Northern Devon Healthcare NHS Trust

North Devon District Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at North Devon District Hospital

Requires Improvement 

We carried out a short notice (30 minutes) comprehensive inspection of medical care at North Devon District Hospital (NDDH) on 13 and 14 July 2021 because we were concerned about medical staffing levels. The aim of this inspection was to understand the extent of the staffing issues and the impact on patient care within medical care at the hospital.

Northern Devon Healthcare NHS Trust (NDHT) provides integrated acute and community health and care services across north Devon together with a range of specialist community services across Devon and Cornwall.

There are 2,939 staff delivering services across a wide geographical area, including in people's homes, clinics, five community hospitals and the acute district general hospital (NDDH). The trust has 275 acute and general beds, 17 maternity beds and 8 critical care beds.

NDDH is the most remote acute hospital in mainland England, with over an hour and a half drive from its nearest neighbouring acute hospital. NDDH, located in Barnstaple, provides 24-hour emergency and urgent care, seven days a week and has an intensive care unit, women's and children's services and full diagnostic and outpatient services including an endoscopy unit and pathology laboratories. The hospital also has a stroke unit, medical and surgical specialties, paediatric care, a maternity unit and a special care baby unit.

In 2020/21, staff at North Devon District Hospital treated 35,702 inpatients, 385,799 outpatients and delivered 1,171 babies. They also saw 44,447 patients in the emergency department.

The medical wards are Staples Ward (stroke), Capener Ward (gastroenterology), Fortescue Ward (Healthcare for the older person ward), Tarka Ward (acute respiratory ward) and Victoria Ward (Cardiology, haematology and oncology).

Medical care (including older people's care)

Requires Improvement 

Our rating of this location went down. We rated it as requires improvement because:

- The shortage of medical and nursing staff meant patient safety was not always maintained. Staff identified patients at risk of deterioration, but they did not always provide care in a timely manner. The system of allocation of patients to doctors in some areas was not clear and led to confusion for nursing and medical staff when patients needed urgent medical review. Care records were not always complete and/or legible. Medicines were not always well managed. Mandatory training was below the trust compliance target of 85%.
- In some cases, patients were admitted onto medical wards which were not designed or equipped to deal with their specific illness or needs. There was a shortage of medical staff and the arrangements to cover this shortage were not always effective. These arrangements did not ensure continuity of care for some patients.
- Processes to oversee locum doctors' activities were not established.

However:

- Staff understood how to protect patients from abuse. Infection risks were controlled well and staff kept equipment and the premises visibly clean. Staff managed clinical waste well. Staff completed and updated risk assessments for each patient and removed or minimised risks when possible.
- Managers monitored the effectiveness of some aspects of the service. Staff worked well together in most cases, for the benefit of patients. They advised them how to lead healthier lives and supported them to make decisions about their care.
- Patients were complimentary about the meals and availability of food and drinks. Staff ensured patients had enough to eat and drink and gave them pain relief when they needed it.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Staff felt pride in their role and the work they undertook.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- There was a new leadership team and while they were yet to be fully established, they understood risks to patients and shared the same vision and strategy to improve care.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to continually improving services.

See the medical care section for our detailed findings.

How we carried out the inspection

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

Medical care (including older people's care)

Is the service safe?

Requires Improvement 

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

Mandatory Training

The service provided mandatory training in key skills to all staff and had a system to track compliance. Training compliance fell below the trust target largely because of the impact of COVID-19.

Most staff kept up to date with their mandatory training. The trust recorded staff training and had a red, amber and green system for staff compliance across the medicine division. Training compliance above 85% was green, between 65% and 85% was amber and less than 64.9% was red. As at 30 June 2021, the trust had 11 training subjects which were green, 14 which were amber, and one which was red. The one red subject was Safeguarding Adults Level 3 at 63%. Moving and handling compliance, rated amber, was also low at 69%. However, this training had been impacted by COVID-19 and the ability to conduct face to face training.

Staff told us they did not always have access to all the training they required to carry out their day to day jobs. For example, some staff nurses told us they were not given access to Intermediate Life Support Course (ILS) which would give them enhanced knowledge when they had to take charge of the wards.

The trust told us preceptors and new starters who held or would hold a professional registration had a short session on sepsis within the preceptorship course. Most registered nurses working on wards would be offered a place on the ILS, which covered recognising the deteriorating patient (including sepsis). For any registered nurses who had not been offered a place on ILS because of the specific areas they worked on, they attended 'Group A Resus training' (yearly and mandatory). This session included a three-hour learning on recognising the deteriorating patient, sepsis and sepsis management.

Annual Infection Prevention & Control (IPC) training was rated as amber at 76%. However, IPC two-yearly training was green at 92%.

The trust performed well for Dementia training, Equality, Diversity & Human Rights; Health, Safety & Welfare; Resuscitation; safeguarding adult level 1; and safeguarding children level 1, all of which were over 90% compliance.

Although the compliance rate for mandatory training was below the trust target, training was comprehensive and met the needs of patients and staff. For example, clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Face to face training could not take place because of COVID-19 restrictions. This training was provided using Microsoft Teams or as an online training package.

Staff told us they were encouraged to complete their training and would be paid overtime if they undertook training in their own time.

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.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. All the staff we spoke with said they knew how to escalate a safeguarding concern and were aware of the provider's dedicated safeguarding team.

The trust had achieved its training target of 85% or above for Safeguarding Adults and Children level 1 and Safeguarding Adults and Children level 2. However, it had not achieved this for level 3 safeguarding adults or level 3 safeguarding children, which were 63% and 65% respectively as at 30 June 2021.

Cleanliness, infection control and hygiene

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

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

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Cleaning staff told us there was a regular cleaning schedule for them to follow which covered all areas of the wards. We reviewed cleaning audits between May and July 2021 for three medical wards which showed cleaning standards improved when shortfalls were identified.

Staff followed infection prevention and control (IPC) principles including the use of personal protective equipment (PPE). We observed staff wearing necessary PPE on wards when attending to patients. Patients told us they had no concerns about IPC.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. This ensured the risks of cross contamination were minimised. Staff disposed of clinical waste safely. Hand hygiene audits indicated a good standard of compliance.

Data from the trust for June 2020 to May 2021 shows that they have a low level of infection rates for methicillin-resistant staphylococcus aureus("MRSA") and Clostridium Difficile ("C. diff"). Nationally, the trust was in the 25% of trusts with the lowest levels of MRSA and C. diff per 100,000 bed days.

On Tarka Ward we found a hazardous cleaning substance (Taski Sprint Spitfire Spray) which may be damaging to a person's health stored in an unlocked room that could be accessed by unauthorised persons. We notified staff of this who took prompt action to secure this product.

The trust had four COVID-19 outbreaks during the pandemic. The trust implemented actions to minimise the spread of infections and control the risks to patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients told us they could reach call bells and staff responded quickly when called. They told us there were enough facilities available and they could access them when required.

The service had suitable facilities to meet the needs of patients' families. Patients told us there were limits on the number of visitors they were allowed to have in line with COVID-19 restrictions.

Consultant doctors reported a lack of a suitable environment to work in. Consultants did not have adequate room and clinical space to facilitate a move to virtual appointments. The trust was aware of this issue and was looking at options to create more clinical consultant rooms.

Staff carried out daily safety checks of specialist equipment. There were recording sheets for the checks that had been carried out and these were submitted for monthly audits

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Nursing staff identified and quickly acted upon patients at risk of deterioration. However, medical staff did not always attend to deteriorating patients in a timely way.

