rates were low in some subjects. Ability to attend training had been challenged due to the Covid-19 pandemic, staffing levels and lack of available training sessions. There was a new training recording system which managers feel did not accurately reflect completion rates and had escalated it to senior leaders in the trust. Training was offered online and face to face.

Eleven mandatory subjects and five statutory subjects were included in update training. For example, only 57% of staff had attended level 2 resuscitation update training, which included basic lifesaving skills for adults and paediatric patients. Trust targets for completion across all subjects ranged from 85 to 95%.

Clinical staff did not currently undergo any specific update training for people with learning disabilities and autism. Managers told us the trust was awaiting roll out of specific electronic training modules which would be mandatory for all staff from April 2023.

There was evidence all staff working with radiation had relevant training in the regulations, radiation risks, and the use of radiation and we saw from training records, modules covering Ionising Radiation (Medical Exposures) Regulations (IR(ME)R).

The service had a culture of upskilling existing staff. As part of the workforce plan, numbers of radiographer apprenticeship posts and assistant practitioner posts had been increased. Radiation Protection Supervisors (RPS) had recently completed update training to ensure compliance with Ionising Radiation Regulations (2017).

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.

Staff received training specific for their role on how to recognise and report abuse. Training compliance rates for level 1 and 2 safeguarding adults and children, ranged from 91% to.95%. A small number of staff were eligible to attend Level 3 training.

Female genital mutilation (FGM) training was included in safeguarding training and some staff had also completed domestic abuse online training.

Diagnostic imaging

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A member of staff explained how they had been alerted to a safeguarding concern about a child. The team worked together to meet the needs of that child and the adults involved in a caring, calm and professional manner.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff had alert cards attached to their ID badge with details of the trust safeguarding policy and contacts.

Staff followed safe procedures for children visiting the department. There were specific standard operating procedures for children and young adults.

Cleanliness, infection control and hygiene

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

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained.

The service had a service level agreement (SLA) with an external cleaning company. Monthly cleaning audits by the external company indicated the department performed well.

Staff cleaned equipment after patient contact but did not always label equipment to show when it was last cleaned. We saw equipment cleaning was incorporated into daily cleaning checklists for all types of scans except for Magnetic Resonance Imaging (MRI). The MRI team told us they undertook daily cleaning but did not record this. In all clinical areas we saw specialist cleaning wipes and observed staff using them to clean equipment between each patient.

Toilets were visibly clean and well stocked however, cleaning records were not always present.

Staff were aware of infection control principles including the use of personal protective equipment (PPE). Hand hygiene audits were completed monthly to identify any non-compliance and any concerns were raised with individuals to help make improvements.

In the ultrasound department, gel bottles used were clearly dated and disposed of once they had been open for a month. For invasive procedures sterile sachet gel was used. All probes were covered creating a sterile environment and were cleaned using a cleaning solution. Staff were trained in the use of this product.

Precautions were taken when seeing people with suspected communicable diseases. Where a patient was known or suspected as having a communicable disease, they were given an appointment at the end of the scanning list to enable deep cleaning after their scan.

Environment and equipment

Diagnostic imaging

Maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. However, in MRI, quality assurance (QA) processes were not followed, and staff were not aware of the relevant guidelines relating to the equipment used. The service did not consistently undertake annual quality assurance of equipment. Measures to ensure only authorised access to certain areas were not used effectively. Staff managed clinical waste well.

Design of the environment followed national guidance. The service was towards the end of an extensive building and equipment upgrade programme. The use of LED ceiling panels and wall mounted pictures created a calm, welcoming environment, offering a distraction for patients. There was a small area designated for children within the main x-ray waiting area.

Patients had access to call bells where appropriate and staff responded quickly when called.

Resuscitation equipment was readily available, the trolley was stocked and there was evidence of regular checks. Equipment in the MRI unit was labelled as MRI safe or unsafe to reduce the risk of objects being drawn towards the scanner.

We observed the MRI team stored an anaphylaxis kit in an unlocked trolley which was not clearly identifiable or sealed. There were no systems in place to check the equipment or expiration date of the consumables within it. This was highlighted to staff on site and managers who agreed with our concerns and immediately began a review of the trolley contents.

In all modalities except MRI, staff documented daily safety checks of specialist equipment. Staff could describe what they would do if any of the checks fell outside of acceptable ranges.

MRI Checks of specialist equipment were last recorded in April 2021, Staff had been completing visual checks and were aware of the requirements of recording daily and weekly QA in MRI but had not been physically recording the checks. The Medicines and Healthcare Products Regulatory Agency (MHRA) Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use (February 2021) were not present. Managers were informed, and this was immediately escalated to the team.

The imaging service had completed risk assessments for all new or modified use of radiation, which were reviewed every two years or whenever a change occurred. Risk assessments addressed occupational safety as well as considering risks to people who used services and the public.

The service ensured controlled areas (where ionising radiation was present) were restricted to authorised personnel only. Doors to the Computerised Tomography (CT) room were locked and there were warning lights on doors into x-ray rooms. In addition, the MRI had locked doors to prevent unauthorised access to the scanners magnetic field.

The service ensured specialised personal protective equipment was available and used by staff and carers when needed. We saw some lead aprons were visibly worn. We requested records of checks for lead aprons, but these were not provided. Since our inspection staff have completed an audit of all lead aprons and found them to be satisfactory.

The service had a QA programme for all scanning equipment and had input from a medical physics expert. The medical physics department schedule 6, 12- or 36-month equipment checks for all modalities depending on the manufacturer requirements. The schedule provided to the inspection team highlighted up to 7 out of 25 pieces of equipment at the site were overdue QA. The report gave no indication of when these were planned for completion.

Diagnostic imaging

There were service contracts for x-ray and scanning equipment with clear processes for maintenance and fault reporting.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and dated.

Digi locks were mounted on all staff areas however, they were not consistently used which could allow unauthorised persons access to areas storing clinical equipment. During the inspection Digi locks were observed not to be in use. Inspectors closed and locked several doors to find them open again when checked later in the day.

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 responded promptly to any sudden deterioration in a patient's health. Level 2 resuscitation training included basic lifesaving skills for both adults and paediatric patients.

There were clear pathways and processes for the management of people who were, or became, clinically unwell. In March 2022, the service completed medical emergency scenario training in CT and MRI to ensure staff were aware of precautions required.

Staff knew about and dealt with any specific risk issues. The radiology nurse team had increased sepsis awareness by providing in house training in the department. Radiographers were encouraged to attend sepsis training.

There were processes to ensure the right person got the right scan, at the right time. The hospital recently implemented a new integrated electronic patient record system. Internal requests came through the system, but external requests were still paper based or emailed to a generic monitored email address if urgent. The service ensured requests were only made by staff or persons in accordance with IR(ME)R. The service held a list of approved referrers and any requests received from persons not on the list were immediately escalated for clarification.

The service appointed Radiation Protection Supervisors (RPS) in departments which used ionising radiation. Staff told us they had attended specialist training to undertake the RPS role and felt supported by senior management. There were plans for a theatre nurse to be RPS trained also.

The service ensured staff were aware of patients who were or may be pregnant, in accordance with IR(ME)R, and Ionising Radiation Regulations (IRR) 2017. We saw posters displayed in patient areas asking patients to speak to a member of staff before they were scanned if they were, or maybe pregnant. The department had procedures to safeguard sexually active children and young people in radiology.

Staff followed the Society of Radiographers "pause and check" guidance when checking patient's identity before administering injections or scanning patients. Staff received training on identifying specific risks such as pacemakers or metal implants.

The service had a dedicated cannulation room for Computerised Tomography (CT). All cannulations were completed by an assistant practitioner. National Reporting and Learning System (NRLS) data showed 6 reported cannula extravasations in the last 12 months.

Diagnostic imaging

The service followed the Royal College of Radiologists' Standards for the communication of radiological reports and fail-safe alert notifications. Staff knew the actions to take should unexpected indicators show on a scan or x-ray.

Staffing

The service had enough 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 several vacancies across different roles. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe however, recruitment and retention was a challenge due to general staffing shortages.

The Senior Management Team (SLT) included a Head of Radiology, Principal Radiographer and a Clinical Lead Radiologist. Each modality had a lead radiographer.

The service was funded for 106.62 whole time equivalent staff however, it had vacancy of 10.65 (WTE) staff in October 2022. Eight radiographers in total had been recruited from oversees and had been inducted into the service in small groups to enable the team to provide adequate support. Senior leaders had actively recruited newly qualified staff and increased the number of radiographer assistants in post as part of the workforce plan.

The service had 7 radiologists with a further radiologist recently appointed. Vacancies had been filled by locum radiologists in the interim. There was currently no paediatric specialist radiologist onsite however, the service had access to advice from other NHS Trusts.

The radiology lead nurse had recently appointed a nurse associate and a paramedic to the team. Administration teams were actively promoting the service on social media to encourage interest. Senior leaders acknowledged that staff retention was key to maintaining the service in the long-term.

Managers accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance. The manager adjusted staffing levels daily according to the needs of patients. The service generally had a low rate of staff sickness.

The service limited their use of bank and agency staff and requested staff familiar with the service. All bank and agency staff had a full induction, and the modality/clinical lead assessed staff before they were signed off to work.

The service had a lone working policy. However, the trust was currently reviewing lone working across all its sites to create a single policy that reflected current arrangements.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, generally stored securely and easily available to all staff providing care.

Diagnostic imaging

The trust had recently implemented a new integrated electronic system at this location which enabled internal electronic imaging requesting. External requests were still paper based or sent via secure email if urgent. Staff acknowledged that paper-based requests could present a clinical risk however, they had daily managerial reviews for oversight. Staff told us they wanted to implement a joint external referring system in the long term.

All requests were entered onto the radiology information system. The service ensured imaging requests were appropriate and included the relevant information to allow for requests to be justified in accordance with Ionising Radiation (Medical Exposures) Regulations (IR(ME)R).

Patient request forms we reviewed included all the required information, medical history, and clinical indication for the scan.

Reporting was undertaken by a mix of in-house radiologist/radiographers and external teleradiology services. The service stored images on a Picture Archive Communication system (PACS). Internal reports were available electronically, but some external reports were paper based. The administration and clerical team managed this with an agreed process for sending urgent results back to referrers.

From November 2022, patients could access results from a web site or mobile phone App called 'My Care'. This was a new initiative to improve patient experience by giving them better access to their health records. Results that required discussion with a clinical team were not shared on My Care without a preliminary discussion with the patient.

Inspectors found a set of paper notes in a staff only access room which had a Digi Lock on but was not locked to prevent unauthorised access.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, portable oxygen cylinders were not always stored in line with guidelines.

Staff followed systems and processes to prescribe and administer medicines such as Glyceryl Trinitrate safely. The service used Patient Group Directions (PGDs) to administer contrast when conducting scans. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presenting for treatment.

Staff stored contrast safely in a lockable cupboard. They monitored and recorded temperatures daily and all contrast were in date. No contrast had been stored in direct sunlight and those in use were temperature controlled.

Staff completed medicines records accurately and kept them up to date. They recorded contrast batch numbers clearly in patient records after administration.

Four portable Oxygen cylinders in a patient waiting area were not stored securely in accordance with the Health Technical Memorandum for cylinder management. We raised this with senior staff and the cylinders were removed for safe storage.

Incidents

Diagnostic imaging

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and electronically reported incidents and near misses in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The provider's incident management policy established the threshold to guide staff in line with

The Royal College of Radiologists position statement in relation to duty of candour in diagnostic imaging (October 2015).

There was evidence that changes had been made as a result of incidents reported. On reviewing extravasation incidents in CT, patients who had a cannula in place on arrival now had their cannula flushed with saline both in the preparation room and again in the scanning room. This was to ensure the correct position of the cannula regardless of how well the cannula was working. Staff used electronic patient records to check the date the cannula was inserted.

Managers investigate incidents thoroughly and feedback findings to staff via a quarterly newsletter called 'Inform'.

Is the service effective?

Inspected but not rated

We have not previously inspected diagnostic imaging as a single service. Effective was inspected but not rated at this inspection, in line with our current methodology.

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service regularly reviewed policies and standard operating procedures with all policies date controlled. These complied with Ionising Radiation (Medical Exposure) Regulations 2017, the Royal College of Radiologists and the National Institute of Health and Care Excellence (NICE). The service ran monthly clinical imaging and reject analysis audits.

The service had a comprehensive clinical audit and effectiveness programme. This included auditing radiation dose reference levels (LDRLs) for comparison to national levels (NDRLs) to ensure radiation doses were kept as low as reasonably practicable.

Staff audited practice against the World Health Organisation (WHO) imaging and 'pause and check' standards. Of the 50 patients audited in February 2022, 48 patients (96%) had their ID checked.

Diagnostic imaging

The ultrasound service authorised and consented procedures in line with British Medical Ultrasound Society (BMUS) policies. Some local protocols were found to be out of date, but all reflected current BMUS guidelines.

Computerised Tomography (CT) protocols were currently being reviewed. However, at the time of our inspection most were out of date.

Dual energy X-ray absorptiometry (DXA) scans met standards outlined by the Royal Osteoporosis Society Quality Standards for Osteoporosis and Prevention of Fragility Fractures.

Nutrition and hydration

Staff gave patients food and drink when needed.

Patients were provided with specific instructions relating to eating and drinking prior to their scan within the appointment/booking information if required.

Staff made sure patients had enough to eat and drink. There were facilities for hot and cold drinks available.

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 patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

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. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit with a structured audit programme. Managers and staff used results to produce action plans and improve patient outcomes.

The service did not currently have Quality Standards for Imaging (QSI) accreditation from the United Kingdom Accreditation Service (UKAS). The QSI were developed by The Royal College of Radiologists and the College of Radiographers. It sets out criteria that define a quality imaging service. UKAS accreditation is a patient-focused assessment designed to give patients and their carers, confidence in their diagnosis and all aspects of their care. However, the service was working towards trust accreditation in 2024.

The service used onsite and teleradiology remote reporting. In the previous 12 months average reporting times for X-ray were 5 days, CT and Magnetic Resonance Imaging (MRI) were 4 days, fluoroscopy 2 days and mammography 1 day. Quality assurance and audit standards for ultrasound reflected national best practice and staff reported scans immediately.

Diagnostic imaging

The service completed a radiology health and safety audit with an associated action plan in September 2021.

Competent staff

The service made sure staff were competent for their roles. However, managers had not appraised work performance for all staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role and gave them the time and opportunity to develop their skills and knowledge.

Staff maintained up to date training on the safe use of equipment in line with their professional registration and manufacturer guidance. Managers made sure staff received any specialist training for their role. Nursing staff and radiographers were supported to maintain registration with relevant clinical bodies.

The service had a yearly staff appraisal system. However, as of November, only 49.50% of staff had been appraised. Managers felt this was due to the ongoing impact of the Covid-19 pandemic and time constraints within the department.

Results from the 2021 staff survey showed that 78.4% of staff felt they had opportunities to improve their knowledge and skills and 56.8% felt there were opportunities for them to develop their career.

The clinical practice facilitator supported the learning and development needs of staff. Performance of clinical staff was monitored through peer review and quality audit. Any issues were discussed in a supportive environment to enhance learning or highlight areas of improvement.

Managers completed an induction process for bank/agency staff. General induction included an introduction to the team, department and facilities, equipment training, policies and procedures including IR(ME)R and local rules. Specific requirements were completed for entry into radiation-controlled areas.

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 multidisciplinary meetings to discuss patients and improve their care.

Patients could see all the health professionals involved in their care at one-stop clinics. This included the breast clinic where patients saw a consultant, nurse specialist, and imaging staff in the same appointment.

Seven-day services

Key services were available to support timely patient care.

The service provided access for plain film 24 hours a day 7 days a week. There was an on-call system for CT during evenings and weekends. Out of hours advice was provided as part of the Peninsula Registrar on call system.

Diagnostic imaging

The location also hosted mobile MRI and CT services onsite which sometimes ran over weekends providing routine, urgent and 2 week wait scans.

Out of hours, the service used an emergency teleradiology service to provide reporting and diagnostic support.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needing to live a healthier lifestyle. In the DXA scanning department staff told us they explored aspects of good bone health with patients and signposted them to relevant information to read further.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If staff felt a patient lacked the capacity to consent to the procedure, they would seek further advice from the referrer. Patients were provided with written and verbal information prior to their appointment to enable them to understand the planned diagnostic test.

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. Where written consent was required, staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Is the service caring?

Good

We have not previously inspected diagnostic imaging as a single service. We rated caring as good.

Compassionate care

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

Diagnostic imaging

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a professional, respectful, and considerate way. We observed staff treating patients in a friendly and courteous manner.

Patients said staff treated them well and with kindness. In a recent radiology patient experience survey (July 2022), 97% of patients felt that staff treated them with the level of care they expected. Ninety-eight percent felt staff gave clear instructions during their examination and 100% of reception staff were helpful.

Staff followed policy to keep patient care and treatment confidential. The main waiting area was open plan but designed in such a way that there was opportunity to speak in confidence with reception staff if requested.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff had access to mandatory update training in assessing mental capacity, however compliance across all staff groups was currently only 56%.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they related to care needs. Patient information notices showed information about chaperones. Patients were offered the choice of who chaperoned them.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff in the Computerised Tomography (CT) preparation room checked patients understanding of their procedure and gave them time to discuss their concerns at length if needed.

Magnetic Resonance Imaging (MRI) staff provided patients with choices to listen to music, wear headphones and provided ear protection to reduce stress during scans. Patients had access to changing areas and lockers were available to safely store personal belongings during their appointment.

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. The ultrasound team were observed to be particularly responsive, kind and caring when scanning patients.

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 made sure patients and those close to them understood their care and treatment. Information sheets were available for patients as well as concise information about each modality available on the hospital's website. We saw pop up posters in the reception area and in the x-ray waiting room. These gave information about x-rays in general, radiation doses and results. Boards in the waiting areas displayed relevant information about staff uniforms, pregnancy status and updates about the department. However, some of this was a mix of staff and patient information and it was not always clear which target group it was aimed at.

Diagnostic imaging

Staff spoke with patients, families, and carers in a way they could understand. Patients were encouraged to share their experience on the Care Opinion website, which was a non-profit social enterprise enabling people to share the story of their care. Comments about radiology staff included “A good experience all round” and “Staff are worth their weight in gold”.

Staff supported patients to make informed decisions about their care. We saw staff gain consent, either verbal or written depending on the modality. This included checklists with details of contra-indications and any contrast medium to be used. We observed patients having CT scans being informed about associated dangers of radiation in an open, calm, professional manner.

Is the service responsive?

Good

We have not previously inspected diagnostic imaging as a single service. We rated responsive as good.

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 changing needs of the local population. The service had undergone a significant equipment replacement programme over the last 2 years which had resulted in improvements in capacity for some modalities.

Facilities and premises were appropriate for the services being delivered. The environment was appropriate, and patient centred. The main waiting room was a good size and seating was available for the number of patients and allowed for social distancing. There was a small area in the main waiting room for children. There were several smaller waiting areas in the department for specific modalities with changing facilities and toilets.

There was enough car parking, including disabled parking, available onsite for a charge. The department was clearly signposted with lifts and wheelchair access throughout.

The service had systems to help care for patients in need of additional support or specialist intervention. For those patients coming from the inpatient wards, timing was considered to support their other medical needs. Small separate waiting areas were identified for inpatients however, these were not always private and at times, located in corridors. Staff escorted inpatients to maintain patient safety and dignity.

The service minimised the number of times patients needed to attend the hospital, by providing one stop clinics. The breast care clinics was one example. They ensured patients had access to the required staff and tests on one occasion.

Managers monitored and took action to minimise missed appointments. Staff were also available by telephone to discuss any concerns. When booking appointments, staff considered the time and location of each patient. Community sites were offered if open and to increase capacity in some modalities, and options to attend other trust facilities were given.

Diagnostic imaging

If a patient did not attend (DNA) their appointment, the referral was cancelled and returned to the referrer with a notification of the non-attendance. The referrer was responsible for following up with the patient and contacting the department if the appointment needed to be rescheduled. DNA rates were currently around 2% across all modalities.

Senior leaders were aware of service pressures on other departments. They monitored inpatient referrals to facilitate timely discharge, provided support to urgent and emergency care and inpatients by providing mobile imaging services.

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 access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients in the local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care. Managers and staff were very aware that 6 week waiting times for treatment was not always in line with national standards.

National reports on waiting times for key diagnostic tests highlighted differences amongst modalities. Overall, the number of patients waiting over 6 weeks had decreased over the last quarter. The trust board papers indicated that 43.2% of patients were waiting less than 6 weeks as of January 2023. However, numbers of patient waiting over 6 weeks for dual energy x-ray absorptiometry (DXA) bone density scans and non-obstetric ultrasound were consistently high.

Managers and staff were acutely aware of the waiting times, mainly due to staffing shortfalls and ongoing backlogs from the Covid-19 pandemic. The trust planned a regional focus on diagnostic imaging in March 2023. The goal was to achieve a consistent reduction in 6 week wait backlogs.

Managers worked to keep the number of cancelled appointments to a minimum by giving 3 weeks' notice if possible. If less than 3 weeks patients were phoned to inform them of their appointment date and time.

When patients had their appointments cancelled at the last minute, managers rearranged them as soon as possible.

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.

Diagnostic imaging

Patients, relatives, and carers knew how to complain or raise concerns. The hospital had a Complaints, Concerns and Compliments Policy which was out of date in April 2022. An extension had been given to this policy in June 2022 to allow time for a joint policy to be devised trust wide, but this was not available at the time of our inspection.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on managing complaints and concerns stating the roles, responsibilities, and processes for managing complaints. Written complaints were acknowledged within three working days by telephone or email depending on patients' preference. Details of the complaint were entered onto the management software programme. Trust policy stated that all formal complaints must have a written response from the Chief Executive or a deputy within 6 months.

The service had few complaints and a high level of patient satisfaction. Handling of complaints had followed trust policy. Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good

We have not previously inspected diagnostic imaging as a single service. We rated well led as good.

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.

Leaders had the skills, knowledge, experience and integrity that they needed. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges the service faced and were addressing them.

A new Divisional Director was substantively appointed in December 2021 to lead the Clinical support and Specialist services division. Consultants and senior management team had been part of integration discussion during the merger as well as the wider diagnostic hub across the peninsula.

There was a clearly defined leadership team who led the day-to-day operation of diagnostic imaging. Individual services had a lead or named point of contact. Staff told us leaders were visible, approachable and offered a high level of support.

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.

Diagnostic imaging

North Devon District Hospital (NDDH) had a strategy focussed around working with patients, staff, stakeholders, and partners, called 'Better Together'. Their mission was to help people stay healthy and to care for people when they were not. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. Services had been planned to meet the needs of the population and progress was monitored and reviewed.

NDDH was included in the Government's New Hospital Programme (NHP) as a priority for investment in 2020. The diagnostic imaging service had managed an extensive procurement programme which had seen most of the radiological equipment replaced in the last 2 years.

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 recognised and valued the work of their colleagues. The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

The service demonstrated openness, honesty and transparency when responding to incidents and complaints and had systems to ensure compliance with the requirements of the duty of candour.

Staff had access to a comprehensive range of support in the event they needed to escalate a concern. We observed pop up information banners in staff areas giving details about how they could contact their local Freedom to Speak Up Guardian.

Staff survey results showed that 72.2% of staff at the service felt confident in raising concerns, which was higher than the result for the whole organisation.

The service had a bi-monthly newsletter which included, thank you to staff, a focus on well-being and details about training opportunities.

Governance

Leaders operated effective daily and weekly governance processes in all modalities except MRI and not all medical physic equipment checks had been completed. Most staff had regular opportunities to meet, discuss and learn from the performance of the service.

The senior leadership team held monthly meetings covering key aspects of performance and safety monitoring. Records showed these meetings were well attended with actions recorded, shared and monitored.

The department had daily staff handover meetings at 8am and 5pm. Departmental safer staffing reviews at 8am daily discussed allocation of staff for interventional cases.

Managers were aware that a new electronic training record system did not accurately reflect mandatory training compliance. They had escalated this to senior leaders in the trust as it was acknowledged to be a trust wide rather than a local issue.

Diagnostic imaging

Managers acted quickly to resolve issues found around clinical governance requirements for the MRI department (see safe domain). Written daily and weekly QA checklists were developed immediately. All other modalities had appropriate daily/weekly quality assurances processes in place however, some were overdue medical physics quality assurance checks.

The senior leadership team were aware of challenges they faced especially in terms of staffing and building resilience into the team. For example, DXA bone density scan waiting times did not meet national targets. One assistant practitioner is undergoing training/upskilling to fill gaps in service provision. Capacity had been secured from other local trusts, but patients felt travel times were too high and often refused to attend DXA scans at other sites. Opportunities for cross cover with Royal Devon and Exeter hospital had been explored but had not yet been agreed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and documented actions to reduce their impact. They had plans to cope with unexpected events.

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit.

Managers monitored risks within the provider's overarching risk register and management process. Each record had undergone a full risk assessment which included detail about mitigation and actions. Risk registers were reviewed by the service and divisional governance groups. In addition, the trusts risk manager held risk surgeries to review.

The department used a quarterly risk management newsletter, called 'Inform', to cascade relevant information to all staff. This included information on incident reporting, learning from serious events, complaints, and compliments.

The trust had business continuity plans in place and the service had completed a business impact analysis.

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 submitted to external organisations as required.

All staff were required to complete data security and protection awareness training and 90% were up to date with this. Staff used their training to work within the provider's data protection policies and ensure they avoided risks associated with data breaches. This ensured they protected patient identifiable data and acted with integrity when handling personal information.

The service had a newly established internal electronic information and patient record system and systems were password protected. External communications were still largely paper based at the time of the inspection. Information was used to measure improvement. Quality and sustainability both received coverage in relevant meetings at all levels.

Diagnostic imaging

There were service level agreements for Teleradiology reporting services. Images were stored on teleradiology workstations for no longer than 10 days to allow for queries to be processed quickly. Teleradiology workstation access is controlled by 2 factor authentications, biometric and pin code. The images were retained on central servers for 30 days before being automatically and permanently deleted. Teleradiology companies provided audits of date and reporting compliance.

The service was aware of its responsibilities around IR(ME)R reportable incidents. Incidents were investigated appropriately, with oversight from the Radiation Protection Advisor and the Medical Physics Expert.

The last reportable incident was around the use of a tray on new ICU beds (reported to NRLS May 2021). Investigations resulted in these trays no longer being used and a new method was developed and implemented for obtaining images. Staff received training in their use.