Staff told us they were frustrated about the lack of clarity of which doctor was responsible for which patient. Some of the wards had patients with different needs to the speciality of the ward, which meant there were different doctors on the wards throughout the course of the day. We were told as a small district general hospital, it was not always possible to have wards for each specialty. This contributed to the issues when staff raised deteriorating patients to doctors. They told us sometimes doctors would not know if a patient was on their list. In one case, staff told us they had to ask a doctor to verify their list to confirm if they had responsibility for the patient.

We were told in several cases, doctors did not answer when they had been paged. In one case, staff had to contact the intensive care unit to ask one of their doctors to urgently review the patient. This created unnecessary delays to the care of a deteriorating patient. We reviewed two serious incident reports which were related to patients not being seen in a timely way. One incident related to the lack of senior consultant oversight, the second was a case at the weekend where a second opinion was not accessed in a timely way.

Staff completed risk assessments for each patient on admission using recognised tools. They reviewed these regularly, including after any incident. They used Situation, Background, Assessment, Recommendation (SBAR) and national early warning score (NEWS2), which recorded clinical indicators and required staff to respond when the score reached or passed certain limits. Both were nationally recognised tools to identify and escalate deteriorating patients. Nurses escalated deteriorating patients by raising this directly with the doctor responsible for the care of the patient, or by paging them. However, we were told there were instances when the medical staff did not respond in a timely way. We saw evidence of this in two cases: one patient was experiencing chest pains and the other respiratory difficulties. Both waited for an hour or more for the doctor to assess them and administer appropriate treatment.

The trust audited the NEWS2 charts. Compliance against observations at the correct frequency was generally good across the medical wards. However, the audits did identify learning points around complying with fluid input and urine output monitoring across all the medical wards.

On Tarka Ward staff had designed a wall-mounted folder of patient care information for staff, for example information about Type II Respiratory Failure. The folder was easy for staff to access and could be easily cleaned after each use. This helped to improve accessibility of information to patients and staff.

Staff knew about and dealt with any specific risk issues. Nationally recognised tools for assessing and mitigating risks were used, for example for venous thromboembolism (VTE), falls and pressure ulcers. (VTE is a condition in which a

blood clot (a thrombus) forms in a vein, most commonly in the deep veins of the legs or pelvis). A whiteboard was placed on the entrance to each bay with anonymised patient details. The board contained essential patient information including NEWS 2 score and when observations were next due. This meant staff could find information about the patient's health needs, especially if they were from an unfamiliar ward, and patient observations could be performed in a timely way.

We looked at 12 VTE assessments. There was a VTE assessment for all 12 patients, however we saw some were not signed as having been reviewed by a consultant.

Staff completed or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had access to mental health liaison and specialist mental health support from 8am to 10pm on weekdays and from 10am to 6pm on weekends. This service was provided by another trust. During out of hours on weekdays and weekends, urgent referrals or assessments were undertaken by the psychiatric on call junior doctor or the night nurse practitioner from another nearby trust. The psychiatric team told us they provided training, guidance and support to staff to enable them to provide care tailored to meet the needs of patients with mental health issues. The psychiatric team told us they aimed to see patients referred from the emergency department within one hour and all other patients within 24 hours. There was not a Child and Adolescent Mental Health Services team locally. This meant children and adolescents experiencing mental ill health could not access support from a dedicated team in a timely fashion.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank, agency and locum staff a full induction. However, they were not always able to fill gaps in staffing.

Managers calculated and reviewed the numbers and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, they could not always adjust staffing levels daily according to the needs of patients. The trust did not use an acuity tool to assess the needs of patients when calculating nurse staffing levels. We were told bed space, and not acuity of patients or staffing levels, was the only measure used to calculate how many patients were cared for on each ward.

The service had reducing vacancy rates. The Medical Admissions Unit had only one nurse vacancy after successfully recruiting from oversees. However, they had undertaken a skill mix evaluation and identified there was a shortage of between three to four senior nurses to enable more senior presence on the unit. They currently used bank staff who knew the unit well to fill senior positions. Other medical wards had also successfully recruited nurses from overseas. For example, on Capener ward two nurses were awaiting to complete their assessments and receive their Nursing and Midwifery Council registration so they could start practicing as registered nurses.

At trust level, contracted whole time equivalent (WTE) nursing staff increased by 28 between March 2019 and March 2020 and increased again by the same amount between March 2020 and March 2021.

The trust had decreasing sickness rates between January and April 2021 for nursing staff. For example, sickness rates reduced from 4.4% in January 2021 to 4% in April 2021. *(Source: Electronic Staff Records)*

There were quality information boards on all the wards we visited. These could be seen by patients, their relatives and staff. The boards showed how many staff should be working on that shift and how many staff were actually working. The

numbers of nurses and healthcare assistants did not always match the planned numbers. On the first day of our inspection one ward had a full establishment of staff, and one ward was one registered nurse short. Nursing staff told us the wards were regularly short of nursing and support staff. Seven of the 11 nurses we spoke with said at least once a week they did not have the full establishment of staff on their wards. If they did have a full staff establishment at the start of a shift, a member of the team could be moved to cover staff shortage on another ward leaving their ward short. We also visited a ward where a band 5 was the nurse in charge due to shortage of staff. Usually the nurse in charge is a band 6 and has more experience, however this was not uncommon nationally.

Information provided by the trust showed on average between April and June 2021, 84% of vacant nursing hours were filled with bank and agency staff. Sixteen percent remained unfilled.

Although managers limited their use of bank and agency staff and requested staff familiar with the service, this was not always possible. We were told sometimes they would only be to cover the last hour or two of the shift. We were told there were times when bank or agency staff were either late or did not turn up for their shifts. When these situations happened, managers were informed and they worked hard to try and resolve the issues which sometimes meant moving staff around where it was needed more or supplying more healthcare assistants to support the wards in need. We were told in some cases, managers stepped in to cover staff shortages.

Managers made sure all bank and agency staff had a full induction and understood the service. Staff working on the bank told us the induction was good and they were well supported.

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 and gave locum staff a full induction. There was a lack of oversight of locum (non-substantive doctors who did not have a permanent contract) activities when providing medical care.

The trust had support from another trust with consultant cover during the week. For example, North Devon District Hospital received consultant support for gastroenterology from the other trust twice a week. The rest of the week, excluding weekends, cover for the service was provided by one substantive consultant and one locum doctor. There were arrangements with the surgical division to provide weekend cover and support in emergencies, for example if a patient experienced gastro-intestinal bleeding.

The Trust had experienced a shortage of medical staff since 2019 and had been trying to recruit since then. Locum doctors were often used to cover the medicines division. Six long term locums were used to cover the medical admissions unit, health care for older people, gastroenterology and general medicines. There were arrangements for locum doctors to contact consultants at another trust for specialist advice if required. We received feedback that locum doctors at the hospital rarely contacted the team at the other trust for advice.

We were told a shortage of doctors on the ward did not always allow for a comprehensive review of patients and led to a lack of continuity for patients. We were told of a serious incident which was currently being investigated where a patient who required specialist care for feeding did not receive appropriate care over a weekend as there was a lack of medical staff available. The shortage of medical staff often led to pre-discharge medical reviews being delayed, which prevented patients from leaving the hospital in a timely fashion.

Medical care (including older people's care)

The service did not always have a good skill mix of medical staff on each shift. The shortage of medical staff meant sometimes junior doctors were placed where they were needed more, as opposed to the planned rotation. Some doctors told us they had to cover general medicine when they were planned to work in another specialty as part of their training. We were told some junior doctors were concerned about the pressure to fulfil their training requirement of completing 100 clinics within a three-year period. Because they were often required to cover the wards due to increased demands and shortage of staff, they were concerned they could not spread the number of clinics over the three-year period to make it more manageable.