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.

Leaders engaged with staff using a variety of methods, including; annual staff surveys, team meetings, electronic communication, appraisals, monthly supervision, and informal discussions.

People's views and experiences were gathered and acted on to shape and improve the services and culture. Staff encouraged patients to complete a friends and family survey following their appointment. Staff had completed a patient experience survey and used the 'You said We did' data to improve services.

Staff survey results showed that 80.6% of staff felt the organisation acted on concerns raised by patients, families and other service users.

The senior leadership team had been involved in discussions regarding integration with Royal Devon and Exeter Hospital to improve capacity and flow through the regional health system. The team had service level agreements with other hospitals in the provider's network and provided reciprocal support in the event of equipment failures or other service disruption.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Leaders and staff aspired to continuous learning, improvement and innovation. Staff had helped develop the role of Assistant Practitioners, particularly in the Computerised Tomography (CT) scanner, both in the region and nationally.

Advanced practice mammographer roles had been developed to support the one stop breast clinics. Reporting radiographers were now in place in Mammography, plain film, MRI and DXA.

A Cancer Navigator Role was being trialled to support patients on the 2-week wait pathway aiming to solve any issues relating to booking an appointment and completion of examinations.

Diagnostic imaging

The trust merger had facilitated a shared pacemaker database. Patients went to the Exeter site for pacemaker implantation, but the system allowed for effective communication of any ongoing concerns. Staff were able to remotely monitor unwell and housebound patients using cardiac device monitoring systems.

The CT/Radiology equipment replacement project team won the trusts ‘extraordinary team’ award for their work and commitment to the managed procurement programme.

Royal Devon & Exeter Hospital (Wonford)

Barrack Road
Exeter
EX2 5DW
Tel: 01392411611
www.rdehospital.nhs.uk

Description of this hospital

Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust is part of the Royal Devon University Healthcare NHS Foundation Trust which was established in April 2022. Stretching across Northern, Eastern and Mid Devon, the trust has a workforce of over 15,000 staff, making it the largest employer in Devon. The trust provides services for more than 615,000 people, covers more than 2,000 square miles across Devon. Some of the trust's specialist services cover the whole of the peninsula, extending as far as Cornwall and the Isles of Scilly.

Royal Devon and Exeter Hospital (Wonford) is the largest hospital in the trust where many acute clinical services are based. This includes emergency department and a number of specialist units and centres. The Royal Devon and Exeter hospital is a teaching hospital, delivering undergraduate education for clinical professions. They are a leading centre for research and development in the South West peninsula.

Clinical services at Wonford include; maternity, breast, paediatrics, neonatal, diabetic medicine, ear nose and throat, oncology, dementia, orthopaedics, vascular, cardiology, respiratory, ophthalmology, healthcare for older people and neurology/Parkinson.

The medical care service includes 18 medical wards delivering specialist and general medical services. The combined medical admissions for the trust was 71,958 from March 2021 to Feb 2022.

The surgical service at Wonford includes 10 surgical wards and 10 operating theatres which provide access for colorectal, upper gastrointestinal, breast and endocrine, urology, vascular, maxillofacial, ears nose and throat, trauma, plastics and reconstructive surgery and 24-hour emergency surgery. The surgical services division also includes ophthalmology theatres, community theatres in Heavitree and Exmouth, the princess Elizabeth orthopaedic centre and intensive care unit.

The diagnostic imaging department has a large medical imaging department including general X-rays, fluoroscopy and Interventional procedures, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Nuclear medicine, Ultrasound imaging, Vascular Ultrasound, Mammography and Dual Energy X-ray Absorptiometry (DXA) scans. For the purposes of this report the different types of examinations taken will be referred to as modalities. In the 12 months up until the inspection the service had performed a total of 448,374 examinations across all modalities. This included 75,341 CT scans, 37,491 MRI scans and 251,156 plain film x-rays and DXA scans.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This included recording physical observations; for example, blood pressure, pulse and respirations. This information was recorded and stored electronically and calculated the national early warning score (NEWS2). NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis, in hospitals in England. Staff told us they knew when they had to call for a medical review. The service had changed its electronic patient record system in October 2020. We were informed that there had not been any NEWS2 audits undertaken in the past 12 months. Auditing helps to identify which wards are performing well and which wards are underperforming. This helps to drive improvement in the quality of the services and outcome to service users.

There was a protocol for the management of sepsis. There was a designated pathway for suspected sepsis on the electronic recording system which took staff through the required actions and escalations.

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool, and did not review this regularly. Staff were required to complete risk assessments for patients using nationally recognised tools. These included, falls assessments, nutrition and hydration assessments and pressure care assessments. Risk assessments were completed electronically, however at times, we saw these had not been completed. For example, the service used the malnutrition universal screening tool (MUST). Of the 26 records we reviewed across the medical service, only 2 had been completed. For the 26 falls risk assessments we reviewed, 14 had been completed. We could not be assured that risks to patients were understood and being managed effectively.

Staff were not always aware of specific risk issues around Venous thromboembolism (VTE) (a serious but preventable condition that happens when blood clots form in deep veins in the legs). VTE assessments were not always completed or reviewed when required. We saw that the doctors and the nurses accessed the electronic care record differently and VTE assessment completion did not pull through to the electronic ward boards to show its status (completed or requiring review). This meant that patients who may have required intervention to prevent against VTE may not have been receiving this. However it should be noted that the Trust board papers of March 2023 show a snapshot position taken from the electronic patient record system which shows in January 2023 81% of patients had been risk assessed for VTE on admission.

When aware of risks to patients, staff dealt with any specific risk issues. We saw a patient who had scored as a high risk of pressure damage. We saw corresponding care plans and action which had been taken to mitigate the risk to this patient.

Data showed there was an increase in pressure ulcers from April 2021 to October 2021. The increase in pressure ulcers could be linked to the shortage of nursing and health care assistants which is discussed under the nurse staffing section of this report. During the year from November 2021 to October 2022 staff incident reported 63 instances when they had missed intentional rounding.

Patients at high risk of falls were cared for in a bay near to the nurse's station which was in the line of sight to all clinicians at the station. A system of bay tagging was also in operation, where one member of staff had to be in the bay at all times.

Due to pressures on capacity and bed availability, some patients were cared for in escalation areas. The service had implemented standing operating procedures (SOP) for staff to follow with criterion for the type of patient that could use the escalation areas.

The service had 24-hour access to mental health liaison and specialist mental health support Mental health support was provided by another local NHS trust.

Staff shared key information to keep patients safe when handing over their care to others. Handover information to inform the new ward of the patients' needs was provided electronically. Nurses also provided a verbal handover via telephone to the accepting ward. Shift changes and handovers included all necessary key information to keep patients safe. Safety briefings were held to ensure important information was shared between staff.

Staffing

Nurse staffing

The service had high vacancy rates for nursing and health care staff and the turnover rate meant some staff were not yet experienced in their roles. Managers regularly reviewed and adjusted staffing levels and skill mix to the best of their ability dependent on staff availability.

The service did not always have enough nursing and support staff to keep patients safe. Nationally there is a shortage of both health care workers and registered nurses. Work was ongoing through regular recruitment fairs, international recruitment, use of bank and agency staff and daily review and mitigation of staff shortages. The trust had used technology to help reduce the time taken to carry out the necessary checks on a new staff member from acceptance of the job offer to the time the person could commence employment. This had helped with the recruitment of health care staff. The service was short of 47.66 full time equivalent band 5 nurses and 76.52 health care assistants. The service did not always comply with its safe care compliance target of 85%, during November 2021 to October 2022, it hovered around the low 60% compliance rate. This meant, at times, some wards were short staffed despite efforts from the management team to redeploy staff to the areas that required support. Between November 2021 and October 2022, staff reported 155 red flag incidents when there were fewer than 2 registered nurses rostered for that shift. In particular, there were high numbers of red flag reporting during the months July 2022 to September 2022. We were assured via data evidenced on SafeCare that no ward was ever left with just one registered nurse.

Medical care (including older people's care)

In order to ensure patient safety, staff moved from ward to ward to cover the gaps. Staff reported they did not always feel supported as they were sometimes moved to wards they were not familiar with and did not have the support of regular colleagues. Staff told us they were so used to not having a full staffing establishment on the wards that the shortages had become normalised. Staff said this impacted patient care as tasks such as feeding and personal care sometimes took longer to complete. A Nursing Safer Staffing Escalation Standard Operating Procedure was available detailing the escalation process regarding staffing issues.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service used the SafeCare nursing tool to support with the calculation of nursing requirements. Acuity of patients was recorded twice daily through SafeCare, which was used to discuss any issues in the staffing meetings

Despite the pressures, where possible, daily staffing levels could be adjusted according to the needs of patients. Information added to the safer care nursing tool was scrutinised and wards were provided with bank or agency staff or staff were re-allocated to areas where there were staff shortages. Despite this, the number of nurses and healthcare assistants did not always match the planned numbers.

The turnover of staff was high but stable when compared to pre-pandemic rates. In August 2022 the turnover rate was 10.3% for registered nurses and 16.8% for health care assistants. This provided opportunities for remaining staff for progression and promotion. However, Royal college the relatively high turnover rate, on some wards, there was a relatively new and inexperienced workforce. This created challenges for ensuring safe staffing across the wards and impacted on other aspects of staff training and development. The majority of the band 6 and 7 nurses whose role was to provide support and oversight to the ward and the staff were newly promoted in post.

A clinical nurse advisor managed the staffing challenges across the medical service. The nurse in this role was constantly sighted on staffing levels and managing staff to ensure safety across the wards. At the time of the inspection, this role was only carried out during the day. In the evening and at the weekend, the on-call team was responsible for managing staffing levels. There was an ongoing business case to recruit a further two nurses into this role and for there to be an extension of their presence on the weekends and in the evenings to manage the night shifts.

The service had a quite high, but relatively stable sickness rate. For the last 12 months the average sickness rate was 6.20% and was high compared to pre-pandemic levels. The trust target for sickness was 3.5%.

The international nursing recruitment drive was improving staffing shortages across the service, however it took time to get the nurses into post working as a qualified nurse. Nurses worked as supernumerary until they had passed their objective structured clinical examination (OSCE) designed to test theoretical knowledge of nursing applied to clinical practice in the UK. There was no timeframe in which the nurses sat this exam which often delayed them starting to work as a registered nurse on the wards. The trust had developed a programme to support overseas nurses offering support both within and out of work.

There was a focus on staff retention which was seen as a challenge across the service. Matrons told us they needed to be better sighted on the reasons for staff leaving. Exit interviews had been changed to ‘stay interviews’ and were now carried out by an independent senior member of staff from another area. Matrons also gave an example of trying to support and encourage staff who wanted to leave to move to work in another area of the trust, which may be better suited to them, rather than them leaving.

Different staff roles were utilised to improve the skill mix on the wards. Nurse Associates and Trainee nurse associates (TNA) (a role which helped to bridge care between Healthcare Support Workers and Registered Nurses) worked on the wards. Staff development was supported and encouraged and some TNAs and Nurse Associates were being supported to extend their training to become registered nurses.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service mostly had enough medical staff to keep patients safe. However, it should be noted that there is a national shortage of consultants. The service was not fully established for consultants and the trust was continuously running recruitment campaigns to try and fill the vacant positions. Compared to the position in 2021, the trust had seen some success in recruitment in areas such as gastroenterology and renal. This had enabled the eastern site to provide consultant support to the northern site for these specialties. However, some specialties were challenged more than others. For example, respiratory services were short 3 respiratory consultants in July 2022. At the time of our inspection, 2 vacancies for respiratory consultants remained.

The service required additional junior doctors. The service was looking to work with the Deanery to increase the numbers of posts which will support doctor training. The service was also looking at alternative posts such as Physician Associates and Advanced Care Practitioners.

Managers could mostly access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Records

Patient records were not always completed fully. Records were stored securely and available to all staff providing care.

Patient notes were not always comprehensive but were stored securely. The system stored notes in chronological order and all were named, timed and dated automatically at each entry. However, risk assessments and care plans weren't always completed (see assessing and responding to risk).

The integrated electronic patient record introduced in October 2020 had mixed reviews from staff. Some staff were positive about the system and the benefits it provided, for example, being able to send direct messages to clinicians for advice and having all information in one place. Other staff felt the system enabled too many direct messages and that at times it was difficult to prioritise these messages about patient care.

Access to patient records was restricted by clinical role and grade. This meant staff only saw patient information appropriate to the role and care they were providing which was good in terms of protecting patients' private information and confidentiality. The electronic patient record was password protected.

Medical care (including older people's care)

Agency staff were given a one-hour induction on how to use the electronic patient record system prior to working on the wards. Some staff indicated that this was not enough time to ensure staff were able to use the system.

When patients transferred to a new team, there were no delays in staff accessing their records. Nursing, and medical notes could be accessed electronically on every ward. Medical staff said it was helpful that both the eastern and northern sites were using the same system as often patients from the northern site were transferred to the eastern site for treatment and this meant there were no delays in accessing patient records.

Documentation audits from the patient reporting system were completed, but re-auditing in line with the outcome had not been completed. For example, AMU scored 55% on their audit in June 2022. The result (red), as per the frequency rules should have been re-audited in 8 weeks. No further audits had been completed since June 2022. Also, for Creedy ward, the ward had scored 51% (red) on their audit in June 2022 with no further re-audit in line with the frequency rules. Both wards had action plans to address improvements which needed to be made, both included issues around completion of risk assessments, admission documentation and care plans for patients.

Medicines

The service used systems and processes to safely prescribe and administer medicines safely. However there were instances when medicines were not stored and monitored according to trust policies.

Staff mostly stored medicines safely however we found one instance where medicines stored in a fridge were unsecured. We notified the trust and the medicines were moved to a fridge that could be secured immediately.

Fridge temperatures that stored medicines were not always checked daily and logged in line with trust policies. The medicine documentation audit for the 2021 to 2022 showed that wards were performing below trust targets. Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff learned from safety alerts and incidents to improve practice.

Is the service effective?

Good 

The service was previously rated good. We did inspect aspects of effective but did not rate the service according to our current focused methodology.

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.

Medical care (including older people's care)

A nationally recognised screening tool was used to monitor patients at risk of malnutrition, however this was not always completed. The service used the malnutrition universal screening tool (MUST). Of the 26 records we reviewed, only 2 had been completed. The completion of the MUST tool helps to inform onward care planning therefore we could not be assured that patients nutrition and hydration care plans were individualised for optimal care. The lead for safety and quality had been working with health care and nursing staff to improve completion of the MUST assessments.

Audit data for MUST compliance had not been collected by the trust since the introduction of the integrated electronic patient record system in October 2020. We requested data following the inspection regarding the compliance with completing MUST assessments. We were told this information was not available and were not informed when the service planned to recommence this audit. Managers were aware completion of the MUST tool was a problem and actions were being taken to address the issue. These included a mandatory training package and a prompt on the electronic system when MUST assessments had not been completed. Nutrition and hydration were going to be a main focus point of the new ward accreditation (a programme of work engaging staff to improve standards and quality on wards). The aim of this was to provide regular reports on whether elements of the MUST assessments and care plans were being implemented.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Water jugs were easily accessible for patients and patients also had supplement drinks and snacks to support with enhanced nutritional needs. Pictorial food menus were also available for patients who had additional needs. Colour coded tops were used on water jugs on some wards so staff could manage hydration needs. For example, a jug with a red top signified the patient was on a fluid restriction.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. We saw examples where dieticians and speech and language therapists had been requested to review patients and we observed a discussion between a speech and language therapist and a nurse discussing a patient's swallow and the onward management plan.

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 mostly assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a numerical scoring system to understand the severity of patient's pain. This was recorded on the NEWS2. Staff reported 47 red flag incidents of delays in providing pain relief to patients from November 2021 to October 2022.

Patients received pain relief soon after requesting it. We observed staff discussing pain with patients during medicine rounds and taking prompt action to manage those with pain.

Staff prescribed, administered and recorded pain relief accurately.

Is the service caring?

Good 

Medical care (including older people's care)

The service was previously rated good. We did inspect aspects of caring but did not rate the service according to our current focused methodology.

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 made sure patients and those close to them understood their care and treatment. We observed staff carry out ward rounds. Discussions about care and treatment were held with the patient and communicated clearly in a way the patient could understand. We saw reassurance was provided when patients became emotional and time was taken so patients didn't feel rushed.

Staff talked with patients, families and carers in a way they could understand. We heard a telephone call from an occupational therapist (OT) to a patient's family discussing discharge plans. The OT was caring in their approach but also realistic and informative so the family knew what they could expect when the patient was discharged home.

Patients and those close to them were actively involved in ward round discussions. We observed a patient and their husband communicating with staff on the ward round. Staff used diagrams to help explain complex issues surrounding the patient's condition to make things easier to understand. All information was sensitively discussed and options and consequences thoroughly explained.

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. One patient left a review stating "the staff were so caring and looked after me extremely well and their kindness made all the difference me as I was so far away from home."

Is the service responsive?

Good  

The service was previously rated good. We did inspect aspects of responsive but did not rate the service according to our current focused methodology.

Access and flow

The service was blocked by patients in beds who were medically fit for discharge due to a lack of community and social care packages in the region.

The number of medically fit for discharge patients waiting for an onward package of care as at the time of inspection was 93. These patients did not have a medical reason for remaining in hospital. The lack of onward community and social care packages is a national problem which presently remains unsolved. There were 93 patients remaining in hospital who were fit for discharge, this is the equivalent of almost 4 (25 person) wards. Despite being medically fit to be discharged these patients still require care and attention from medical and nursing staff. Long hospital stays could also be linked to negative outcomes, such as a decline in physical ability, as well as an increased risk of picking up a hospital-

acquired infection for frail elderly people. When compared against other NHS trusts, the Royal Devon & Exeter site had a relatively small proportion of medically fit patients at 4.5% of total patients, whereas in some trusts this figure had risen as high as 30%. We spoke with the bed management and discharge teams who were extremely proud of the work they had undertaken to ensure hospital flow was maintained against the backdrop of the difficult environment they were working within. The average length of stay for a medical patient was 15.5 days.

The trust used an established tool to identify the capacity of wards and assessment units at any point in time. The trust tried to use these tools to best meet the needs of the patients. The trust had been consistently over 93% bed occupancy since December 2021, with bed occupancy peaking at 95.4% in November 2022. This made flow throughout the hospital difficult to manage. Hospitals cannot operate at 100% occupancy, as spare bed capacity is needed to accommodate variations in demand and ensure that patients can flow through the system. The National Institute for Health and Care Excellence Guideline 94 talks about 85% bed occupancy being recognised in literature as the ideal occupancy rate and states “high levels of bed occupancy may affect patient care as directing patients to the bed most suitable for their care is less likely to be possible”. When capacity within the trust was pressured, medical patients were being cared for in areas which were not meant for medical patients, such as surgery beds and the Same Day Emergency services triage room. Staff told us in some escalation areas washing facilities were often shared between many patients and this was sometimes difficult to manage. We were also told patients did not have access to television whilst staying in some escalation areas.

Consultant led referral to treatment waiting times were not always being met and patients were not always treated within the 18 week window. Most NHS trusts are struggling to meet these targets as a result of the impact of the pandemic. Trust wide data for the month of August 2022 Source: NHS England Consultant led referral to treatment times) indicated the trust was struggling to meet targets in Neurology, Respiratory and Ophthalmology, however were performing well for the elderly medicine service. The information was not site specific.

We were not assured all patients were being seen by a consultant within 12 hours of admission, or 14 hours of arrival to hospital, because the information was not accessible on the new electronic patient record system. The service had requested that this information is made available, however we have not been told when this information will be able to be accessed. This information has not been available since the start of the pandemic. Clinicians can access this information from running a local report, however, the trust does not currently have oversight of this information.vte

The hospital monitored the demand on its service. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. The service had been at OPEL level three and four for the last six months. Level four is the highest OPEL level and means the trust is at high pressure. Each day bed meetings took place to review the flow of patients through the hospital. Those meetings were attended by bed managers and ward nurses.

Managers and staff worked to make sure patients did not stay longer than they needed to. The trust had a Same Day Emergency Care (SDEC) centre especially designed for patients to avoid admission and to help the patient to remain at home. In November 2022 the service saw 566 patients of which 86.70% were discharged the same day, thus avoiding an unnecessary hospital stay. The service received referrals from the emergency department as well as from the community and General Practitioners. The triage area was sometimes bedded over night with inpatients, which meant the service could not receive as many referrals in the morning, until an alternative bed was found for those patients who had been bedded over night.

Medical care (including older people's care)

The service also had an acute care of the elderly (ACE) ward which aimed to discharge patients within 72 hours of their admission. ACE nurse specialists would assess patients in areas such as the emergency department and the acute medical unit and have them transferred to the ACE ward. A multidisciplinary team of clinicians would then manage the patient and look to discharge them back to their home in 72 hours. Staff told us they were proud to offer this service and how it had been meeting its targets to safely ensure patients were discharged back to their homes.

The service was running an acute hospital at home service which had virtual wards. Patients identified as being suitable and stable were monitored whilst at home remotely. We spoke with members of this team who believed there was scope to extend the service if this could be staffed safely. The team spoke of the benefits to the patient who would rather be in their own home as opposed to a hospital bed.

Managers and staff started planning each patient's discharge as early as possible. We heard discharge planning was discussed at daily board rounds by all of the multidisciplinary team. Different clinicians took away actions to move the discharge process forward to ensure the patient was ready to leave the hospital once they were medically fit for discharge. Reset week in October 2022 aimed to discharge patients in the morning to improve flow through the medical service during the day. However, the majority of discharges still happened between 4pm and 8pm. For the three-month period from August 2022 to October 2022 there was a total of 4,985 discharges that happened between 08.01 to midday, whereas there were 11,181 discharges that happened between 4pm – 8pm.

The hospital had employed 4 discharge coordinators who worked across the wards at the eastern site. There had been winter funding for an additional 6 discharge coordinators and these posts had been appointed and were due to start within the next month. The discharge coordinators helped with complex discharge cases such as out of area patients. They attended board rounds but were situated in an office away from the ward areas. Ward nurses had the responsibility of liaising with care homes and / or family members to help arrange a safe patient discharge.

The service had a permanent discharge lounge that was used by wards to send patients who were waiting to be discharged on the day. This meant a bed could potentially be made available sooner for a new inpatient than otherwise would have been the case. We observed the discharge lounge and saw it was clean with comfortable seats. We talked with patients who were happy to wait in this environment for a lift from their relatives or hospital transport. Staff were able to provide patients with refreshments and food. The discharge lounge did not have its own toilet facilities, patients currently had to use alternative facilities near to the discharge lounge. We were told a toilet facility had been commissioned to be built in the near future.

Due to capacity issues patients were being moved sometimes multiple times and we were told sometimes at night.

Managers worked hard to minimise the number of medical patients on non-medical wards, however this remained an issue whilst the bed capacity of the hospital was nearly full. On the day of our inspection there were medical outliers on two of the surgical wards. There was a system to ensure these patients were seen by the most appropriate medical team to ensure the care and treatment they received met their individual needs.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Medical care (including older people's care)

Leadership

The service had a newly promoted nursing leadership team. They were visible and approachable in the service for patients and staff.

Not all ward leaders had developed the skills, knowledge and experience they needed, as they were new to senior posts. They were being supported by other senior leaders to develop and to identify care issues within the ward.

Leaders mostly understood the challenges to quality and could identify the actions needed to address them, however, the lack of audit information available made the identification of issues challenging.

Matrons felt supported and heard by their associate director of nursing and felt they could raise concerns, however, at times higher escalation of issues to more senior divisional leaders were not always acted on. For example, matrons felt the nursing forum voice had been lost. We were told post Covid-19, the matrons no longer met as a team across the divisions. This was useful for peer support and to share ideas and learning. They felt other forums had also been lost and were not always assured their concerns were heard and understood.

Culture

Staff felt tired and under pressure, however 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 morale was low across the service. This was due to post COVID-19, sickness, ongoing staff shortages and staff being moved at short notice to cover different wards. Leaders understood how disruptive and challenging it could be to move staff to different wards to manage staffing levels and tried to arrange this as early as possible to minimise any disruption

Staff felt supported, respected and valued. Staff told us they felt supported by their leaders and the matron and associate director of nursing were visible on the wards. Staff appreciated that leaders undertook clinical shifts on the wards as they felt they understood the pressures they were under and the challenges they faced. Staff we spoke with stated they were proud to work for the service.

The culture was centred on the needs and experience of people who use services. Staff spoke passionately about the patients they supported and wanting to do their best for them. Staff spoke of frustration at times about feeling like they had not been able to do their best because of the staffing pressures they were under.

Despite the pressures and challenges, some staff felt positive and proud to work in the organisation. Staff who had long term service working across the medical service told us they were proud to work for the organisation and proud of the hospital’s reputation. They told us having a junior workforce was challenging and at times it could be difficult to support newer staff to upskill them. Staff felt they were getting there but the process took time.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution.

There was an emphasis on the safety and well-being of staff. Matrons understood the importance of supporting staff wellbeing to support staff and to retain staff. There was a health and wellbeing practitioner available weekly for conversations with staff to support them.

Medical care (including older people's care)

There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively.

Governance

Leaders mostly had effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities.

There was a clear governance structure and system of accountability to support the delivery of care. Staff at most levels were clear about their roles and understood what they were accountable for, and to whom. Staff were able to tell us who they would go to for support or to raise concerns.

There was a clear reporting structure, with governance meetings being held monthly. We reviewed three sets of minutes from August, September and October 2022. There was a rolling agenda which covered all aspects of governance, for example, incidents, complaints, risk register review, patient experience and a round up and assurance from the different departments. An action log was available, and it was clear actions were reviewed and discussed at meetings and closed accordingly. However, the complaints process and incident reporting had experienced delays in responding to concerns and investigating incidents and concerns.

Management of risk, issues and performance

There was a lack of intelligence reporting which impacted on the ability of teams to plan and provide assurance on service delivery.

We were not assured there were comprehensive assurance systems, and performance issues could be escalated appropriately due to the lack of availability of data and audit. We were told by senior members of staff that accessing safety and quality metrics was challenging and assurance information from ward to board had been lost. For example, there had been no malnutrition universal screening tool audits since the start of the pandemic and there had been no comprehensive falls audit or NEWS 2 audits performed in the last 12 months. This had been ongoing since the introduction of the integrated electronic patient record system in October 2020. The ability to access audit data was dependent on the functionality of the electronic system. Work was ongoing to rectify the challenges with accessing this information and we were told things were slowly improving. We were not provided with timescales as to when audits would recommence. It should be noted that the new electronic patient record did bring benefits in terms of real-time reporting, safety, prevention of harm and clinical responsiveness.