Actions identified were not always viable or did not ensure continuity of care. For example, for the stroke unit it was not possible for the trust to find a suitable locum to support the service when the single-handed stroke specialist was on leave or unavailable.

Although the service had low turnover rates for medical staff, the issues they faced with recruitment were partly due to the rurality of the hospital. In addition, the clinical model operated by the hospital meant consultants were required to cover general medicine, which sometimes did not attract new recruits. At trust level, the number of contracted whole time equivalent (WTE) consultants in post in March 2021 was one more than in March 2019. Non-consultant medical staff had increased by 21 WTE over the same period.

In January 2021, 31% % of all medical staff working in medical services at the trust were consultants, which was lower than the England average of 45%. The proportion of junior (foundation year 1-2) staff was higher than the England average by 8%. Information provided by the trust showed there was a 54% vacancy of consultants, for which they received 6% support from another trust. We were told there was a 20% vacancy for specialty doctors. The trust was recruiting to those posts and expected to appoint in July 2021. There was additional temporary funding for five whole time equivalent junior doctors, and they had a full complement at the time of our inspection.

Records

Staff did not always keep detailed and up-to-date records of patients' care and treatment. Records were stored securely and easily available to all staff providing care.

Staff could access patient notes easily when needed and they were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records.

However, we reviewed six sets of patient notes and found:

- Notes did not always contain a record of the time or date and they were not always filed chronologically. This made it difficult for staff to have accurate and up to date information about patient care.
- Paperwork which required a signature was not always signed. This meant the trust could not assure itself patients had been reviewed by a consultant within a set period of time as per national guidelines. It could also be difficult to investigate incidents if something went wrong as the trust would not know who was involved in the care of the patient.
- Notes were not always legible. This meant staff could not easily read information about patient care.
- Some of the documents referred to in the patient notes could not be found in the file. This meant there was not an accurate record of patient care and treatment. For example, in the notes of a patient who had received an alcohol detoxification, a reference was made to their Clinical Institute Withdrawal Assessment for Alcohol (CIWA). However, their CIWA was not filed in their clinical notes.

Medical care (including older people's care)

Medicines

The service had systems and processes to safely prescribe, administer, record. However, the storage of medicines including medical gases did not always reflect local practice and staff did not always follow them.

Medicines were seen to be stored safely and keys were kept in the possession of a dedicated member of staff. Temperatures of medicines fridge were not always monitored in accordance with Trust policy and where this was identified an incident was reported.

Different wards followed different processes for the storage of Glucagen®. On some wards this was stored in the 'Hypobox' whilst on others it was stored in the medicines fridge. While there was no issues with the management of these medicines on individual wards, there was a potential that if a member of staff was not familiar with the process on that particular ward, there could be a delay in obtaining the correct medicine.

Oxygen was not always stored safely. Tarka ward had oxygen cylinders stored on the floor and not secured. This was a fire safety hazard and a health and safety risk as they were not secure and could fall on someone and cause injury. We raised this at the time of the inspection and action was taken to store these cylinders safely.

Antimicrobial reporting was disrupted during the pandemic and there was no annual report submitted to the Infection Control Operational Group. The trust had now started reporting on antimicrobial usage on a quarterly basis.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff followed current national practice/guidance to check patients had the correct medicines. Patient medicines were seen to be reconciled mostly with 24 hours, although this was sometimes longer when admission took place over the weekend.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trust operated an incident reporting system on which staff could record any medicine safety concerns. Staff told us they would get updates locally about errors and incidents.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents but they did not always report near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. In most cases, when things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Most staff knew which incidents to report and how to report them. However, a few staff said they did not always report near misses and they were not aware of their responsibility to do so. This meant opportunity to learn from near misses did not always occur. We were also made aware of a few cases where staff were labelled negatively if they reported too many incidents. This prevented staff from reporting some incidents, but specifically from reporting when they thought their ward was short staffed.

Staff told us they were sometimes too busy to report incidents. However, staff reported serious incidents clearly and in line with trust policy. They said they always reported certain incidents such as falls, pressure sores and medicines errors but they regularly did not report being short staffed. Equally, due to pressures and demand, medical staff told us they sometimes asked the nursing staff to report incidents on their behalf, but they could not confirm if these requests were always carried out.

Medical care (including older people's care)

Staff understood the duty of candour. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were able to explain what the duty of candour was and when it should be applied. We saw evidence in patient's notes of the duty of candour being applied following a prescribing error. Duty of candour was also completed on serious incidents. However, one patient told us of an example where they had not received an explanation and apology when things went wrong. This was when a member of staff did not successfully insert a cannula and the medicine was administered into their flesh. This resulted in the patient experiencing a temporary lump in their arm and was disappointed the nurse had not apologised and explained what had gone wrong. This was a known risk for these types of procedures. (A cannula is a thin tube which healthcare staff insert into a person's to administer medicine).

Staff received feedback from investigations of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care and there was evidence changes had been made as a result of feedback.

The 2020 NHS staff survey showed:

- Sixty-seven percent of staff who responded stated the trust treated staff who were involved in an error, near miss or incident fairly. This was a slight decline from the previous year's result.
- Seventy-three percent of staff who responded stated when errors, near misses or incidents were reported, the trust took action to ensure that they did not happen again. This was a decline from the previous year's result.
- Sixty percent of staff who responded stated they were given feedback about changes made in response to reported errors, near misses and incidents. This was a decline from the previous year's result.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, we were told about an incident involving a patient with learning disabilities. Staff, including the learning disability liaison nurse, told us they involved the patient and their families in the investigation and informed them of progress.

Staff told us debrief and support for staff after any serious incident was not always effective. They told us there were information leaflets and a debrief policy, but they did not feel there was a structure for debrief sessions.

Safety Thermometer

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

We saw ward-based quality information boards on all the wards we visited. However, safety performance data was not displayed for staff and patients to see. We were told this information was unavailable because audits had been paused due to the COVID-19 pandemic. The trust was auditing venous thromboembolism (VTE – blood clot) assessments and pressure damage centrally, but this was not being displayed.

Is the service effective?

Requires Improvement ↓

Medical care (including older people's care)

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE) guidelines and quality standards.

Policies were available to all staff on the trust intranet system and staff demonstrated they knew how to access them. All policies and updates to policies went through a governance process before they were ratified and uploaded to the trust intranet system. However, the team which was in charge of the governance processes for policies was impacted adversely by the pandemic. We were informed of three instances where guidance was out of date, which were reported in serious incident reports. In each of these instances the trust was taking steps to update the guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Most of the staff we spoke to were able to demonstrate a knowledge and understanding of the Mental Health Act and the Code of Practice. All staff told us they were aware of and knew how to contact the onsite team that could support them with mental health and learning disabilities.

An audit in February 2021 identified patients with heart problems were not receiving an angiography within 72 hours of admission. (Angiography is an imaging test that uses X-rays to view the body's blood vessels). The trust had an action plan for improving transfer times from Northern Devon to another trust. However, it should be noted that 95% of heart patients were seen by a cardiologist.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. However, complex patients were more at risk of poorer outcome during the weekends due to the shortage of specialist staff.

Staff made sure patients had enough to eat and drink. Patients told us food choices were available.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. A malnutrition universal screening tool (MUST) was used by the trust to determine individual hydration and nutritional risks. This was completed on admission and once a week thereafter. We saw clear information on diet types was recorded on patient doorways and whiteboards. Where patients were not eating or drinking well, we saw fluid and food charts were available. However, we saw these were not always completed which meant there was little assurance to show patients nutrition and hydration needs were met. Audits relating to nutrition assessment and fluid monitoring were suspended during the COVID-19 pandemic.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Diabetic patients were able to access food throughout the day to manage their condition.