Teams were trying to overcome the challenges around accessing quality and performance data. For example, the falls team validated each fall every month and summarised these in a report. This was then used to monitor falls rates over time. This method was time consuming for teams to continually keep up to date with. The falls and pressure damage information was also available from scrutinising the incident reporting system.

The service tried to monitor the effectiveness of care, treatment and performance however this was challenging since the introduction of the integrated electronic patient record system. The service took part in national and local audits, however accessing the data from the electronic patient record system to scrutinise services was an ongoing problem. For example, renal services were unable to report to the national renal registry, this was a risk highlighted on the risk register.

Medical care (including older people's care)

The trust shared how the implementation of the integrated electronic patient record (EPR) has enabled advancements in many aspects of safe patient care and service delivery across the trust. The trust is recognised nationally in this area being the first in the UK to go live with an integrated EPR across acute and community services and providing patients with a single integrated patient record, accessible by primary care. This enables patient information to be shared quickly and securely. The trust was aware of improvements which needed to be made to the EPR system and had a work plan to optimise functionality, provide further end user training and refine governance.

The trust told us they were unable to provide EPR user training in the way they had planned due to the COVID-19 pandemic and social distancing requirements. The trust said this had an impact on end user proficiency which continues to be addressed through other training and educational methods.

There were local arrangements for identifying, recording and managing risks and issues. There were 50 risks on the risk register. Each risk had a risk score, a risk owner and contained the date at which the risk needed to be reviewed.

There was alignment between the recorded risks and what staff said was ‘on their worry list.’

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

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 deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS 2) framework was used. Vital observation scores were flagged up on the integrated electronic patient record system. There were good systems for escalation and good outreach support for critical care. There was an escalation policy for patients with presumed or confirmed sepsis who required immediate review and we found staff were aware of sepsis protocols. The NEWS 2 system was also used in theatres to monitor patients post-operatively.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed them regularly. We reviewed 3 sets of electronic notes and found risk assessments completed and updated with corresponding care plans.

Urgent care pathways were available on the electronic patient record system with good pathways for surgical specialities, for example fractured neck of femur, burns, major trauma, vascular and renal. The emergency department (ED) was undergoing a planned redevelopment, and this was nearly complete. However, care pathways were not always able to function effectively due to difficulties with hospital flow and bed availability.

The trust patient safety group had overseen the development of a comprehensive Local Safety Standards for Invasive Procedures (LocSSIP) programme since the publication of the National Standards for Invasive Procedures (NatSSIPs) in 2015. In 2021, the Trust became part of a regional collaborative to review and share best practice. Local Safety Standards for Invasive Procedures using the NatSSIPs were available on the electronic patient record system. Some staff displayed good knowledge base of them and several staff we spoke to had been involved in design and development of new LocSSIPs.

The service complied with the 5 steps to safer surgery, World Health Organisation (WHO) surgical checklist including marking of the surgical site. In theatres, we observed 4 WHO surgical checklists completed to a high standard. However, the electronic patient record system did not allow for clear auditing of this process to measure its completeness and effectiveness.

In theatres there were protocols in cases of life-threatening haemorrhage which had recently been revised. There was at least one member of recovery staff who was trained and certified to an appropriate level in life support and an anaesthetist available to support patients if they became unwell.

Surgery

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 was provided onsite by the local mental health trust.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes, handovers and safety briefings included all necessary key information to keep patients safe. This included the wards, from theatre to recovery and recovery to ward staff.

Nurse staffing

The service did not always have enough nursing and support staff with the right 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.

Within surgery, the service did not always have enough staff to keep patients safe. Managers calculated and reviewed the number and grade of registered nurses (RNs), healthcare assistants (HCAs), operating department practitioners (ODPs) and theatre support staff needed for each shift in accordance with national guidance. The vacancy rate for these posts was 13.4%. This meant there were 10.5 whole time equivalent (wte) RN posts, 52.7 wte HCA posts, 9.5 ODP wte and 9.5 wte theatre support staff posts vacant across the speciality.

The number of nurses, healthcare assistants and theatre staff did not always match the planned numbers. Staff told us they covered vacant shifts, staff were redeployed from other more well-staffed wards, covered by bank or agency staff. This helped to maintain safety and supported skill mix within the surgical division. The ward manager could adjust staffing levels daily according to the needs of patients. Managers made sure all bank and agency staff had a full induction and understood the service. Managers used bank and agency staff and requested staff familiar with the service or block booked staff to ensure continuity of care. There was an established process to escalate staffing shortages.

RN sickness had decreased from 5.19% in August to 4.82% in September 2022. Turnover rates were relatively static at 14.4% in September 2022. The highest turnover rate was in trauma and orthopaedics at 21.4% due to a high number of inexperienced Band 2's leaving as the job was not what they thought, however, this improved from 23.7% in April 2022.

The way staff were managed in surgery staffing was effective. Managers told us about the high degree of collaboration and cooperation from staff across the division to maintain safe staffing levels. Twice daily staffing meetings were held for trust wide view with collaboration and understanding of the staffing position throughout the trust. Band 7 staff coordinated staffing across several wards, with one for surgery and one for orthopaedics, supported by a clinical matron to help maintain safety and quality of care.

Surgery had developed extended roles for staff, for example, assistant care practitioners and surgical care practitioners. The trust was also developing apprenticeship routes for various roles. The division was actively recruiting through the trust recruitment programme, at recruitment events monthly and used social media.

Medical staffing

The service did not always have 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.

Surgery

The service did not always have enough medical staff to keep patients safe. However, medical staffing was had 11.2% whole time equivalent posts over budget. This was due to medical staff budgets overspend to cover long term absence, sickness, waiting list initiatives and the ability to recruit to cover all emergency and urgent commitments. Therefore, locums were required, causing the overspend, rather than over establishment.

However, while some specialities were over established with staff, some areas had vacancies including anaesthetics, head and neck, ophthalmology and oral surgery. Staff told us, during long operations, there was not always enough staff to enable anaesthetists to have a comfort break. The trust was actively recruiting to fill these positions.

The service usually had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Junior medical staff we spoke with felt consultants were supportive and approachable. No concerns were expressed to us about difficulties in contacting or obtaining consultant input.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them including serious incidents. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had never events that occurred on wards and theatres. Within surgery, the provider had 9 Never Events (patient safety incidents that are wholly preventable where guidance or safety recommendations providing strong systemic protective barriers available at a national level and have been implemented by healthcare providers) between July 2021 and October 2022. Of these never events, 5 were wrong site administration of an anaesthetic block, 2 wrong site surgery, a retained swab and a misplaced naso-gastric feeding tube.

Between 5000 and 6000 peripheral nerve blocks were performed each year by anaesthetists across the eastern division of the trust. Since July 2021, 5 wrong side nerve blocks have been performed despite the use of local safer surgery guidelines and previous measures implemented to prevent wrong side block. However, it should be noted that some nerve blocks were performed outside of the theatre environment and bypassed safety procedures designed to prevent a wrong side block.

There was evidence that some changes had been made as a result of investigations but were not embedded in clinical practice or embedded in a timely manner. The trust failed to embed learning from the first never event involving a wrong site anaesthetic block, resulting in 3 further never events of the same type. Following a wrong site nerve block in October 2021, the first action was ‘To introduce ‘Prep, Stop and Block’ process across all specialties and clinical environments where a nerve block is to be given to ensure a check by the surgeon with a second checker’. However, following another wrong site nerve block 8 months later in June 2022, the first action was the same.

When asked, the trust did not provide numbers of staff trained in ‘prep, stop and block‘. However, we observed good safety protocols in theatre for ‘stop before you block’ and special packs that could not be opened until safety checks were completed and confirmed. We found medical staff were aware of written formal departmental guideline on ‘stop before you block’. There was also training, and competency assessment of junior medical staff and the equipment to be used for extra safeguards. We saw information posters in theatres about ‘stop before you block’.

Surgery

We found the safe surgery and interventional procedures policy was not reviewed and changed, as an action in the actions plans despite being marked as completed on an action plan, following wrong site anaesthetic block never events in July 2021 and June 2022. A review of the policy was undertaken in July 2021 before the wrong site blocks occurred. The standard operating procedure for safe performance of peripheral nerve blockade dated 8 November 2022 was waiting to be approved before being added to the main safe surgery policy, 16 months after the first wrong side block occurred. The trust clinical guideline for performing a fascia iliaca block in adults with a hip fracture was updated in October 2022, 21 months after its previous review in January 2021.

The trust was not able to regularly audit the results of the 'Stop Before You Block' education as the current patient record system was not set up to extract this type of information. However, the trust had mitigated this by conducting an audit completed by operating department practitioners. It was conducted for a period of 1 week from the 14th of July 2022 in 14 operating theatres. It showed 90% of the 22 nerve blocks performed were conducted correctly. The lead anaesthetist was currently building an audit process into the electronic patient record system to enable audit information to be extracted. When this has been approved, it will go live on the system.

Medical staff told us human factors were an issue for never events at this location. They were concerned about the breakup of regular anaesthetist and surgeon partnerships they felt were important for successful management of complex surgery. These concerns have been highlighted to managers, but staff felt the awareness of the importance of human factors in safe surgery had been overlooked.

Staff were provided with human factors training during their induction process. Human factors training aims to reduce human error and improve quality care and patient safety. Following a never event of wrong side block in August 2021, human factors was found to be a contributory factor and the investigation methodology used. As part of the action plan for this investigation, the anaesthetic and theatre governance group were tasked with considering whether human factors training should be commissioned. This action was to be completed by April 2022. However, it was not discussed until September 2022 and the training/education was to be further discussed in March 2023. The hospital has had 4 more never events of wrong site block occurring with human factors considered partly responsible.

There was some sharing of learning about never events with staff and across the trust. We found action plans discussed the sharing of learning with staff involved in the incident but staff we spoke to were unable to discuss learning across the trust, division or hospital. Staff we spoke with had not participated in, and learned from, reviews and investigations by other services and organisations. Medical staff talked about the openness and honesty at all levels within the organisation in response to incidents. They understood the importance about learning from patient safety incidents especially never events. Several members of the medical staff were concerned the learning from the never events that occurred was not being shared widely enough but felt this would be addressed by appointment of new patient safety lead across all trust sites.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff did not meet to discuss the feedback and look at improvements to patient care. Staff we spoke to were not always aware of outcomes and learning from investigations including serious incidents and never events. The 'Surgical Services Digest' (a learning newsletter) and the trust wide iBulletin were circulated to staff. However, no ward staff mentioned this when asked about ways of learning from incidents. They were also not printed and displayed on the wards we visited. A member of staff was unaware of a never event that had occurred on the ward they worked on and were not aware of a never event at another site. However, we found medical staff were familiar with the high number of never events and the learning from them.

Surgery

In response to the high number of never events, the provider recently commissioned a never events task and finish group (see Well-led domain). Surgical mortality and morbidity reviews from all specialities of surgery fed into service improvement. These were undertaken monthly, minuted and lessons learned were documented.

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. This was well documented in investigation reports.

Is the service effective?

Good

The service was previously rated good. We did inspect aspects of responsive but did not rate the service according to our current focused methodology.

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 not yet been accredited under relevant clinical accreditation schemes.

The service participated in 48 relevant national clinical audits covering most surgical specialities which were voluntary and mandatory and submitted data for surgical site infections (SSIs). The hospital participated in national audits such as the national joint registry, national hip fracture database, national oesophagus gastric cancer audit, adult cataract surgery audit, national prostate and the national bowel cancer audit. Most of the audits were continuous ongoing data collections.

The results of surveillance for SSIs showed a mixed picture. However, the figures were skewed for total hip replacements due to fewer operations being performed than normal as a result of lower than predicted surgical availability of beds due to winter pressures and capacity and flow in the hospital.

The service usually had a lower than expected risk of readmission for orthopaedic elective care than the England average. For total hip replacement, inpatient/readmission infected at 3 months post-surgery was 0.8% but this only represented 1 infection from 118 operations from April to June 2022. Total knee replacement operations for the same time period showed no infections or readmissions at 3 months post-surgery after 71 operations.

Outcomes for patients were not always positive and did not always meet expectations, such as national standards. The surgical division was under huge pressure with long waiting lists which were increasing. Within orthopaedics, another location was performing some elective work, but only certain patients could be operated on there. As the number of trauma patients had increased and require more theatre time, this meant elective patients had to be cancelled as a result.

Managers and staff were unable to carry out the programme of repeated audits to check improvement over time due to issues with the new electronic patient record system. This meant managers could not use information from the audits to improve care and treatment (see well led domain).

Surgery

The service was working towards anaesthesia clinical services accreditation since January 2022. Volunteers were working on 140 of the standards, 3 have been achieved and 14 are yet to be started.

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 patients. There was a good training programme for junior surgical, nurse practitioners and anaesthetic staff with monitoring of competencies. Staff told us they felt properly trained and supported.

Managers gave all new staff a full induction tailored to their role before they started work.

The clinical educators supported the learning and development needs of staff. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us the trust was making development available for all grades of staff with funding for training and education relevant to their place of work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Is the service caring?

Good

Due to the focused nature of the inspection we did not rate caring on this occasion. Previously this domain was rated as good.

Is the service responsive?

Good

The service was previously rated good. We did inspect aspects of responsive but did not rate the service according to our current focused methodology.

Access and flow

People could access the service but not always when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times and made sure patients could access services, but treatment was not always within agreed timeframes and national targets. One of the biggest contributing factors of not meeting timeframes and national targets was the COVID-19 pandemic. For example, orthopaedic surgery stopped operating for 6 months which caused a backlog, along with available theatre capacity. The growth in trauma demand meant reducing elective capacity and theatre infrastructure had not kept pace with this.

Surgery

Latest data (August 2022) showed trauma and orthopaedics was only meeting 40.2.% of 18-week targets for consultant-led referral to treatment waiting times. Best performing was general surgery at 65.7%. Average wait for a trauma and orthopaedic appointment was 24.4 weeks and 10.6 weeks for general surgery. From August to October 2022, 278 patients had their surgery cancelled. Reasons for cancellation included lack of anaesthetic cover, patient unfit for surgery or testing positive for COVID 19 and lack of an inpatient bed. However, the trust had less than 200 patients waiting over 2 years for surgery, down from 950 patients in February 2022.

Performance against the cancer 2 week wait standard was much lower than the 93% target. In October 2022 there was a slight increase in patients seen from September 2022. Provisional data currently showed a further improvement in November 2022. Performance for breast patients improved by in October with a projection of hitting 83.2% of patients seen for November 2022.

Performance of the 31-day cancer target to treat to treatment standard, (cancer patients receive their first treatment within a month of a decision to treat following diagnosis) was currently decreasing and below the expectation of 95% at 94.3% in October 2022 with a current prediction of 79.5% in November 2022. At the time of inspection there was 6-8 weeks wait for new breast patients with theatre capacity being expressed as a challenge. The average wait in some specialties (breast/urology and lower gastro-intestinal) for surgery was 5 weeks. Urology had a significant number of patients waiting, approximately 30. To mitigate this long wait, we saw how the team reviewed the clinical priority of patients to ensure those who need to be treated urgently were prioritised.

Performance of the 62-day standard for GP referral to cancer treatment target was below the expectation of 85% it was reported at 64.2% in September, 73.9% in October 2022 and for November was currently at 61.49%. Colorectal performance was challenged with 33.33% performance in October 2022 and currently 8% in November. This was due to lack of capacity throughout the care pathway including availability of access to diagnostic tests (endoscopy), reporting of diagnostics (radiology), outpatient and theatre capacity.

The aim for all fractured neck of femur patients was to undergo surgery within 36 hours of admission. Surgery should not be delayed unless there is a specific medical condition which could be improved. From the latest data available, August to October 2022 showed an average of only 54.2% of medically fit patients underwent surgery within 36 hours.

Managers told us of innovations, a new breast surgery department and hand surgery (plastics) department from the NHSE/I transformation innovation fund based at another location. This freed up capacity elsewhere. Patients with lower priority for hand plastics now had a ‘see and treat model’. This provided a better pathway for patients and relieved pressure on the main site.

Managers worked to keep the number of cancelled appointments, treatments and operations to a minimum despite issues with capacity and flow through the hospital. The service monitored and managed elective waiting times closely for each surgical speciality. The hospital acknowledged the large backlog of elective patients waiting for surgery and was committed to reduce the number of patients waiting 104 weeks to zero by the end of March 2023. There were weekly patient tracking meetings to directly support and oversee the waiting list and delivery of cancer waiting times.

When patients had their appointments/treatments/operations cancelled at the last minute, managers made sure they were rearranged as soon as possible but not always within national targets and guidance which included patients who were considered long waiters, over 104 weeks.

Surgery

Managers worked to minimise the number of surgical patients on non-surgical wards. There were good arrangements for surgical staff to review any surgical patients on non-surgical wards and medical staff to review medical outlying patients on surgical wards. Some orthopaedic beds were ringfenced to control infection risk. This meant there were no other types of medical or surgical patients on the elective orthopaedic ward and this included their Nightingale hospital location.

There were medical staffing rotas to manage the provision of emergency surgery, particularly at night, weekends and public holidays.

Managers and staff worked to make sure patients did not stay longer than they needed to and started planning each patient's discharge as early as possible. A multidisciplinary daily board round was held on the wards from Monday to Friday to discuss progress of patients and discharge arrangements. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

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 to take on more senior roles.

Leaders at all levels had the knowledge or experience and felt well supported to run the service. They understood the challenges to quality and sustainability and could identify the actions needed to address them. Staff told us leaders at all levels were visible and approachable and a matron was based on each ward. Leadership and management courses were available for staff.

Leaders told us they were very proud of the teamwork and strength of how hard staff work to do the job and the strong leadership teams. Also, the dedication teams had shown throughout COVID-19 pandemic and the commitment they had provided, despite the circumstances, especially as staffing had been and continued to be in a difficult and challenged position.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service generally had an open culture where patients, their families and staff could raise concerns without fear.

Not all staff felt supported, respected and valued. Medical staff felt their well-being was suffering for several reasons including changes to parking and the importance of human factors in safe surgery. However, they also said the culture encouraged openness and honesty at all levels within the organisation. Nursing staff we spoke with at all levels felt

supported, respected, valued for their work and empowered to speak up. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Learning and action taken as a result of concerns raised had improved. Staff felt positive and proud to work in the organisation. Leaders expressed their admiration for staff to change and adapt during recent challenges.

There was a strong emphasis on the safety and well-being of staff. There had been issues with culture in theatres as noted in the last inspection report of December 2017. At this inspection we found the culture to be much improved. Staff told us they felt empowered to speak up especially during WHO checklists and stop before you block time. There were cooperative, supportive and appreciative collaborative relationships among staff.

The trust provided a psychological safety and staff wellbeing resource for managers education of which 280 members of staff had completed this.

The division planned activities to ensure the culture and morale of staff was high. Managers wanted to showcase what was positive about the division and bring the team together at recruitment events.

Governance

Leaders operated governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities but did not always discuss and learn from the performance of the service.

There was a clear governance structure and system of accountability to support the delivery of care with surgical governance meetings held monthly. However, this was not always as effective as it could be. In response to the large number of patient safety never events across both locations, the provider commissioned a never events task and finish group led by the trust's chief nurse and chief medical officer. The group was formed with the purpose of reviewing actions taken to date to mitigate the risk of further never events occurring and what additional actions could be taken to further reduce the risk of re-occurrence. The group had formulated a never event improvement plan which identified issues, actions required, a timeframe for achievement and a monthly update report to the safety and risk committee. The trust was also seeking external support from NHSE/I for a review of relevant systems/processes/culture to add an objective assessment to the trusts' insight.

We found leaders did not always understand fully the root cause of some never events occurring at the trust. The trust had a method of implementing actions and sharing widely the lessons learned for serious incidents and never events with staff within the division but not across the whole trust. Oversight and monitoring of actions plans were not as effective as it could have been. We found several instances of repeated actions that had not been completed in a timely manner to prevent other serious incidents and never events occurring. For example, human factors and training were not mentioned in the never event improvement plan. The human factors training was only mentioned in 2 investigation reports despite it being a significant factor in most of the never events that had occurred. Human factors methodology was used as the investigation technique of a never event. Human factors training for staff has been established since first being identified as a requirement as an action in 2021. However, no theatre staff, except on induction, (apart from anaesthetists) have completed this.

At the safety and risk meeting in October 2022, the trust acknowledged they were not sufficiently assured that all the steps taken, to minimise the amount of never events, were being taken. Whilst individual investigations were completed, the trust recognised the need to join up the learning and communicate this between all trust locations.

There was a programme of clinical and internal audit to monitor quality and operational processes, but it did not monitor performance closely enough. There were definite challenges with the new integrated electronic patient record system as full oversight of the service provided by the division was not possible. Audits results were currently unavailable due to the implementation of the new integrated electronic patient record system since October 2020 and had also been postponed during the pandemic. This did not give managers sufficient oversight of performance and the need for improvement. We saw some evidence of 5 steps to safer surgery audits and a 'stop before you block' audit recorded and reported up through the governance system as they were completed manually.

Medical and nursing staff at junior levels told us they were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Leaders and teams used systems but did not always 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.

Leaders and teams did not always use systems to manage performance effectively. They were not always able to identify and escalate relevant risks and issues or identified actions to reduce their impact. However, they had plans to cope with these issues. The service had implemented a new electronic patient record system in October 2020. Since then, there had been a lack of clinical audits carried out. Clinical audits highlight any good or poor performance in different ward areas. For example, there had been no MUST audits since the start of the pandemic, or falls audit performed in the last 12 months. This meant there was a gap in the governance process as it was difficult to celebrate or drive improvement in areas when there was no information on how the service was performing.

The trust shared how the implementation of the integrated electronic patient record (EPR) has enabled advancements in many aspects of safe patient care and service delivery across the trust. The trust is recognised nationally in this area being the first in the UK to go live with an integrated EPR across acute and community services and providing patients with a single integrated patient record, accessible by primary care. This enables patient information to be shared quickly and securely. The trust was aware of improvements which needed to be made to the EPR system and had a work plan to optimise functionality, provide further end user training and refine governance.

The trust told us they were unable to provide EPR user training in the way they had planned due to the COVID-19 pandemic and social distancing requirements. The trust said this had an impact on end user proficiency which continues to be addressed through other training and educational methods.

The risk register reflected the picture of open risks across the division. However, the risk register did not reflect all the major issues faced within the directorate. For example, the high number of never events that had occurred within the division, the shortcomings of the new integrated electronic patient record system and the lack of internal audit and its impact on oversight of performance and improvement.

There was a clinical governance group responsible for reviewing surgical procedures and developing new local safety standards for invasive procedures.

Diagnostic imaging

Good

Is the service safe?

Requires Improvement

We have not previously inspected diagnostic imaging as a single service. We rated safe as requires improvement

Mandatory training

The service provided mandatory training in key skills to all staff but data showed this was not always completed or training records did not provide an accurate view.

Staff received and tried to keep up to date with their mandatory training. During the COVID-19 pandemic, mandatory training was stood down. When services were restored, the service risk assessed requirements and prioritised moving and handling and resuscitation training. Staff had to cancel training because of sickness to maintain core services. In house training was available but required staff to leave the clinical environment to attend.

Thirteen mandatory subjects were included in update training. For example, the trust target for level 2 resuscitation training and moving and handling was 85%. Current documented overall trust compliance rates for resuscitation update training was 60%. Compliance rates for diagnostic imaging services was 50%. For moving and handling overall trust compliance rates were 70%. Compliance rates for diagnostic imaging were 35%. There was a new training recording system which managers felt did not accurately reflect completion rates. Staff told us they had attended training which had not been fully recorded.

Staff working with radiation had training in the regulations, radiation risks, and the use of radiation. Radiation Protection Supervisors (RPS) completed training every 3 years provided by a University to ensure compliance with Ionising Radiation Regulations (2017).

Managers monitored mandatory update training and alerted staff when they needed to update their training.

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.

Staff received training specific for their role on how to recognise and report abuse. Training compliance rates for safeguarding adults and children, level 1 and 2 in different staff groups ranged from 76% to 86%. Level 3 training had been completed by 54% of staff but concerns were raised it did not reflect the number of staff eligible to attend.

Female genital mutilation (FGM) training was included in safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Diagnostic imaging

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Safeguarding policies for both adults and children were in date. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff told us they had noted an increase in the number of patients attending for appointments who presented with children and expected to leave them in the waiting room during their examination. Advice was taken from the trust safeguarding team who recommended a child over 14 could be left in the waiting room alone if required. To reduce the number of children accompanying adults to the department, patient information leaflets were updated and reviewed to advise patients not to bring children or to consider bringing another adult to the appointment.

Cleanliness, infection control and hygiene

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

Clinical areas were visibly clean and had suitable furnishings. A small number of seats in waiting areas required replacement due to small tears. Linen curtains were noted in ultrasound room 4 and in nuclear medicine, but we did not see evidence of a cleaning programme, other areas had single use disposable curtains, and were in date.

Toilets were visibly clean and well stocked; however, cleaning records were not always present in individual toilets. The service generally performed well for cleanliness. Cleaning audits scored between 96-100% and the service had received a five-star audit twice in the last year.

Staff cleaned equipment after patient contact using specialist cleaning wipes. We saw equipment cleaning was incorporated into daily cleaning checklists for all modalities.

Staff followed infection control principles including the use of personal protective equipment. Hand hygiene audits were completed monthly to assess staff compliance of the five moments of hand hygiene.

In the ultrasound department, gel bottles used were clearly dated and disposed of once they had been open for a month. The trust had a standard operating procedure for ultrasound of the female pelvis and an ultrasound probe decontamination policy. Departmental bi-annual audits indicated 97% compliance to these policies. Results were discussed at the audit meeting and actions set to achieve 100%.

Areas where radioactive materials were kept clean by clinical staff. All restricted areas including waste storage areas were visibly clean and uncluttered. Cleaning staff were only able to enter a room once it had been monitored and declared safe to do so, as indicated by a sign on the door.

Precautions were taken when seeing people with suspected communicable diseases. Where a patient was known or suspected as having a communicable disease, they were given an appointment at the end of the scanning list to enable deep cleaning after their scan.

Environment and equipment

Maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use the facilities and equipment. However, the service did not consistently undertake annual quality assurance of equipment. Staff managed clinical waste well.