Medical care (including older people's care)

Due to the shortage of medical staff in gastroenterology, we were told there was a shortage of specialist medical staff to provide leadership on nutrition, especially at weekends. Staff told us they felt patients needing parenteral feeding were more at risk of poorer outcome due to the lack of specialist consultants at weekends. (Parenteral feeding is the intravenous administration of nutrients. This may be supplemental to oral or tube feeding, or it may provide the only source of nutrition as total parenteral nutrition).

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.

The trust had two pain nurses who worked across the trust to help with patients experiencing pain.

Patients told us that they received pain relief soon after requesting it and were not left in pain. Staff asked about levels of pain and assessed patient comfort levels.

Staff prescribed, administered and recorded pain relief accurately. Staff discussed patients' pain management needs during handovers to ensure pain was managed appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. However, outcomes for patients were mixed.

The service participated in relevant national clinical audits. The National Clinical Audit & Patient Outcome Programme (NCAPOP) was mostly suspended during the COVID-19 pandemic. Due to the challenges of the pandemic, audit work had been limited in 2020.

Outcomes for patients were mixed:

- The Myocardial Ischaemia National Audit programme, published in December 2020, showed the hospital was performing well for the rate of referral to a cardiac rehabilitation programme after discharge. There was good adherence to secondary prevention medicines guidelines, however the trust identified room for improvement on some blood thinning medicines. The audit also identified 95% of patients were seen by a cardiologist.
- The national audit of seizure management in hospitals 2018 showed the hospital was performing well in most areas. For example, 97% of patients experiencing seizures were seen within four hours of arriving at the emergency department. Onward referral to a neurologist from the emergency department was 83%. The trust had appointed a clinical nurse specialist to support with the management of patients presenting with first seizures and those with epilepsy.
- The National Early Inflammatory Arthritis Audit 2020 showed the trust was performing above (better than) the national average in six out of the seven quality statements. The one quality statement where the trust performed below (worse than) the national average related to patients receiving annual reviews. In two of the quality statements, the trust performed above the target of 80%. These related to patients receiving prompt education about their condition (88%) and patients having access to emergency advice (98%). This meant patients living with early inflammatory arthritis were likely to have positive outcomes.

Medical care (including older people's care)

- The trust took part in the quarterly Sentinel Stroke National Audit programme in latest audit, October to December 2019. On a scale of A-E, where A is best, North Devon District Hospital achieved grade A. Although the trust achieved the top rating, we identified shortfalls such as insufficient specialist staff to support the stroke service and time to scanning within the one hour target. The trust told us there had been ongoing work with the stroke team and stroke services and an action plan had been implemented to address the shortfalls. The service had improved its stroke rating from a B across a number of years. The 'Getting It Right First Time Stroke Medicine' report for the South West (Nov 19) stated "this should be highly commended given the lack of workforce across all disciplines and with only one substantive consultant, with no consistent stroke specific out-of-hours-on-call". Despite the grade A rating, the trust was identified as not performing well in the 2020 SSNAP audit for 30-day mortality level for patients admitted for stroke. An action plan was implemented to address shortfalls and improve services.
- The National Audit of Dementia 2018 highlighted the hospital as an outlier in respect of assessing patients for delirium on admission into hospital. Initial assessment was worse than the national average of 58%, at just 4%. Clinical assessment following indications of delirium was worse than the national average of 67%, at 40%. Information from the trust showed a decline compared to national performance.

The service had a higher than expected risk of readmission for elective and lower than expected for non-elective admissions than the England average. From February 2020 to January 2021, data indicates medical patients at the trust had a higher than expected risk of readmission for elective admissions which is worse than the England average however patients had a lower than expected risk of readmission for non-elective admissions when compared to the England average

Managers used information from the audits to improve care and treatment. For example, the trust audited compliance with the National Early Warning Score (NEWS2) on a quarterly basis for the medical wards. The trust looked at whether the frequency of observations were completed as indicated by the NEWS2 chart and whether the chart was completed in full. The trust had a target of 95%, however this target was not reached on any of the medical wards according to the latest audit data reviewed.

Competent staff

The service did not always make sure staff had the right skills and knowledge for the roles they undertook. However, they made sure there were support available when staff worked in higher grade 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. Staff had the right skills and knowledge to provide safe care and treatment for patients. Staff received induction and new staff said they were well supported by other staff.

Nursing staff told us they would be paid overtime if they completed their training in their own time. Medical staff told us often supporting the wards took priority over their training, however the hospital recognised this and made efforts to ensure they had the time back to complete training.

Staff did not always have the right skills and knowledge for the roles they undertook, and we saw there were times when newly qualified or staff nurses were in charge of the wards. For example, on the first day of our inspection we observed a junior registered nurse was in charge. Staff at this level told us this was happening more often. However, they told us

they received a lot of support from the trust when they had to be in charge. For example, the service made sure they had all contact numbers for the doctors in case of an emergency. There was an "outreach team", who responded to urgent and emergency needs of patients. Nurses told us this team responded quickly when required. Staff told us they needed more training such as advanced life support but were told this was not a requirement of the ward.

Managers gave all new staff a full induction tailored to their role before they started work. Staff who had recently started told us they received a full induction and they were well supported by managers.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the trust showed the medicines division had achieved 86% in the number of staff receiving an appraisal. This met the trust target of 85%.

There were practice educators who supported the learning and development needs of staff. Feedback from nurses was positive about those staff. Managers told us it was difficult in the past to support staff learning and development and this had improved since the appointment of the practice educators.

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. Staff worked collaboratively to ensure continuity of care to patients and ensured the appropriate professionals were involved in care and treatment. Nursing, medical and therapy staff on wards and units worked together to facilitate care and treatment and assist patients to improve enough to go home.

Multidisciplinary team meetings took place on the wards to ensure a full medical overview was maintained and action plans completed. We attended a meeting where multiple agencies worked together to support the patients. Each patient identified for the meeting was discussed and the team looked at arrangements for their future care. Patients were spoken about respectfully and their views and those of their families were also considered. Referrals to other agencies were discussed as well as mental capacity and any safeguards needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patients identified on admission as needing frailty support were seen in the emergency department and then transferred to an appropriate ward. There was no specific frailty area so the frailty consultant would visit patients across a range of wards. We were told the lack of a frailty service in the hospital was an issue for consultants because they found it difficult to effectively review all frail patients. Ward staff did not always have the relevant skills and capacity to provide appropriate care to frail patients. They told us these issues combined with a challenged discharge to assess service meant patients who were frail often stayed in hospital longer. We were told of a case where a patient attended the emergency department for a wounded finger who stayed in hospital for 24 days when they could have been discharged after two to three days. Muscle loss is accelerated in older adults during bed rest. This meant patients who were frail often had poorer outcomes in terms of their mobility levels and an increase in risk of falls.

Staff referred patients for mental health assessments when they showed signs of mental illness. Staff completed or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide or when displaying other signs of mental ill health.

There was a process for the learning disability liaison nurse to check if patients were admitted to the hospital or had an appointment in outpatient clinics. They would then visit the wards or outpatient areas to offer any necessary support. The hospital team, mental health team and learning disability team worked well together to meet the needs of patients.

Although there were sometimes delays, patients had their care pathway reviewed by relevant consultants. This ensured patients had the care and treatment they needed.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, but not on weekends. There were remote on-call support arrangements from the hospital's own consultants when they were available or from another trust at other times. Patients were reviewed by relevant consultants depending on the care pathway.