Diagnostic imaging

The design of the environment followed national guidance. The main waiting area was next to reception and had good visualisation of patients waiting. However, it did risk patients being overheard if sharing confidential information. Due to the size of the department some patients were directed towards other waiting areas. Different coloured lines on the floor directed patients to the area they needed to go.

Patients had access to call bells where appropriate and staff responded quickly when called.

The nuclear medicine department had swipe access from the main corridor to prevent unauthorised entry. A further entry point from the main radiology department was controlled with a barrier and labelled 'Access to Nuclear Medicine only', this barrier did not restrict access. There was a single waiting room for both 'hot' and 'cold' patients. In nuclear medicine patients who have received radioactive material during their procedure are considered 'hot' due to the risk of unintended radiation exposure to staff and other patients. Patients classed as 'cold' have not yet been exposed to any radioactive material. There were two patient toilets available, however both were labelled 'hot'. Patients or visitors requiring a 'cold' toilet must exit the Nuclear Medicine department by the main door and go into the radiology department. The decontamination utility room had a shower installed should this be required.

The trusts' medical photographer's studio was located with the nuclear medicine department. A demarcation line was noted on the floor at reception, the area beyond this was considered a controlled area.

Resuscitation equipment was readily available. The department had two resuscitation trolleys, one adult and one dual adult and paediatric. Equipment was checked daily and monthly and recorded on a trust electronic system. Documentation was reviewed and compliance rates for checks were 100%. Equipment in the magnetic resonance imaging (MRI) unit was labelled as MRI safe or unsafe to reduce the risk of objects being drawn towards the scanner.

In nuclear medicine the radiation safety policy included detail about radiation risk assessments for staff treating a patient in an emergency. All the projected doses were well below documented safe radiation dose limits.

Staff carried out daily safety checks of specialist equipment. Staff could describe what they would do if any of the checks fell outside of acceptable ranges.

To ensure compliance with Ionising Radiations Regulations (2017), the imaging service had completed risk assessments for all new or modified uses of radiation. These were reviewed every two years or whenever a change occurred. Risk assessments addressed occupational safety as well as considering risks to people who used services and the public.

The service ensured controlled areas (where ionising radiation was present) were restricted to authorised personnel only. Warning lights were seen on doors into all x-ray rooms. Both MRI rooms had lockable doors to prevent unauthorised access to the scanners magnetic field.

The service had enough suitable equipment to help them to safely care for patients. Lead aprons were available in multiple areas. We saw evidence of yearly audits of both general and individually labelled lead aprons. The audit included details of aprons previously condemned.

The service had a medical physics equipment quality assurance programme for all scanning equipment. The medical physics department scheduled 6, 12 or 36-month equipment checks for all modalities depending on the manufacturer requirements. The schedule provided to the inspection team highlighted up to 23 out of 60 pieces of equipment at the site were overdue quality assurance. The report gave no indication of when these were planned for completion.

Diagnostic imaging

Medical Imaging employed two onsite engineers in the department. The engineers had onsite training from diagnostic equipment suppliers. They could fault find then discuss requirements with the supplier who could issue parts to be fitted or send a representative if necessary. As a result, the equipment had less downtime and service contract prices had been reduced.

Staff disposed of clinical waste safely. We observed sharps bins that were labelled correctly and dated.

In nuclear medicine, all radioactive waste bins were shielded and had warning signs stating, 'not to use or empty'. Waste disposal logs included comprehensive details of who and when the waste had been put in or removed from the store. A decontamination trolley containing a spillage kit for radioactive materials was available.

The medical imaging department had an unannounced internal health and safety inspection in February 2022. An action plan was implemented to address the concerns identified and most of these were completed by July 2022.

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 responded promptly to any sudden deterioration in a patient's health. Level 2 resuscitation training included basic lifesaving skills for both adults and paediatric patients.

There were clear pathways and processes for the management of people who were, or became, clinically unwell. Emergency bells linked directly to the emergency department.

The service had two computed tomography (CT) and magnetic resonance imaging (MRI) radiographers who worked closely with the trust resuscitation team to deliver annual refresher training adapted to the local environment. A schedule for CT/MRI resuscitation scenarios had been set for the year. Action plans and learning from these events would be shared with the wider team.

Staff knew about and dealt with any specific risk issues if they arose. The service had access to mental health liaison, specialist mental health support and a learning disability liaison team.

There were processes to ensure the right person got the right scan, at the right time. The hospital implemented an integrated electronic patient record system two years ago. Internal requests came through this system, but external requests were still paper based. Templates had been devised and were completed for external requests. Requests were then emailed to a generic email address for each modality. The service ensured requests were only made by staff or persons in accordance with IR(ME)R regulations.

The service ensured staff were aware of patients who were or may be pregnant, in accordance with IR(ME)R, and Ionising Radiation Regulations (IRR) 2017. We saw posters asking patients to speak to a member of staff before they were scanned if they were, or maybe pregnant. The service had devised a poster specifically for young people to explain why they were asked if they might be pregnant before an examination.

Diagnostic imaging

Staff followed the Society of Radiographers "pause and check" guidance when checking patient's identity before administering injections or scanning patients. If patients were not already cannulated, most were completed within the CT and MRI room itself. Staff had use of a very small room outside CT2 and CT3 containing a chair, hospital couch and a cannulation trolley. The room did not have a door or a curtain to maintain the patient's privacy or dignity.

The service followed the Royal College of Radiologists' Standards for the communication of radiological reports and fail-safe alert notifications. Staff knew the actions to take should unexpected indicators show on a scan.

Staffing

The service had enough 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 several vacancies across different roles. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe, but senior leaders acknowledged recruitment remained a challenge.

The senior management team consisted of a radiology services manager, clinical director for radiology, radiographer lead superintendent and individual modality lead radiographers.

Vacancy rates across staff groups varied within the service. Five radiologists had been recruited over the last 18 months which gave an establishment rate of 19.1 whole time equivalent (WTE). However, the service is funded for 22.6 WTE radiologists.

The service was currently 6.4 WTE under established for radiographers with radiographic assistants the most difficult roles to recruit. Senior leaders worked with Exeter University to support more students and recruited radiology apprentices. International recruitment has been successful as part of a Devon wide recruitment drive.

The main challenges within the nursing team were recruiting to Band 5 vacancies. Recruitment had resulted in the recent employment of a full-time nurse within interventional radiology.

The administration team were generally staffed well, except booking clerk receptionists which had a vacancy rate of 4 WTE.

The service also provided staffing for the Devon Diagnostic Centre based within the NHS Nightingale Hospital Exeter. Agency staff filled these posts with no on call commitments. Moving forward the service wanted to focus on retention through training, and to build resilience in the team and implement a rotational staffing model.

Managers accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance. The manager adjusted staffing levels daily according to the needs of patients.

Across all staff groups, sickness rates were generally low at around 3.8%-4.5% over the previous 6 months.

We saw evidence of induction processes for bank and agency staff. The service had a temporary staffing local induction handbook including details of relevant policies and procedures. Staff completed a checklist alongside a clinical lead before they were signed off to work.

The service had a lone working policy. However, the trust was reviewing lone working across all its sites to create a single policy that reflected current arrangements.

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.

The trust had a patient electronic system which enabled internal electronic imaging requesting. Templates had been developed for each modality for external requests. The completed templates were emailed to a generic email address for each modality. Checks were made every day to ensure all requests were actioned within agreed timeframes. External requests were still paper based. The trust wanted to implement a joint external referring system in the longer term. However, they estimated this could take 6 to 9 months to achieve.

All requests were entered onto the radiology information system. The service ensured imaging requests were appropriate and included the relevant information to allow for requests to be justified in accordance with Ionising Radiation (Medical Exposures) Regulations (IR(ME)R).

Patient request forms we reviewed included all the required information, medical history, and clinical indication for the scan. Requests were electronically triaged daily by the duty registrar.

Administration leads for each modality checked waiting lists and escalated any issues immediately. Daily and weekly meetings highlight any concerns, current waiting lists and good practice.

Results were sent to primary care via the patient electronic system once verified and other external reports were paper based. There was an agreed process for the management of urgent results.

In nuclear medicine most requests were electronic but paper-based requests were scanned into the integrated electronic patient record. Visual checks were completed of patient records post examination to ensure all were correctly completed and scanned into the patient's electronic record.

Medicines

The service generally used systems and processes to safely prescribe, administer, record and store medicines. However, the nuclear medicine radiopharmacy facility did not meet current standards.

Staff followed systems and processes to prescribe and administer medicines safely. The service used patient group directions (PGD) to administer medicines to treat stomach cramps and sodium chloride. PGDs were written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presenting for treatment.

Medicines to treat angina were only administered by doctors within the service. The service regularly reviewed PGDs and discussed medicines that should be included.

Staff stored contrast safely in a lockable cupboard. They monitored and recorded temperatures daily and all contrast was in date. No contrast had been stored in direct sunlight and those in use was temperature controlled. Medicines used to relieve symptoms of angina and treat stomach cramps were kept in a lockable cupboard.

Diagnostic imaging

In nuclear medicine, the team had input from the pharmacy department onsite during the generation of radioactive kits. A quality assurance of aseptic preparation services report (November 2022) reviewed aseptic processes and noted in general practice was good with a high level of pharmacist supervision. However, it highlighted several concerns around the radio pharmacy processes and management systems. Most notable, were concerns around the facility not meeting current standards, increasing the risk of physical and microbiological contamination.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and electronically reported incidents and near misses in line with the service's policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The provider's incident management policy established the threshold to guide staff in line with The Royal College of Radiologists position statement in relation to duty of candour in diagnostic imaging (October 2015).

There was evidence changes had been made as a result of feedback. For example, staff told us about an incident where 100 patients had been put on the wrong waiting list. This had not been picked up because some staff had limited access to the electronic system and were not able to see errors whereas administration managers had full access. The team reviewed the procedure and made improvements so all staff could check for errors on waiting lists daily.

The nuclear medicine department had recently had to defer some scans as a result of a European wide shortage of a radiopharmaceutical drug. Staff told us they had to cancel some patients scans and inform clinical teams of the delay. This impacted cancer pathways and had an emotional impact on patients because of resulting delays in getting a diagnosis. Staff followed duty of candour processes with all affected patients. The situation was not within the control of managers and staff in the service. When the drug became available, staff extended their working day to make the best use of supplies. All cancer patients on the 2-week wait have now been booked for scans as required.

Managers investigated incidents thoroughly and fed back outcomes to staff at daily meetings, a monthly departmental newsletter and trust wide monthly iBulletin. The iBulletin provided details about learning from incidents and deaths within the trust

Is the service effective?

Inspected but not rated

We have not previously inspected diagnostic imaging as a single service. Effective was inspected but not rated at this inspection, in line with our current methodology.

Evidence-based care and treatment

Diagnostic imaging

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service regularly reviewed policies and standard operating procedures which were all date controlled. These complied with Ionising Radiation (Medical Exposure) Regulations 2017, the Royal College of Radiologists and the National Institute of Health and Care Excellence.

The service had a comprehensive clinical and medical imaging audit programme. These included auditing the Computerised Tomography (CT) head imaging policy in emergency situations, quality assurance and regular reject analysis audits. Staff wore badges which were monitored to detect if they had been exposed to harmful levels of radiation. Radiation doses were kept as low as reasonably practicable and radiation dose reference levels were audited for comparison to national levels.

Patient identification audits against the World Health Organisation imaging and 'pause and check' standards had shown compliance rates of 87% in plain film. The trust standard was 100%. Results were shared with staff with reminders to re-read the patient identification standard operating procedure and ensure patients were asked to confirm their details verbally.

Protocols for magnetic resonance imaging (MRI) and CT were all in date, computerised and were reflected on each of the scanners. The protocols reflect all examinations undertaken and were continually revised and updated as live document through standard governance procedures.

A Nuclear Medicine dose and radiopharmaceutical audit showed compliance with Administration of Radioactive Substances Advisory Committee (ARSAC) recommendations. Hand monitoring for any contamination was routine and audited by the medical physics team.

Dual energy X-ray absorptiometry (DXA) scans met standards outlined by the Royal Osteoporosis Society Quality Standards for Osteoporosis and Prevention of Fragility Fractures.

Nutrition and hydration

Staff gave patients food and drink when needed.

Staff made sure patients had enough to eat and drink. Patients were provided with specific instructions relating to eating and drinking prior to their scan within the appointment/booking information if required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patient outcomes

Diagnostic imaging

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 had achieved the Quality Standards for Imaging (QSI) accreditation from the United Kingdom Accreditation Service (UKAS). The QSI were developed by The Royal College of Radiologists and the College of Radiographers. It sets out criteria that define a quality imaging service. UKAS accreditation is a patient-focused assessment designed to give patients and their carers confidence in their diagnosis and all aspects of their care. As a result of the trust merger, the aim is to achieve QSI across all locations in 2024.

The service participated in relevant national clinical audits. The service regularly reviewed the effectiveness of care and treatment with a structured audit programme to include both local and national audits. Managers and staff used results to produce action plans and improve patient outcomes.

The service used a mixture of onsite and teleradiology remote reporting. Key performance indicators (KPIs) for reporting were 14 days for routine outpatients, 48 hours for cancer and urgent pathways and 24 hours for inpatients. KPIs were challenging, especially for cancer and urgent pathways, for the service in the current climate. For example, in the 6 weeks from 10 October to 14 November 2022, the average reporting time compliance for cancer CT scans was 53% and for MRI urgent scans was 47%.