The provision of seven-day services is to ensure patients receive consistent high-quality safe care every day of the week. Patients located on the medical admissions unit should be seen by a consultant each day and each patient should be reviewed within 14 hours of admission by a consultant and then referred to a speciality medicine consultant.

This provision was not maintained as there was no consultant presence on the medical wards at the weekends. This meant decisions regarding patients ongoing care and treatment including transfer, discharge and referrals could be delayed. Arrangements were in place for additional remote support (through the telephone) for junior and locum doctors to contact consultants in another trust. However, feedback we received suggested this facility was not often used. We were told the trust had increased the number of consultants over the weekends in the medical admissions unit from one to two to meet demands.

Audits of the seven-day service priority standards were put on hold during the COVID-19 pandemic. The most recent audit of the seven-day services was carried out between August and September 2019 to look at the numbers of patients being reviewed within 14 hours of admission. Thirty-five patients from the medicines division were audited. The audit identified 91% of patients on weekdays (21 out of 23 patients) and 75% patients (9 out of 12 patients) on weekends were reviewed by a consultant within 14 hours. At the time of this audit, the medicines division had more consultant cover at weekends than at the time of our inspection. Further investigation into the findings showed one patient who was admitted on a weekday evening was not seen until the next morning's ward round. Another patient was admitted on a Thursday morning and was not seen until the following Monday. The weekend's missed standards showed two patients were admitted on a Saturday and Sunday and did not receive a consultant review until the following morning. The third patient was admitted to the surgical admissions unit on a Sunday afternoon and was not seen by a consultant until Monday afternoon. An action plan was developed which included prioritising patients who had been admitted the previous evening during morning ward rounds so they were seen sooner. Additionally, the trust was reviewing consultants' job plans and continuing with recruitment plans within the medical specialities. However, a self-assessment completed by the trust in Autumn/ Winter of 2019 and 2020 identified that daily consultant ward rounds across inpatient medical wards were not possible. In-patient medical wards had two or three regular weekday ward rounds, but did not have weekend consultant ward rounds.

Staff could call for support from doctors 24 hours a day, seven days a week, although there were times when there were delays in the response time. The critical care outreach team were available between 8am and 7pm, and they undertook the assessment and development of treatment plans for patients needing critical care. They also worked with the non-

invasive ventilation (NIV) nurse and provided support for staff in the use of NIV and oversaw all patients requiring ventilation support. On the respiratory ward (Tarka Ward), all staff were NIV trained. There was also a senior nurse on call between 8am and 4pm on Saturdays and Sundays and a clinical site manager who took over from the outreach team between 7pm until 8am on weekdays and the whole weekend.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. We saw display boards with information which staff could use to promote healthier living for patients, as well as boards for patients with advice to help them live healthier lives.

In cardiology, staff liaised with and provided patients with information on atrial fibrillation so they were better informed. Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.

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 who were experiencing mental ill health. They used measures which limited patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. We observed in records where patients lacked capacity to make certain decisions, the capacity assessment and the best interest decision was recorded. Feedback from other professionals involved in the care of patients who lacked capacity were positive about the way hospital staff assessed patients' capacity and made best interest decisions.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in patients' records. We observed staff talking with patients and obtaining consent when providing care. As part of that engagement, staff were heard to ask patients for their understanding of the care to be given and their agreement and consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice. We saw for one patient a Deprivation of Liberty Safeguards application had been completed.

On the medical assessment unit some patients came onto the ward with mental health issues. Staff could describe and knew how to access policies and get accurate advice about the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding.

Medical care (including older people's care)

Compassionate care

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

Staff treated patients with dignity, respect and kindness. Relationships and interactions between staff and patients were positive and patients felt supported and said staff cared about them. We were told of an instance on Victoria ward where staff brought a cake and flowers for a patient who was having their 100th birthday.

Staff were compassionate and supported patients to meet their basic needs. Staff anticipated patients' needs, knowing what a patient might want or need next and made preparations to meet their needs. Doctors, nurses and health care assistants worked together to ensure patients' needs were met.

During the pandemic, the trust told us how they set up a location where essential items for patients could be dropped off by their families. This enabled patients to receive home comforts while they were in hospital during the pandemic. Infection prevention and control measures were included within this initiative to ensure the risks of infections were minimised. During 2020/21, over 1,300 bags of patients' belongings were brought to wards.

The trust told us about a patient communication email inbox it set up where patients' loved ones could send messages to them. The messages were printed on personalised templates and sealed with rainbow stickers and hand delivered to wards by the patient experience team. In all, 710 messages were received and delivered to patients during 2020/21. The trust planned to continue with this initiative as families of patients living oversees found it useful.

The trust told us tablet devices were purchased during the pandemic to facilitate video calls for patients who did not have their own equipment. We were told 445 video calls were organised and the patient experience and involvement lead produced training packs for inpatient wards so they could assist with video calls out of hours.

The trust recognised that some patients would not see a member of staff's whole face due to the need to wear a mask. They told us how they had therefore introduced a 'Hello my name is' photo card which was a laminated pocket photo for staff to use when introducing themselves to patients.

The trust said in response to patients feeling anxious about coming to the hospital for treatment during the COVID-19 pandemic, a drive through area was set up for patients to collect heart monitors and have spirometry tests in their vehicles. NHS friends and family test results for this service showed 99% of patients who responded (out of 266 responses) rated their experience as 'Very good' or 'Good'.

The trust told us how it demonstrated a commitment to identify unpaid carers and worked collaboratively with a local organisation who offered a wide range of support and assistance to unpaid carers. Unpaid carers were either signposted to this organisation or were directly referred by the hospital. The patient flow team and discharge coordinators actively referred carers to this service. Information from the trust showed 2,131 carers were referred for support from the inpatient wards. From October 2020, unpaid carers who were registered received free parking at all of the trust's sites and meal vouchers were provided to the carer when they were supporting the person who they cared for in hospital.

Patients said staff treated them well and with kindness. Patients told us staff were considerate, took time to explain things to them and provided a calm and caring attitude.

Medical care (including older people's care)

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to give examples of how the care they provided considered patients' different needs, for example by involving the hospital chaplain or planning for young children to visit.

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 supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us they used distraction techniques to support patients who appeared to be distressed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Both doctors and nurses told us of the importance to give patients and their families time when giving bad news and explaining information clearly. They were committed to ensuring patients and their families were given time to ask questions.

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. Staff shared examples where elderly patients were isolating in side rooms during the COVID-19 pandemic and how they ensured those patients did not feel alone and made sure they checked on them regularly and made time to have conversations with 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. The restricted visiting hours for families and carers due to the pandemic made this more difficult, however staff would ask patients whether they wanted family members to be given information and the best way for them to receive this. Patients told us they were involved in discussions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients told us doctors explained their condition and treatment in a way they could understand. However, most of the staff we spoke with were not aware if the trust had access to an interpreting service for patients whose first language was not English. Staff thought it was acceptable for interpreting services to be provided by members of the staff team who spoke the same language as the patient.

Staff supported patients to make advanced decisions about their care. We saw treatment escalation plans had been written following discussions with the patient and their relatives.

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

The hospital sought views of patients and relatives by use of the NHS Friends and Family Test. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving NHS care or treatment. The FFT test for June 2021 showed 99.7% of patients would recommend the medicine service.