We observed a departmental video call focused on reviewing long waits. Data discussed showed significant improvements had been made to reporting times over the last 6 months however, managers were aware that not all modalities were fully compliant.

Competent staff

The service made sure staff were competent for their roles. However, managers had not appraised work performance for all staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received specialist training for their role and were able to develop their skills and knowledge.

Staff maintained up to date training on the safe use of equipment in line with their professional registration and manufacturer guidance. Nursing staff and radiographers were supported to maintain registration with relevant clinical bodies.

Managers were keen to support staff to develop through yearly, constructive appraisals of their work. Due to ongoing workload pressures current appraisal rates were only 28% within the service, overall rates for the trust were currently 68% against a target of 80%. Managers hoped to set appraisal dates for staff as soon as able.

In the 2021 staff survey results showed staff had a clear understanding of their work responsibilities. This was maintained through good induction to the service with a clear training structure and staff competencies.

Managers showed us evidence of a full induction tailored to their staff members role before they started work in the service. General induction included an introduction to the team, department and facilities, equipment training, policies and procedures including IR(ME)R and local rules.

Diagnostic imaging

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.

Patients could see all the health professionals involved in their care at one-stop clinics if required thus reducing the need for patients to attend multiple appointments.

Seven-day services

Key services were available to support timely patient care.

The service provided access for plain film 24 hours a day, 7 days a week. Two x-ray rooms were situated next to the emergency department to facilitate this, and mobile imaging equipment was also available. Out of hours advice was provided as part of the Peninsula Registrar on call system.

The service made good use of the Devon Diagnostic Centre based within the NHS Nightingale Hospital Exeter. Patients who had been referred by their GP were given the option of attending this service for plain film, CT and MRI scans.

There was an on-call system for CT during evenings and weekends. The site is a trauma centre and patient access to CT scans may be required at short notice.

Whilst onsite, inspectors expressed concern that the on-call system for CT meant staff did not have to be onsite but would be called in from home when required. The caveat was staff had to be able to scan patients within 30 minutes of being called out.

After further discussion with staff and managers, the inspectors were reassured that due to increased demand, on call staff were present in the department most of the time. The service had not reported negative outcomes as a result of the on-call system. Key indicators for some national audits were reviewed. For example, the Sentinel Stroke National Audit Programme (SSNAP) data did not indicate any concerns in relation to key indicators for CT head targets.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Diagnostic imaging

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If staff felt a patient lacked the capacity to consent to the procedure, they would seek further advice from the referrer. Patients were provided with written and verbal information prior to their appointment to enable them to understand the planned diagnostic test.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During the COVID-19 pandemic, CT scan consent was changed to verbal rather than written and we observed this practice during the inspection. Managers acknowledged they had not revised consent within the CT safety form recently and immediately changed consent back to written after discussion with staff members.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff could describe and knew how to access trust polices on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

We have not previously inspected diagnostic imaging as a single service. We rated caring as good.

Compassionate care

Staff 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. Patients told us staff were amazing and treated them well and with kindness.

We observed one patient who arrived a little confused about where to go. A member of the reception team reassured them by escorting and making sure they were settled in the right waiting area. Staff coming into the waiting area to collect patients were calm, welcoming, and explained who they were.

The service conducted a patient experience survey and reported on them every 6 months. In July 2022 the questionnaire was changed slightly to indicate which site the patient had visited. There were 859 patients (19.6%) who responded to an email invitation to complete the survey a day after their examination. Results showed 62% of patients were very satisfied with the comfort and cleanliness of the waiting area. There were 80% who were very satisfied their privacy and dignity was maintained during the visit and 76% felt their examination was explained in full.

Diagnostic imaging

Staff followed policy to keep patient care and treatment confidential. However, patients did comment in the survey they could hear other patients' confidential information whilst in the main waiting room.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patient information notices showed information about chaperones and patients were offered the choice of who chaperoned them.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. MRI Staff provided patients choices to listen to music, wear headphones and provided ear protection to reduce stress during scans.

Individual adaptations were made for patients who were particularly anxious or concerned about their planned examination. For example, staff told us about a very anxious patient who felt they would need sedation prior to their examination. Staff invited them to the department and gave them a tour of the area where the scan would take place. The patient's anxiety reduced enough for them to be able to proceed without sedation.

The MRI team had a virtual reality headset available for adult and paediatric patients who are particularly anxious. The associated video simulates a real MRI scan and has helped patients understanding of what the procedure involves before attending.

Staff also told us about a paediatric patient who was very anxious about having an MRI scan and might require sedation. Staff worked together to come up with a solution and one of their neighbours knitted a teddy bear for the patient to take into the scanner. This resulted in the patient successfully having the scan without the need for sedation. Staff now keep a supply of the teddy bears available in the department to help their paediatric patients.

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 made sure patients and those close to them understood their care and treatment. Information sheets were available for patients as well as concise information about each modality available on the hospital's website. Information boards in the waiting areas displayed relevant information about staff uniforms, pregnancy status and updates about the department.

Staff spoke with patients, families and carers in a way they could understand, using communication aids where necessary. We observed printed and laminated information sheets in the main waiting area about using signing to support speech.

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

Diagnostic imaging

Staff supported patients to make informed decisions about their care. We saw staff gain consent, either verbal or written depending on the modality. This included checklists with details of contraindications and any contrast medium to be used.

Is the service responsive?

Good

We have not previously inspected diagnostic imaging as a single service. We rated responsive as good.

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 changing needs of the local population.

Facilities and premises were suitable for the services being delivered. The main waiting room was a good size and seating was available for the number of patients and allowed for social distancing. There were several smaller waiting areas in the department for specific modalities with changing facilities and toilets available. There was no separate waiting area for children and young people. However, one of the x-ray rooms had been decorated with a jungle theme to appeal to younger people. There was enough car parking, including disabled parking, available onsite for a charge. The department was clearly signposted with lifts and wheelchair access throughout.

The service had systems to help care for patients in need of additional support or specialist intervention. Play specialists were available onsite if required for paediatric patients.

For those patients coming from the inpatient wards, timing was considered to support their other medical needs. Managers reviewed the hospitals trajected position every morning to ensure they could facilitate diagnostic demand and timely patient discharge.

Waiting areas for inpatients were not always private and at times located in corridors. We observed patients waiting on beds in the corridor outside CT2, other patients had to walk past them to access the area.

The service had its own dedicated porters. They were available 9am to 6pm Monday to Friday and Saturday and Sunday mornings until 2pm. Staff entered requests for porters on the patient electronic system and porters accessed the request on mobile devices. The system alerted the porter to any additional patient requirements, such as portable oxygen, to promote ease of transfer.

The service was aware of the need to minimise the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion if possible.

Diagnostic imaging

Managers monitored and took action to minimise missed appointments. Staff were also available by telephone to discuss any concerns. When booking appointments, staff considered the time and location of each patient. Along with other local trusts the service made good use of the Devon Diagnostic Centre based within the NHS Nightingale Hospital Exeter. If possible, patients referred externally would be offered appointments at this location to release capacity.

The service had a standard operating procedure for patients who did not attend (DNA) their appointment. If a patient DNA and were provided more than 3 weeks' notice of the appointment, the referral was cancelled and returned to the referrer with an accompanying letter. The referrer was responsible for following up the patient and re-requesting the imaging as a new event if required. If the request was for suspected cancer/paediatric patients or those considered vulnerable on the electronic alert system, a further appointment would be arranged. If the patient failed to attend a second time or the appointment was refused, the referring clinician was informed, and the patient removed from the waiting list.

Managers worked to keep the number of cancelled appointments to a minimum by giving 3 weeks' notice of appointments if possible. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. DNA rates ranged from 0.80% for CT guided interventional procedures to 7.56% for dual-energy X-ray absorptiometry (DXA) bone density scans. Some modalities had been impacted by recent postal strikes. Examinations that required medicines to be taken beforehand faced challenges with getting the medicines to patients. Staff encouraged patients to pick up the required medicines from the hospital if possible. The issues were highlighted to referring clinicians, the division and trust leaders at the time.

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 access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by patients and the local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care. Managers and staff were very aware that 6 week waiting times for treatment was not always in line with national standards.

National reports on waiting times for key diagnostic tests highlighted differences amongst modalities. Overall, the number of patients waiting over 6 weeks had decreased over the last quarter. The trust board papers indicated that 64.3% of patients were waiting less than 6 weeks as of January 2023. However, numbers of patient waiting over 6 weeks for urodynamics (urine pressure and flow tests), echocardiology and non-obstetric ultrasound were consistently high.

Diagnostic imaging

Managers and staff were acutely aware of the waiting times, mainly due to staffing shortfalls and ongoing backlogs from the Covid-19 pandemic. The trust planned a regional focus on diagnostic imaging in March 2023. The goal is to achieve a consistent reduction in 6 week wait backlogs.

Managers worked to keep the number of cancelled appointments to a minimum by giving 3 weeks' notice if possible. If less than 3 weeks patients were phoned to inform them of their appointment date and time.

When patients had their appointments cancelled at the last minute, managers rearranged them as soon as possible.

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, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

The hospital had a management of complaints, concerns, comments and compliments policy. The version we saw was out of date at the end of November 2022. Staff understood the policy and knew how to handle them.

The policy stated that written complaints should be acknowledged within three working days by telephone or email depending on patient preference. If the patient was not raising the complaint, a consent form was sent with an acknowledgement letter for the patient to sign. Details of the complaint were then entered onto the incident reporting management software programme. The recommended maximum timeframe for resolving a compliant was 6 months. The trust had established an internal timeframe for all issues to be responded to within 45 working days.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good

We have not previously inspected diagnostic imaging as a single service. We rated well led as good.

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.

Leaders had the skills, knowledge and experience needed to run the service. Leaders were knowledgeable about issues and priorities relating to the quality and future of services and understood the challenges the service faced.

Diagnostic imaging

There was a clearly defined leadership team who led the day-to-day operation of diagnostic imaging. Individual services had a lead or named point of contact.

Staff told us leaders were visible, approachable and offered a high level of support especially weekends and on call rotas.

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 trust had a strategy focused around working with patients, staff, stakeholders, and partners, called 'Better Together'. Their mission was to help people stay healthy and to care for people when they were not. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. Services had been planned to meet the needs of the relevant population and progress was monitored and reviewed.

Managers aim to develop a workforce plan for the next 5 years. Staff including the radiology services manager and lead superintendent radiographers were attending workforce planning master classes as part of a southwest initiative programme. The current focus is general x-ray staffing but would progress to include all areas of diagnostic imaging over time.

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.

The culture was centred on the needs and experience of people who used services. Individual service leads led a culture of improvement and excellence.

Staff told us they could raise concerns and were encouraged to do so. They had confidence these would be addressed. The service had access to a Freedom to Speak Up Guardian. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

The service demonstrated openness, honesty and transparency when responding to incidents and complaints. Managers were aware of and had systems to ensure compliance with the requirements of duty of candour.

Governance

Leaders operated effective daily and weekly governance processes in all modalities. Staff at all levels were clear about their roles and accountabilities.

Managers held monthly meetings covering key aspects of performance and safety monitoring. Records showed these meetings were well attended with actions recorded, shared and monitored.

Diagnostic imaging

The service had daily and weekly staff meetings, actions were recorded and shared with all staff. Each modality had a monthly meeting which explored relevant issues and updates as required.

Managers were aware that a new electronic training record system did not accurately reflect mandatory training compliance. This had been escalated to senior leaders in the trust as it was acknowledged to be a trust wide rather than a local issue.

All modalities had daily and weekly quality assurances processes in place as required, however, some were overdue medical physics quality assurance checks.

Managers were aware of challenges they faced especially in terms of staffing and building resilience into the team.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated risks but had not always identified actions to reduce their impact. They had plans to cope with unexpected events.

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit.

Managers monitored risks within the provider's overarching risk register and management process. Each record had undergone a full risk assessment which included detail about mitigation and actions. Risk registers were reviewed by the service and divisional governance groups. In addition, the trusts risk manager held risk surgeries to review.

The trust had business continuity plans in place to cope with unexpected events.

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 submitted to external organisations as required.

All staff were required to complete data security and protection awareness training updates. Staff used their training to work within the provider's data protection policies and ensure they avoided risks associated with data breaches. This ensured they protected patient identifiable data and acted with integrity when handling personal information.

The service had an internal electronic information and patient record system and systems were password protected. External communications were still largely paper based at the time of the inspection. Information was used to measure improvement.

Teleradiology reporting services had service level agreements (SLAs) in place.

The service was aware of its responsibilities around IR(ME)R reportable incidents. Incidents were investigated, with oversight from the Radiation Protection Advisor and the Medical Physics Expert.

Engagement

Diagnostic imaging

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.

Managers engaged with staff using a variety of methods, including annual staff surveys, team meetings, electronic communication, and informal discussions.

People's views and experiences were gathered and acted on to shape and improve the services and culture. Staff encouraged patients to complete a friends and family survey following their appointment.

The team had service level agreements with other hospitals in the regional network and provided reciprocal support in the event of equipment failures or other service disruption.

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.

Leaders and staff aspired to continuous learning, improvement and innovation. Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which lead to improvements and innovation.

The trust has a yearly staff award system. Last year the led radiographers for MRI/CT were given an excellence in practice award.

Radiologists identified a need for, developed a service and are now a centre of excellence for the treatment of lung tumours. They have also developed a standard operating procedure for performing foetal head MRI scans to prevent the need for patients to travel to Bristol for this procedure.