Medical care (including older people's care)

The trust reported how it received high levels of compliments. Information supplied by the trust showed that compliments had increased significantly from previous years. For example, 1,173 compliments had been received in 2020/21 compared to 458 in 2019/20.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of local people

The service did not always respond in a timely way to meet the needs of local people and the communities it served. It worked with others in the wider system and local organisations to plan care.

Planning to meet the needs of the local population was not always effective. The lack of medical cover over weekends meant there were often delays in patients being discharged. Medical cover also impacted on deteriorating patients where medical staff had not responded in a timely manner. However, the trust demonstrated they were working hard to address the medical staffing issues. They had worked with the wider system and another neighbouring trust to support care provision at the hospital in addition to ongoing recruitment. They also told us funding had been agreed to increase the resuscitation and outreach team availability seven days a week and planned for this to be implemented by the end of October 2021.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Patients were cared for in either female or male (single sex) bays wherever possible. Every effort was made to support care to be provided in single sex areas, including escalation areas.

Facilities and premises were appropriate for the services being delivered. We saw the care of the elderly patients ward was designed to be dementia friendly and promoted a calm environment.

Staff could access mental health liaison and specialist mental health support from 8am to 10pm on weekdays and from 10am to 6pm on weekends for patients with mental health problems. Out of hours weekday and weekends any urgent referrals or assessments are undertaken by the psychiatric on call junior doctor or the night nurse practitioner from another nearby trust. The learning disability liaison nurse was available from Monday to Friday and they worked flexibly to accommodate when patients with learning disabilities and staff needed more support.

The service relieved pressure on other departments when they could treat patients in a day.

The ambulatory care area was used whenever safe to do so to treat patients and return them home. The area was staffed by nursing staff and was planned to lighten the pressure on the emergency department and medical 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. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs.

The dementia ward was designed to meet the needs of people with dementia and had dementia friendly signage and lighting. We saw patients being cared for in a way which protected their dignity.

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.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients with learning difficulties were given longer appointment times with clinicians. The trust had three 'admiral' nurses who worked across the trust to support patients with dementia. One of those nurses told us there was high compliance with the 'This is me' document. They supported and gave information to other staff on dementia and delirium. They told us they were keen to develop the community service for people living with dementia. They actively liaised with other wards to identify patients who may be more suitable to move to the care of the elderly ward where staff had received more specialist training and can cater to the needs of those patients better. Staff valued this service.

The trust had a Mental Health Liaison Group to help provide care to patients with mental health illness and learning difficulties. This group met quarterly and its membership was made up of representatives from other trusts and organisations.

There was evidence of changes being made as a result of patient feedback. For example, the trust told us how a patient who lived in North Devon had to travel long distances to obtain a COVID-19 test so they can have their cancer treatment at another hospital. As a result, agreements were made with other hospitals in Devon so that patients can have a test at their local hospital prior to procedures or treatment at other hospitals.

Access and flow

People could mainly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

From March 2020 to February 2021 the average length of stay for medical elective patients at the trust was 5.8 days, which was lower than the England average of 6.8 days. For medical non-elective patients, the average length of stay was 5.4 days, which was lower than the England average of 5.8 days.

Although managers and staff worked to make sure patients did not stay longer than they needed to, this was not always effective. The trust had a team of people to help with discharge called the pathfinder team. This team comprised of several disciplines, for example nurses and physiotherapists, who were all trained to help with discharge. This team helped with complex discharges and urgent care where help was required at home in order to keep patients safe.

Alex ward was where patients went who were expected to be discharged within a few days and was staffed by locum consultants. We were told that by not having a consistent consultant, some patients were delayed in being discharged as new consultants wanted to run further tests to ensure they were fit for discharge. Whilst this was not unsafe, we were told it did impact on flow.

Medical care (including older people's care)

The trust had a discharge policy that included a section for discharge out of hours which refers to the time as between 5pm and 8am and includes weekends and bank holidays. The policy states that if a patient requires a medical review prior to discharge this should be handed over to the weekend on call team.

The trust trialled a new process for discharge which sought to improve patients' movement in and out of hospital and help discharges at weekend. This process enabled nurses and therapists to discharge patients who met certain criterion rather than require consultant or doctor review. The trust planned to introduce this process trust wide in August 2021 as the initial audit of the ward trial indicated that the discharge process for patients was improved.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Medicine had 4,119 patients on their waiting list overall which made up 30% of the trust waiting list.

Most patients were treated within 18 weeks. *(Source: NHS England Consultant led referral to treatment waiting times).* Referral to treatment data as at April 2021 showed:

- In dermatology, out of 145 patients, 90 (62%) were treated within 18 weeks and 10 (7%) were treated over 52 weeks.
- In gastroenterology, out of 89 patients, 59 (66%) were treated within 18 weeks and three (3%) were treated over 52 weeks.
- All 12 cardiology patients awaiting treatment were seen within 18 weeks.
- In 'other-medical services', four out of six (67%) patients were treated within 18 weeks and one patient (17%) waited 52 weeks or over.
- The hospital only had one patient waiting for treatment in elderly medicines and they were seen between 18 and 26 weeks.
- The rheumatology service saw three patients between 26 and 40 weeks and one patient between 40 to 52 weeks.

Admitted performance for patients waiting more than 52 weeks for treatment showed the number of patients waiting over that length of time started increasing from April 2020 in line with the COVID-19 pandemic activities. The trust provided validated data which they had submitted to NHS England & NHS Improvement, showed, as at April 2021 there were 163 patients who were waiting more than 52 weeks for treatment in medicine services.

A daily tactical meeting was held to review demands from the previous day through the emergency department (ED), and maintain oversight of patients who were fit for discharge and the number of patients who had been admitted.

The hospital monitored the demand on its service and the operational pressures escalation level (OPEL) framework detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. This framework related to adult beds and included medical beds. During our inspection the OPEL framework was at level two.

Managers and staff worked to make sure they started discharge planning as early as possible. However, the lack of frailty services in the hospital and a discharge to assess service and social care provision that struggled to meet demand at times meant patients often stayed in hospital for longer than intended. On ward rounds we saw several patients who were medically fit for discharge waiting for a package of care. Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them where possible.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The ward discharge coordinators kept track of patients' referral letters and discharge summaries to ensure these were ready for when the patient left the hospital.

The arrangements for doctors to review patients who were admitted on wards outside of the ward's specialism was not always effective. Some doctors told us they found it difficult to coordinate their rounds where patients on their list were placed on different wards. There were not always clear arrangements for medical cover, which put patients at risk of delayed care. For example, there were time doctors were not sure if they were responsible for some patients which caused confusion for both nursing and medical staff.

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.

Patients, carers and relatives were able to complain by letter, email, telephone, via the Patient Advice Liaison Service (PALS) or in person to any member of staff. Staff described the process they would follow to try and resolve any issues locally and directly and advise patients of how to escalate their concerns if not satisfied.

The Patient Experience department had two generic e-mail boxes, one of which was for PALS which advised the person to forward their concerns to the Trust's complaint e-mail box if they wished to raise a formal complaint.

More serious concerns were discussed with people to give them the option to complain, explaining the formal complaint process and how they could access the Parliamentary Health Service Ombudsman if they were unsatisfied with the trust's response.

The team had a target to investigate complaints within 45 days, however this was not always achieved. For example, in June 2021, this was achieved for only 45% of complaints. If complaints were not completed within the 45 days, the trust would contact the complainant to let them know when they could expect a response.

The trust had a subscription to an internet-based service which monitored patient experience and provided the option to respond to comments. This was helping the trust identify issues and learning directly from patients once they had left the hospital.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Complaints and learning from complaints were discussed at monthly governance meetings which fed into the quarterly Information Performance Report presented at board meetings. Managers also shared feedback from complaints with ward sisters, however staff were unable to tell us of any learning or changes made as a result of complaints.

Medical care (including older people's care)

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 not always visible in the service for patients and staff but were approachable if staff needed support.

The leadership team was relatively new in post and were still embedding in the service. There was a planned integration of the trust with another trust to enable more support and to build resilience in the hospital for the local population. A site triumvirate had been created which included a site medical director, site director of nursing and site director of operations who were new in these roles. They demonstrated awareness of the challenges the trust faced.

Leaders demonstrated they had the skills and abilities to run the service. They understood the issues the service faced and although there was a focus on managing them, actions they took did not have the desired impact in a timely way. For example, they understood they needed to build resilience in the medical team and had actively recruited staff. They worked with neighbouring trusts and external partners to find short and long-term solutions. However, short term solutions had not ensured continuity of care for patients and consistency for the existing team within the medicine division. Long-term solutions were being discussed but had yet to have an impact.

Whilst most staff we met could not recall seeing the leadership team, they did not identify this as an issue. Staff knew who they were and how to contact the relevant members of the leadership team if they needed to. They also told us they knew who the site director of operations and the site director of nursing were, and said they were visible and approachable.

The leadership team recognised the clinical operating model at the hospital needed to be reviewed and as part of the integration they were looking at developing more advance nurse practitioner roles to support the clinical model. This would include university masters level courses. To facilitate this, they also told us they needed to recruit more newly qualified or staff nurses to enable more senior nursing staff to progress into advanced roles. This work was at an early stage and had not had an impact yet.

The pressures experienced by staff created a disconnect between front line staff and the senior leadership team. Staff felt they raised concerns about staffing levels but were not always aware about how the issues were being addressed.

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 understood and knew how to apply them and monitor progress. However, front line staff could not describe the vision or strategy.

Staff did not know or understand what the vision, values and strategy were, or their role in achieving them. Staff told us there was little collaboration to create or understand the vision, values and strategy for the organisation, and they did not know how they fitted into the structure.

The senior management team told us they understood that without improved staffing, staff and services would continue to be under pressure. They were looking at ways to make North Devon District Hospital a more attractive place to work. They had recruited from overseas and looked forward to increased nursing support. However, while these actions were ongoing the existing staff remained in the same position.

The senior management team were clear their priority was to ensure a sustainable service and as such were working with the clinical commissioning group and a neighbouring trust to develop policies, systems and processes so these were aligned once they integrated. They recognised the need for a more fluid way of working and were developing their IT systems to enable swift information sharing.

They recognised that by not having a seven-day service in all areas, this impacted on medical care in terms of delays in and out of the hospital as well as responding to emergencies out of hours and at weekends. This was part of their conversation with the neighbouring trust to facilitate a seven-day service and some progress had already been made. For example, the hospital received additional support so there were now two medical consultants covering weekends instead of one. There was also a senior nurse on call between 8am and 4pm on Saturdays and Sundays and a clinical site manager who took over from the outreach team as from 7pm until 8am on weekdays and the whole weekend.

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 responded positively about working at the trust. We saw evidence of a good culture of working between different teams and grades of staff.

Leaders understood the challenges faced by staff and they were committed to promoting their safety and well-being. They recognise the impact of the pandemic and that staff may experience fatigue and stress. We saw the wards had rooms for staff to rest and there was an employee assistance programme which staff could use to get additional support. The deputy director of nursing also visited the wards to check on the well-being of staff. However, their efforts to improve the well being of staff was challenged by the shortage of staff, sickness and staff having to isolate.

There were opportunities for career development. The trust had a position where health care assistants could progress onto training to be a registered nurse.

As well as registered nurse training schemes there was a route for progressing to matron or advanced nurse practitioner. The numbers were small, however the trust was looking at expanding these schemes.

Although most staff told us they were encouraged to raise concerns and these were well received, some reported they were labelled negatively by their managers if they reported too many incidents. The trust senior management team did not support this behaviour when we raised this with them and were keen to investigate this. Some staff told us they reported concerns but felt little was done or the response was slow.

Medical care (including older people's care)

Results from the 2020 NHS staff survey were mixed and the medicine division performed worse than other areas of the trust in some key areas. The response rate from the trust was 55% (which accounted for 1,897 staff) compared to 45% nationally. The main highlights of the results (out of a score of 10 where 10 is the best) showed:

- The trust scored 9.5 for equality, diversity and inclusion and 6.9 for health and well-being and morale. The medical division scored worse than the whole trust.
- The trust scored 8.3 for working in a safe environment free from bullying and harassment, and 9.5 for working in a safe environment free from violence. The medical division scored worse than the whole trust.
- Eighty-one percent of staff who responded stated the trust made adequate adjustment(s) to enable them to carry out their work. This was an increase from the previous year's results.
- Thirty-six percent of staff who responded stated the organisation took positive action on health and well-being. This was similar to the previous year's results.
- Forty percent of staff who responded stated they had come to work despite not feeling well enough to perform their duties. This was a significant decline from the previous year's results.
- Forty-one percent of staff who responded stated they had felt unwell as a result of work-related stress in the last 12 months. This was an increase from the previous year's results.
- Eight percent of staff who responded stated they had personally experienced discrimination at work from manager / team leader or other colleagues. This was a slight increase from the previous year's results.
- Seventy-seven percent of staff who responded stated they felt secure raising concerns about unsafe clinical practice. This was an increase from the previous year's results.
- Sixty-three percent of staff who responded stated they felt confident the trust would address their concern. This was a decline from the previous year's results.
- Seventy-eight percent of staff who responded stated the trust acted on concerns raised by patients. This was a decline from the previous year's results.

The trust board report in June 2021 acknowledged the downward trend in some of the areas of the staff survey. They reported that some work had been done to address the issues but not all the actions were complete. It was identified that management teams needed training and support that would enable them to access the necessary tools to support their teams.

Staff were aware of the trust's freedom to speak up guardian, who provided independent and impartial support to workers to speak up.

Staff received training on, and understood, the duty of candour. We heard of examples of staff having applied the duty of candour in response to incidents. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Governance

Leaders operated governance processes throughout the service and with partner organisations, however these were not always effective. 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.

Medical care (including older people's care)

Staff at all levels were clear about their roles and accountabilities. For example, although some of the leadership team were new to either the trust or the role, they were clear on the issues the trust faced and could demonstrate they understood the actions they needed to take. Regular meetings were held to review actions and performance. Managers worked with partner organisation to have open discussions about the challenges the hospital faced and seek support where it was needed.

Teams held regular meetings where governance was discussed, for example incidents, risk and audit outcomes. The medical division also held regular governance meetings which then fed into the trust governance committee which was a sub committee of the board. Minutes from meetings were shared with teams and learning cascaded. Actions were monitored to ensure they were completed. Despite these processes, they were not always effective. For example, the divisional leadership team described actions taken to improve recruitment, including safer staffing, but staff shortages continued to happen on the wards and staff did not always feel involved or updated on developments to improve staffing. Incident reporting of staffing issues did not create sustainable changes to the practices and was not used for learning. However, staff told us when they reported staff shortages managers acted quickly to fill in gaps in the short-term.

Medical staff could not support governance as well as clinical work due to capacity constraints caused by insufficient staffing and demand on the service. There was a lack of oversight of locum activities. The issues we identified on inspection in relation to delayed response to deteriorating patients and management of patient list were not always known by the senior management team.

We found some of the challenges the trust experienced were due to their unsuccessful efforts to recruit medical staff. Using locums and agency staff on a regular basis meant there was not a consistent workforce to enable development and implement improvement. Instead efforts were focused on maintaining safe staffing. This was also not helped by the challenges of the pandemic where there was increased sickness levels and several staff isolating.

The trust governance process identified staff had not been completing details of venous thromboembolism (VTE) assessments on its IT system since July 2020. The trust undertook spot audits to confirm staff were completing VTE assessments. However, the issue of reporting VTE assessments on the IT system remained according to the latest audit received in March 2021. Figures for VTE assessments between January and March 2021 ranged between 7% and 83% with a mean percentage of 38% across Alex, Capener, Fortescue, Medical Admissions Unit, Staples, Tarka and Victoria wards. Despite the trust working with staff to promote the importance of entering details of the assessment on the IT system, the process had only marginally improved from July 2020. This made it difficult for the trust to identify areas where learning may be required which could impact on patient care.

Managers worked hard to facilitate staff to attend team meetings or had access to full notes when they could not attend. There were times when this was difficult due to staff needing to cover the clinical work. Staff told us they received emails with updates on information.

Management of risk, issues and performance

Leaders and teams used systems to manage performance however they were not always effective. They had plans to cope with unexpected events.

The leadership team recognised the issues in the service and were moving forward to address these, however, there were still a number of substantial issues to be addressed.

There were arrangements for identifying and escalating relevant risks and issues and the trust identified actions to reduce their impact. Risks were entered onto the trust system and the risk register monitored at divisional risk meetings. Risks scoring over 15 were reported for consideration for inclusion onto the corporate risk register to the safety and risk committee. The top three risks recorded were all about insufficient capacity within the medicines division, which aligned to the risks identified by senior leaders. The risk register had highlighted these risks as high since around November 2019. The leadership team and all staff we spoke with were fully aware of these risks. Several avenues of recruitment had been explored which had not always been successful. Staff views of risks was aligned with the trust recorded risks.

Leaders explained recruitment was a challenge and the service was not meeting this challenge effectively. In some cases, there was little time for staff involvement in governance and opportunities for discussions to look at management of performance due to the need to prioritise clinical work. However, some consultants told us they were able to attend governance meetings and these meetings had had improved in terms of better representations and attendance compared to previous years.

The consultant lead in cardiology told us major progress had been made in the last 18 months in terms of consultant cover. They raised concerns around patients on the waiting list and told us the trust responded quickly to the concerns. This led to 20 months' worth of patient lists being reviewed which identified no patients had come to harm due to waiting. They told us risks were monitored at governance meetings and actions were reviewed to ensure they were completed.

The trust recognised there was a risk in relation to not having a seven-day service and there was a need to expand the Resuscitation and Outreach Team in 2019 and a business case was put together in early 2020. However, the impact of the pandemic meant there was no funding available at the time. A seven-day trial of this service was undertaken between March and August 2020 which proved beneficial for staff and patients. Following this the operations board agreed investment into this service was required to extend to a seven-day service. Although additional recruitment into the team had been challenging, the trust told us there would be a full team by the middle of September 2021 following successful recruitment in June, and they planned to provide the service seven days a week from late October 2021.

Information Management

The service collected reliable data and analysed it. In most cases staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Data was gathered and used to look at themes and trends across the trust. The medicine division had a dashboard which identified levels of sickness for staff, appraisal compliance, training compliance, turnover rate and vacancy rates for staff. The information collated through the dashboard was discussed at operations board and triumvirate meetings and shared with the executive team and trust board.

A dashboard was used to look at audit outcomes and where action was needed. Notifications were submitted when needed to ensure recordable information was gathered. Audit outcomes were monitored at governance meetings and actions were taken where necessary. For example, the trust improved the frequency of data sharing on waiting list information with the cardiology team so they can respond to increase demands more quickly.

The trust recognised that as part of future integration with another trust, there was a need for improved IT systems so information could be shared in a timely way. As such, they told us work was underway to align the IT systems across both trusts.

There was an electronic system used to refer patients between specialities and pathways, and other organisations. For organisations that did not use the electronic system, paper referral forms were available.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust worked with an organisation made up of a partnership between public services, businesses, voluntary & community groups. The aim of this organisation was to improve local services in making them more person-centred and to tackle health inequalities. The trust led on some of the projects including working with the Department for Works and Pension to identify local young people and supporting them to have equal opportunities to employment. They also worked with other groups to develop local mental health services which patients had identified would help their well being.

The trust was working closely with a neighbouring trust to plan and manage its services they integrate in April 2022. There has been a close working relationship between the two trusts over the preceding years. This relationship has helped to improve the services for the patients at the trust over the past year with agreements to help with medical staffing. The leadership team met with staff to seek their views on the integration and new ways of working. They recognised where there were challenges and worked with teams to address these.

In line with guidance from NHS England, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted for December 2020 data in January 2021. In June 2021, the medicine division had 324 responses, of whom, 99% said they would recommend the service.

During 2020/21, the trust reported how an additional method of capturing compliments was introduced. A ‘Wonderwall’ was installed in the main entrance of the hospital, enabling patients, relatives, carers and visitors to leave message of appreciation which was then displayed on the wall. The patient experience team uploaded the feedback to the reporting system for inclusion in governance reporting. Messages relating to a specific service were forwarded to the manager and shared with the team.

The June 2021 board report highlighted a need to gather more information from staff and there was a new quarterly survey being introduced to capture more targeted information from staff.

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.

All areas of the trust were encouraged to continually improve services using QI processes. Staff received training in QI methodology to support the successful delivery of projects. For example, following an increase in falls during 2020, the falls team had worked with clinical staff to improve the falls risk assessment. This was due to an increase in the number of falls in 2020. They told us falls assessments were carried out well by staff, however they often lacked information on

what the assessment meant for patients. As a result, they improved the documents used for recording assessment to include outcomes for patient. A new falls prevention and management policy was being tested and the team was gathering feedback on the policy and the new improved documentation. The falls team were undertaking learning sessions on wards for staff. The team told us there was a lot of learning from what had gone wrong, but they were keen to encourage staff to learn from near misses and things that had gone well. An inpatient post fall checklist had been developed and implemented. This was designed to guide staff on what to do when they experienced a patient falling especially as these incidents could be distressing. Feedback from junior doctors about this checklist was positive. They told us this prompted them on what checks needed to be carried out on patients.

The trust participated in clinical trials and research. During the past year Urgent Public Health studies have been prioritised by the National Institute for Health Research. Staff had also participated in COVID-19 immunity and re-infection evaluation with 369 staff taking part in this study.

Areas for improvement

MUSTS

The trust must:

- Ensure there are sufficient arrangements to respond appropriately and in good time to people's changing needs. Regulation 12 (2) Safe care and treatment.
- Ensure there is always adequate cover and support for the medical workforce, including out of hours. Where support is available, ensure this is used effectively. Regulation 12 (2) Safe care and treatment.
- Ensure substances hazardous to health and medical gases such as oxygen are checked and stored securely in line with the trusts policies and procedures. Regulation 12 (2) Safe care and treatment.
- Ensure the management of patients with different needs to the speciality of the ward are safe and ensure appropriate medical oversight. Regulation 12 – Safe care and treatment.
- Ensure staff are encouraged and enabled to report all incidents including near misses. Regulation 12 – Safe care and treatment.

SHOULDS

The trust should:

- Consistently check fridges used for the storage of medicines.
- Improve the standards of record keeping so they are legible, complete and where necessary, indicate they have been reviewed by a consultant by way of appropriate signature.
- Monitor and improve mandatory training compliance so staff are up to date with training appropriate to their role.
- Review the provision of services for patients who are frail to improve their outcome.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment