Care Quality Commission

Buckinghamshire Healthcare NHS Trust

Wycombe Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
End of life care	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Wycombe Hospital is part of Buckinghamshire Healthcare NHS Trust. The hospital offers a wide range of surgical services and specialist medical care for stroke and heart conditions. The hospital also offers specialist cancer and urological services. The hospital has 250 beds.

The hospital is the area's major hub for planned surgical care. Surgical teams carry out over 24,900 operations every year. Wycombe Hospital sees more than 36,000 inpatients and 145,000 outpatients a year. Wycombe is also home to a modern midwifery-led maternity unit aimed at providing a more home-from-home environment for women and their partners.

We carried out a focused unannounced inspection visit on 7 September 2016. We inspected the medical, surgical and end of life care services provided at this location. During the inspection, we also followed up issues identified at the inspection in February 2014 and March 2015 relevant to the service types inspected.

Overall, medical care, surgery and end of life care were rated as 'requires improvement'. All the services required improvement to provide safe care. Medical care and end of life care services required improvement to provide effective care and surgery required improvement to provide responsive care. We rated all of them 'good' for caring and 'well led' services.

Are services safe?

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

- Staff felt confident and able to report incidents. The trust recognised the importance of learning from incidents to improve the care provided to patients. However, staff could not always describe where learning from incidents had changed clinical practice. Staff demonstrated a good understanding of duty of candour and gave examples where they had used this to support patients.
- Staff did not always follow the trust's medicine management policies and procedures.For example for controlled drugs orders and monitoring medicine fridge temperatures. Staffing shortages in the pharmacy department resulted in reduced support to departments and we found evidence of some unsafe practices, including out-of-date medicines and some medicines not stored securely on the wards.
- Patients' records were not always completed in full, including the signing of medicine charts and completion of an assessment of the patient's capacity. We found that patient's did not always have a diagnosis, management plan or care plan which assessed risks to their care. Some DNACPR forms we inspected were not completed according to national guidelines. The trust audits had identified this as an area for further improvement.
- Patient confidential information was not always stored securely and there was a risk of unauthorised access.
- Not all staff were trained in areas that the trust had identified as essential in providing safe care and treatment. Staff completion of statutory and mandatory training was not in line with the trust's target in some areas, this included safeguarding children and vulnerable adults level 2, duty of candour, infection control, medicines management, basic life support and tissue viability.
- Staff were completing the Five Steps to Safer Surgery and the most recent trust patients' record and observational audit showed 95% compliance.However, during the inspection, we observed some members of the theatre team were not engaged for each step of the process and this, potentially, could placing patients at risk of harm.
- In general, all clinical areas were visibly clean and staff had access to sufficient equipment to provide safe care and treatment. Staff in general adhered to infection prevention and control practice on the wards and in theatres.

However, the mortuary trolley was found to be dirty with no agreed cleaning schedule in place and deceased clothing was not appropriately stored while awaiting collection.There was also one cubicle on In the Cardiac and Stroke Receiving Unit (CSRU), where deterioration in the décor presented an infection control and patient safety risk.

- Patient's safety and daily staffing information was prominently displayed for patients, staff and visitors to read, as part of the trust's open and honest approach.
- In the operating departments, the anaesthetic logbooks were not complete, to provide assurance the daily safety checks had been completed and equipment was fit for purpose, prior to patient surgery. On some of the wards, staff had not completed the daily checks on the resuscitation equipment in line with the trust policy, to ensure it was ready for use in an emergency. Staff had concerns over night time security at the hospital.
- Staffing was planned using a recognised Department of Health patient acuity and dependency tool, which had clear guidance on levels of care and inclusion criteria for clinical staff to follow. There were escalation processes in place when staffing shortages were identified.
- Overall, staffing levels in the surgical departments met the planned levels for theatre, nursing and medical staffing. The trust achieved this using bank and agency staff for some shifts, particularly in the operating departments. The cardiac and stroke unit did not always meet their own planned staffing levels. In August 2016, 28 shifts were understaffed by at least one member of staff and four of these were understaffed by two members of staff. Medical staffing for the end of life care did not meet national guidance.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns. Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate.

Are services effective?

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

- Staff planned and delivered people's care and treatment in line with current evidence based guidance, standards and best practice across the medical and surgical services. While there was some evidence of evidence-based care for end of life care this was not constantly applied across the hospital. For example the trust did not have a protocol for withdrawal of treatment, which was not in line with national guidance
- The hospital participated in national and regional audits and undertook a local audit programme. The hospital had received an A grade in the Sentinel Stroke National Audit Programme (SSNAP) which is the highest possible grade. The hospital also performed better than the England average in the myocardial ischaemia national audit project (MINAP) for the treatment of patient with non-ST-elevation infarction (nSTEMI).For the surgical services results from these audits showed patient outcomes were in keeping with the national average.
- Staff assessed and managed patient's pain appropriately and had access to the acute pain service for advice and support. However, for patients receiving end of life care staff did not use a standardised pain assessment tool to ensure staff delivered a consistent approach to pain measurement or management.
- Patients identified as having end of life care needs were assessed, reviewed and their symptoms managed effectively.However, for medical patients there was lack of consistently in care planning for patients.
- Patients told us they had made an informed decision to give consent for surgery. The most recent informed consent audit showed medical staff were not completing all consent forms and patient care records to the expected trust and national standards.

Summary of findings

- There was some variability in staff awareness of their responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLs). We saw that patient's capacity was not always formally assessed when decisions were being made on behalf of patients who were deemed to lack capacity.Staff did not always recognise when a patient was being deprived of the liberty and apply for a DoLS order. We observed a patient who had received chemical restraint without the correct order in place.
- Staff had good access to training and professional development. The specialist palliative and end of life care staff were skilled and competent to perform their roles effectively.
- Multidisciplinary working was embedded across all the wards. Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs.
- The hospital had systems in place to ensure they provided care for inpatients seven days a week. This included access to on-call theatre and diagnostic imaging staff in an emergency and consultants carried out ward rounds seven days a week. The hospital performed above the national and regional average for most standards set out in the NHS services, seven days a week guidance.

Are services caring?

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

- In all areas, patients and relatives were positive about the caring attitude of staff, their kindness and their compassion. All patients we spoke with would recommend the service to their friends and family.This was supported by data collected for the Friends and Family Test.
- Staff took time to ensure patients and their relatives understood their care and treatment. Patients told us they felt involved in their care and understood their treatment plans. Medical and nursing staff showed sensitivity when communicating with patients and relatives.
- Staff we spoke with valued and respected the needs of patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered.
- We observed staff did not maintain patients' privacy and dignity at all times when providing care and treatment in both the operating department and on ward 2a.

Are services responsive?

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

- The trust worked in partnership with local commissioners to plan and deliver services, to meet the needs of local people. Some elective surgery such as for ear, nose and throat (ENT) and breast surgery had been relocated to the hospital to improve efficiency and a prompter service for patients. Stroke services had been merged to provide a single specialist provision to reduce patient transfer between two sites.
- Patient with chest pain or stroke had access to rapid assessment and treatment via the cardiac and stroke receiving unit (CSRU). The stroke unit held a transient ischaemic attack (TIA) clinic everyday prioritising the most urgent cases.These services took referrals directly from GP's and paramedics.
- In the surgical division, there was a significant backlog of patients requiring pre-operative assessment. The division had not achieved 90% of patients being seen and admitted within 18 weeks of referral.
- Staff took account of the needs of different people, including those with complex needs, when planning and delivering services. There were adequate facilities to meet individual's spiritual and cultural needs. We observed staff using alternative methods to communicate with non-verbal patients and making flexible arrangements for families to support patients living with dementia and learning disabilities. However, patient assessments, measuring the suitability of the environment for people with dementia and people with a learning disability, were consistently low scoring.

Summary of findings

- The trust operated a rapid discharge home to die pathway which served to discharge a dying patient who expressed wanting to die at home within 24 hours. However, there were some external delays with funding and care packages for patients with complex needs and patients who expressed a wish to die at home, did not always get to do so.
- Complaints were investigated thoroughly to improve the quality of care. However, this was not effective on the medicine wards where staff told us learning from complaints was not always shared at ward meetings.

Are services well led?

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

- The staff we spoke with told us they were passionate about providing safe and compassionate care. Staff enjoyed working at the hospital and told us they found managers and their team supportive. There was a clear sense of teamwork and collaboration between wards and members of the multidisciplinary team. Staff told us there was an open and transparent culture within the hospital.Most staff felt the leadership of the trust and within the division were visible and supportive.
- There was a clear governance structure in place, which linked in with the trust's overall governance structure.Meetings took place at all levels of the divisions and were well attended by members of the multidisciplinary team (MDT) staff reported on quality, safety and performance. However, minutes of all meetings at all level were not always recorded and therefore it was not always possible to evidence what had been discussed.We identified a number of concerns around staff not following practices designed to keep patients safe which had not been identified by the trust.
- There was a local and a national audit programme and staff had knowledge of the audits that directly linked to their clinical area. The clinical governance teams had an oversight of audit performance and there was evidence of improvement in clinical audit results.
- Systems were in place to gather patient feedback and departments and the division had used this feedback make changes to services. The trust had set up a patient panel to ask for opinions and suggestions in what mattered to them regarding developing plans for end of life care. There had also been a public consultation,"Better Healthcare in Buckinghamshire" which had fed into plans to centralise the stroke and cardiac services.
- However, patient views had not been sought in the planning stages for the design and improvement of cardiac and stroke service. The trust had not audited the views of the bereaved as recommended by the National care of the Dying audit hospitals) NCDAH) 2014/15

We saw several areas of outstanding practice including:

- Excellence reporting had been introduced in the operating departments to encourage staff to report and learn from examples of good practice.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the hospital must ensure:

- Staff comply with all aspects of the trust's medicine management policy and associated standard operating procedures.
- Medicine stock is checked in line with policy and expired or unwanted medicines are disposed of in a timely manner.
- Staff working in theatres fully comply and are engaged with each of the stages of the five steps for safer surgery.

Summary of findings

- All staff working in theatres comply with the trust's uniform policy, in particular changing their scrubs, if they leave and then return to theatre.
- Pharmacy staffing is as planned to provide clinical pharmacy support to departments.
- Anaesthetic machines and resuscitation equipment have appropriate checks and are safe to use
- Patients' medical records are stored securely and confidential information is not accessible to unauthorised staff.
- Patients' have care plans which accurately reflect their needs and risk assessments are completed in a timely manner.
- Patients who are thought to lack the capacity to make a decision about their care have a formal mental capacity assessment.
- All staff are up to date with their mandatory training.
- Action is taken to ensure compliance with informed consent.
- A standardised pain assessment tool across the hospital to ensure end of life patients have their pain accurately assessed and responded to.
- The end of life care strategy is completed and published and all clinical staff are aware.
- Prepare a protocol for withdrawing treatment as recommended in the 2015 National Institute of Clinical Excellence guidelines and train clinical staff in its use.
- The new end of life care plans "Getting it right for me" and the associated "Getting it right for me patient held record" are used by clinical staff for all end of life care patients in the trust.

In addition the trust should ensure:

- The pharmacy service does not supply out of date British National Formularies.
- Audits completed by the pharmacy service are used to drive improvements and progress should be demonstrated over time.
- There is a clear process to demonstrate the mortuary trolley has been cleaned, with appropriate dates and times recorded.
- Suitable sealed storage is in place for deceased patients' belongings in the bereavement office and a documented cleaning schedule for the storage receptacle to be cleaned at least weekly.
- Nursing staffing levels are as planned and this takes account of staffing of the TIA clinic.
- The standard of record keeping is monitored through regular audits and action taken for areas of non- compliance.
- Medical staff receive yearly appraisals.
- All staff understand the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and are confident to apply this in the clinical setting to safeguard patients.
- The learning from complaints and incidents is shared with all members of staff.
- The hospital should consider reviewing night time security arrangements to ensure staff are protected at work.
- The privacy and dignity of patients is maintained at all times in the operating departments.
- Meetings held within the division of surgery and critical care have documented actions to provide assurance that concerns are being addressed.

Summary of findings

- Advance care plans are fully documented in order to comply with patient's wishes.
- Information leaflets on advance care planning, what happens when someone dies and how to register a death are available and up to date for patients and families
- Audit the views of bereaved relatives to make care change to improve to the service
- Porters, cleaners and mortuary staff receive standardised formal end of life care training.
- All staff are aware of how to contact different faith ministers to visit the hospital out of hours.
- All patient identifiable information is kept confidential at all times, including patient's namesin ward areas.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Requires improvement 	Overall we rated this service as requires improvement because: The service had made a number of improvements since our 2014 inspection report. However, governance processes still did not effectively address safety concerns. We found a number of issues which impacted patient safety such as medicine management, security of records and patient documentation. Senior staff were not aware of these issues and had not yet developed an action plan to address them. The cardiology ward was in need of refurbishment and could pose an infection control risk as cracked and broken areas could not be adequately cleaned. This had been escalated to the risk register in December 2012 but no significant progress had been made to resolve this issue. Staffing levels in the pharmacy service were not as planned and they could not deliver an effective service, including to the medicine division. Although the service prioritised patients with the greatest need, some key performance indicators were not achieved. Staff did not follow policies and procedures to ensure the safe storage of medicines. Expired or unwanted medicines were stored alongside ward stock, which posed a risk that patients would receive incorrect or expired medicines. Staff did not record fridge temperatures on a daily basis and did not take action when the medicines fridge temperature was out of range. We found prescription charts without clear prescriber identifiers' and patient allergy status had not been signed in line with the trust policy. Patients' medical records did not always include a clear diagnosis and management plan. Some patients did not have a nursing care plan that reflected their needs or have risk assessments for pressure ulcers and malnutrition completed. Patient information was not always stored securely. We found trolleys with patients' medical records were left unlocked and unattended in public areas. We also found computer screens were open and

Summary of findings

unattended displaying patient test results in corridors and ward bays. There was a risk that unauthorised people could access confidential information. Staff on the stroke unit conducted their multidisciplinary board meeting in an open office behind the reception desk, which meant other patients and visitors could overhear confidential information.

There was not always adequate numbers of staff on duty and the data submitted showed the hospital did not meet their own planned staffing levels for August 2016. Not all staff had completed their statutory and mandatory training and this included safeguarding children and vulnerable adults level 2, Duty of Candour, infection control, medicines management and basic life support.

Not all staff had a good understanding of the principles of Mental Capacity Act and associated Deprivation of Liberty Safeguards (DoLS) and their responsibilities in relation to these areas, to support people whose circumstances made them vulnerable. We saw evidence that a patient had been given sedation to enable compliance with treatment without consent or a DoLS application.

Ward and senior managers had a good understanding of learning from incidents and complaints. However, there was little evidence that this learning was shared with staff. Managers did not always document minutes from meetings. This meant that staff who could not attend did not have an accurate record of issues discussed.

Although staff adhered to the 'bare below the elbow' policy to minimise spread of infection, we observed some staff did not use appropriate personal protective equipment and hand sanitiser when entering the ward.

Patients and relatives told us staff provided caring and compassionate care and they felt involved in their care. Staff recognised the importance of patient's emotional wellbeing and had developed initiatives to support this. Staff assessed and managed patient's pain and had access to the acute pain team if required.

The stroke and cardiac services provided services to meet the needs of patients. Paramedics and GP's

Summary of findings

could refer patients directly to the CSRU. The stroke unit ran a daily transient ischaemic attack (TIA) clinic which provided consultant review and access to diagnostic tests within the same appointment.
The hospital had clear vision and values, which staff knew about and were displayed in every ward area. The stroke and cardiac service had a clear strategy for development to expand the catchment area. The hospital participated in regional and national audits and had recently been awarded an A grading for the stroke service in the Sentinel Stroke National Audit Programme (SSNAP). There was also a local audit programme in place. The hospital had clear pathways for stroke and cardiac patients based of National Institute for Health and Care Excellence (NICE) guidelines.
The hospital had a clear governance structure and the medical division followed governance processes to ensure a review of performance, risk and quality. There was clear documentation of actions with detail of who was responsible for completing these.
The service had made some significant improvements since our last inspection in 2014. However, we found some concerns particularly about medicines management, which had not been addressed.
There was a culture of collaborative, multidisciplinary working across teams to coordinate patients' care. We observed multidisciplinary meetings where staff considered patient's individual risks and needs and agreed plans to support their care and treatment.
All staff understood the concepts of openness and transparency and some gave examples of where they had used the principles of Duty of Candour in practice.
Staff told us the leadership across the service was good and the senior team were visible and accessible. Nursing staff had annual appraisals and good access to professional development. Although junior doctors told us they had good access to support and training, they did not always receive an annual appraisal.

Surgery	**Requires improvement**		Overall we rated this service as requires improvement because:

Summary of findings

Staffing levels in the pharmacy service were not as planned and they could not deliver an effective service, including to the medicine division. Although the service prioritised patients with the greatest need, some key performance indicators were not achieved.

Staff on the wards did not always dispose of out of date medicines promptly. They did not always follow the trust's controlled drugs policy when documenting receipt of controlled drugs.

We found incomplete records for the anaesthetic machine logbooks in the operating departments and for the resuscitation equipment on the wards. It was not clear if staff completed the daily safety checks and the equipment was safe to use .

While staff in theatres followed the World Health Organisation (WHO) surgical safety checklist, we observed staff who did not always pay full attention for each stage of the process to ensure patients' safety.

Theatre staff did not always comply with the trust's uniform policy to minimise the risk of infection.

Staff did not have a good understanding of the principles of Mental Capacity Act and associated Deprivation of Liberty Safeguards and their responsibilities in relation to these areas, to support people whose circumstances made them vulnerable and who could not always give consent.

Patients' record keeping was not to a consistent standard. Although patients told us they made informed decisions about their surgery, medical staff did not always document the conversation fully.

The division had not achieved the 18 week referral to treatment time indicator for 90% of patients admitted for an operation over the last five months.

Three trust policies and standard operating procedures were out of date for review. .

Departmental and managers' meetings did not record discussion and actions and there was not a formal record of decisions or assurance that concerns were addressed.

Staff knew the process for reporting incidents. They received feedback from reported incidents and felt supported by managers when considering lessons learned.

Summary of findings

Areas we visited were clean and tidy, we saw most staff following good infection prevention and control practices.
There was good multidisciplinary working across teams at the hospital so patients received co-ordinated care and treatment. Staff planned and delivered patients' care and treatment using evidence based guidance and audited compliance with National Institute Health and Care excellence (NICE) guidelines.
Nursing staff completed risk assessments for patients. If a patient became unwell, there were systems for staff to escalate these concerns and refer them to another hospital if necessary. The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
We saw staff care and treat patients with compassion. They were kind and treated them with dignity, and respect. There were systems to support patients with additional or complex needs. Patients felt informed and involved in their care. They said they would recommend the service to others.
Staff followed the governance processes to monitor the quality and risks of the surgical service. They completed audits and monitored patient outcomes, making changes to practice when necessary.
Outcomes for patients were similar to the England average compared to data from national audits such as the bowel cancer audit. The divisional leads used the monthly quality reports and dashboards to support this.
Feedback from patients and staff had been used to develop and improve the service. The divisional leads and executive team considered the sustainability of the service and had a strategy in place to support this.
Staff told us the leadership across the service was good and the senior team were visible and accessible. Staff had an annual appraisal and could access additional training to develop in their role.

End of life care — **Requires improvement**

Overall this core service was rated as 'requires improvement'
We rated end of life services as 'requires improvement' for safe and effective care and 'good' for being caring, responsive and well led.

Summary of findings

Advance care plans were not fully documented for some patients, so staff and families were not routinely aware of patient's care preferences before and after death.
DNACPR forms were not completed according to national guidelines, which include the need to document discussions with patients and families and that Mental Capacity Act decisions were documented.
Infection prevention and control practices were not all being followed. We observed in the bereavement office deceased patients' belongings were stored in cupboards in open plastic carrier bags; this has the potential for cross infection.
There was no protocol for withdrawing treatment as recommended in the 2015 National Institute of Clinical Excellence guidelines. However, the trust said that they were prioritising this guidance for completion in 2017.
The hospital did not classify end of life care training as a mandatory subject as recommended by of the National Care of the Dying Audit 2013/14
There were governance processes, including evidence of investigation of incidents and audits and lessons learnt for staff to improve patient care.
Patients' needs were mostly met through the way end of life care was organised and delivered. However, a rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way due to external delays with funding and care packages for complex needs
Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was consistently positive. We saw good examples of staff providing care that maintained respect and dignity for individuals. There was good care for the relatives of dying patients, and staff showed sensitivity to their needs.
The trust had on going engagement with a people panel to ask for opinions and suggestions in what mattered to them regarding developing plans for end of life care. The panel were consulted regarding the trust wide end of life patient care plans called "Getting it right for me" We saw that the care plans were not consistently used for end of life care patients during the inspection. The trust were aware

of the concern and had appointed an end of life care facilitator to improve end of life care education for clinical staff and to ensure the care plans were used correctly.
The people panel were consulted on the trust wide end of life care strategy, which was complete but not published at time of inspection. Staff we spoke with was aware of end of life care priorities and described high quality patient care as the key component of the trust's vision.

Wycombe Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; End of life care

Detailed findings

Contents

Background to Wycombe Hospital

Wycombe Hospital is part of Buckinghamshire Healthcare NHS Trust. The hospital offers a wide range of surgical services and specialist medical care for stroke and heart conditions. The hospital also offers specialist cancer and urological services. The hospital has 250 beds.

The hospital is the area's major hub for planned surgical care. Surgical teams carry out over 24,900 operations every year. Wycombe Hospital sees more than 36,000 inpatients and 145,000 outpatients a year. Wycombe is also home to a modern midwifery-led maternity unit aimed at providing a more home-from-home environment for women and their partners.

We carried out a focused unannounced inspection visit on 7 September 2016. We inspected the medical, surgical and end of life care services provided at this location. During the inspection, we also followed up issues identified at the inspection in February 2014 and March 2015 relevant to the service types inspected.

Our inspection team

Our inspection team was led by:

Team leader : Lisa Cook, Inspection Manager, Care Quality Commission (CQC)

The inspection team included two CQC inspection managers, five inspectors, an assistant inspector, two pharmacy inspector and a nine specialists: a theatre manager, a surgeon, a surgical nurse a senior sister/ward manager, a consultant in palliative medicine, a end of life care lead nurse, physiotherapist, director of nursing and clinical services; nurse practitioner from medicine and an expert by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out a focused unannounced inspection visit on 7 September 2016.

Detailed findings

During this comprehensive inspection, we assessed the surgical, medical and end of life care services. We spoke with members of staff and patients, observed patient care, looked at patients' care and treatment records and trust policies.

We would like to thank all staff for sharing their balanced views and experiences of the quality of care and treatment at Wycombe Hospital.

Facts and data about Wycombe Hospital

This information relates to the acute services provided Buckinghamshire Healthcare NHS Trust

Safe

- There were 82 serious incidents reported.
- The trust reported a lower number of incidents per 100 admissions compared to the England average.
- Thirty four Clostridium difficile cases and 43 Meticillin Sensitive Staphylococcus Aureus cases reported.
- Prevalence rates of pressure ulcers and catheter UTIs have remained similar over time.
- Staffing skill mix is similar to the England average for consultants and junior doctor
- Three never events, two of which were in ophthalmology both regarding a cataract operation. The other was a medication error.
- One methicillin-resistant staphylococcus aureus case has been reported in March 2016.

Caring

- Scored similar to the England average for Patient-led assessments of the care environment (PLACE) indicators .
- Numbers of written complaints has decreased in 2015/16.
- This trust is in the middle 60% of trusts for the majority of the indicators (45) in the Cancer Patient Experience Survey.
- The trust performed similar to the England average in the Friends and Family Test.
- In the inpatient survey the trust performed about the same as other trusts for all questions

Responsive

- Forty four percent of delayed transfers of care in the trust are due to 'Awaiting Residential Home Placement or Availability.
- Bed occupancy is higher than the England average and is frequently close to 100% capacity.

Well led

- Staff sickness absence rate is lower than the England average throughout the time period.
- The trust performed similar to the England average for the majority (31) of indicators in the NHS Staff Survey.
- Performed worse than expected to the England average for two out of 12 indicators ('induction' and 'feedback') in the GMC National Training Scheme Survey.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Wycombe Hospital is part of Buckinghamshire Healthcare NHS Trust. The hospital provides cardiology, respiratory, oncology, medicine and stroke services. The hospital has a cardiac and stroke receiving unit (CSRU), cardiac investigation unit, cancer day unit, endoscopy unit, and stroke unit.

During this inspection, we inspected the cardiac and stroke receiving unit (CSRU), the cardiac ward (2a) and the hyper acute stroke ward (ward 8) and the stroke ward (ward 9).

We spoke with 18 members of staff including the cardiology and stroke lead nurse, nurses of different grades, healthcare assistants, medical staff, ward clerks, housekeeping staff and therapists. We observed interactions between staff and patients, considered the environment, reviewed 27 records and spoke with 10 patients. In addition, we reviewed documents relating to the management and performance of the trust before and after our inspection.

Summary of findings

Overall we rated this service as requires improvement because:

- Although the service had made a number of improvements since our 2014 inspection report, we had concerns governance processes did not effectively address safety concerns.
- The cardiology ward was in need of refurbishment and could pose an infection control risk as cracked and broken areas could not be adequately cleaned. This had been escalated to the risk register in December 2012 but no significant progress had been made to resolve this issue.
- We found a number of issues which impacted patient safety such as medicine management, security of records and patient documentation. Senior staff were not aware of these issues and had not yet developed an action plan to address them.
- The pharmacy service did not have enough staff and could not deliver an effective service, including to the medicine division. Although the service prioritised patients with the greatest need, some key performance indicators were not achieved.
- Staff did not follow policies and procedures to ensure the safe storage of medicines. Expired or unwanted medicines were stored alongside ward stock, which posed a risk that patients would receive

incorrect or expired medicines.Staff did not record fridge temperatures on a daily basis and did not take action when the medicines fridge temperature was out of range.

- We found prescription charts without clear prescriber identifiers' and patient allergy status had not been signed in line with the trust policy.
- Patients' medical records did not always include a clear diagnosis and management plan. Some patients did not have a nursing care plan that reflected their needs or have risk assessments for pressure ulcers and malnutrition completed.
- Patient information was not always stored securely. We found trolleys with patients' medical records were left unlocked and unattended in public areas. We also found computer screens were open and unattended displaying patient test results in corridors and ward bays. There was a risk that unauthorised people could access confidential information. Staff on the stroke unit conducted their multidisciplinary board meeting in an open office behind the reception desk, which meant other patients and visitors could overhear confidential information.
- There was not always adequate numbers of staff on duty and the data submitted showed the hospital did not meet their own planned staffing levels for August 2016. Not all staff had completed their statutory and mandatory training and this included safeguarding children and vulnerable adults level 2, Duty of Candour, infection control, medicines management and basic life support.
- Not all staff had a good understanding of the principles of Mental Capacity Act and associated Deprivation of Liberty Safeguards (DoLS) and their responsibilities in relation to these areas, to support people whose circumstances made them vulnerable. We saw evidence that a patient had been given sedation to enable compliance with treatment without consent or a DoLS application.
- Ward and senior managers had a good understanding of learning from incidents and complaints. However, there was little evidence that this learning was shared with staff. Managers did not always document minutes from meetings. This meant that staff who could not attend did not have an accurate record of issues discussed.
- Although staff adhered to the 'bare below the elbow' policy to minimise spread of infection, we observed some staff did not use appropriate personal protective equipment and hand sanitiser when entering the ward.

However,

- Patients and relatives told us staff provided caring and compassionate care and they felt involved in their care. Staff recognised the importance of patient's emotional wellbeing and had developed initiatives to support this. Staff assessed and managed patient's pain and had access to the acute pain team if required.
- The stroke and cardiac services provided services to meet the needs of patients. Paramedics and GP's could refer patients directly to the CSRU. The stroke unit ran a daily transient ischaemic attack (TIA) clinic which provided consultant review and access to diagnostic tests within the same appointment.
- The hospital had clear vision and values, which staff knew about and were displayed in every ward area. The stroke and cardiac service had a clear strategy for development to expand the catchment area. The hospital participated in regional and national audits and had recently been awarded an A grading for the stroke service in the Sentinel Stroke National Audit Programme (SSNAP). There was also a local audit programme in place. The hospital had clear pathways for stroke and cardiac patients based of National Institute for Health and Care Excellence (NICE) guidelines.
- The hospital had a clear governance structure and the medical division followed governance processes to ensure a review of performance, risk and quality. There was clear documentation of actions with detail of who was responsible for completing these. The service had made some significant improvements since our last inspection in 2014. However, we found some concerns particularly about medicines management, which had not been addressed.

Medical care (including older people's care)

- There was a culture of collaborative, multidisciplinary working across teams to coordinate patients' care. We observed multidisciplinary meetings where staff considered patient's individual risks and needs and agreed plans to support their care and treatment.
- All staff understood the concepts of openness and transparency and some gave examples of where they had used the principles of Duty of Candour in practice.
- Staff told us the leadership across the service was good and the senior team were visible and accessible. Nursing staff had annual appraisals and good access to professional development. Although junior doctors told us they had good access to support and training, they did not always receive an annual appraisal.

Are medical care services safe?

Requires improvement

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

We rated safe as requires improvement because:

- Staff did not always follow the trust's medicine management policies and procedures. We found staff were not always recording the medicine fridge temperature on a daily basis and did not take any action when the temperature was out of range. We also found expired or unwanted medicines such as insulin and intravenous fluid stored alongside stock medicines, staff had not recognised they had expired.
- Staff did not always complete medicine records accurately, we found prescription charts without prescriber identifiers' and the patient allergy status was not always signed as per the trust policy.
- The trust was significantly below their target for medicines reconciliation. Pharmacists had started between 46% to 49% of medicines reconciliation within 24 hours in July and August 2016 against a target of 60%.
- Staff could not always describe where learning from incidents had changed clinical practice. Staff told us they could not attend education sessions on learning from incidents due to clinical duties. Staff told us they attended ward meetings but the minutes from these were not documented. Therefore, it is difficult to conclude the quality of the discussions or if managers shared learning.
- In the Cardiac and Stroke Receiving Unit (CSRU), one cubicle which was used for acute admissions did not have a nurse call bell. We also observed the sink was cracked and paint was peeling off the walls. In ward 2a, there were patches of uneven flooring covered with tape. These represented an infection control risk.
- The cardiac and stroke unit did not always meet their own planned staffing levels. In August 2016, 28 shifts

were understaffed by at least one member of staff and four of these were understaffed by two members of staff. Patients told us nursing staff could not always answer the call bell in a timely way.

- Patient confidential information was not always stored securely and there was a risk of unauthorised access. We found patients' notes trolleys left unlocked and unattended in public areas. We also found patient confidential information left on desks and computer screens where patients or visitors could see it.
- We found that patient's did not always have a diagnosis, management plan or care plan which assessed risks to their care. We also found some patients did not have an adequate pressure ulcer or malnutrition risk assessment completed.
- Not all staff had completed their statutory and mandatory training, this included safeguarding children and vulnerable adults level 2, duty of candour, infection control, medicines management, basic life support and tissue viability.
- Staff had concerns over night- time security at the hospital. We highlighted this issue when we inspected the hospital in February 2014. Although some action had been taken such as the implementation of CCTV cameras, at least one incident had occurred within the cardiac and stroke speciality. Staff were concerned that the lack of security staff at night left them vulnerable if a patient or relative become aggressive. Staff had not received feedback into the investigation after the incident or how security issues were going to be addressed.

However:

- Medical staff held monthly morbidity and mortality meetings to discuss unexpected deaths or adverse incidents that had affected patients.
- The wards we visited were visibly clean and equipment displayed stickers showing it was clean and ready for use.
- The stroke and cardiac unit had clear pathways for identification and treatment of patients who had suffered a stroke, chest pain and heart failure.
- Staff could explain the concept of openness and transparency and some gave examples of where they had used duty of candour in practice.
- Staff had a good understanding of safeguarding protocols and could give examples of where they had made referrals or shared concerns to protect vulnerable patients.
- The hospital used a National Early Warning System (NEWS) to identify significant changes in patients' condition. Staff had a good knowledge of the NEWS scoring responded appropriately to scores outside acceptable limits.
- The hospital had emergency and major incident plans in place and copies of these were available on every ward. Staff had a good knowledge of local major incident and emergency plans for their ward area.

Incidents

- Staff reported incidents using the trusts electronic reporting system. All the staff we spoke with understood the process to report an incident and could give examples of when they had done so.
- Ward managers had a good knowledge on trends of incidents relevant to their area. The ward manager of the stroke unit told us about changes that had taken place because of incident reporting. For example, a steering group was formed to look at how to prevent patient falls and the hospital had adopted a 'stay in the bay' initiative that had been in place since April 2016. This involved allocating computers in the bay for staff use and at least one member of staff, be it nurse, doctor, or therapist, present in the bay to supervise patients at all times. Throughout our inspection, we observed staff adhering to this initiative. However, staff told us they did not always receive individual feedback on incidents they had reported and not all staff could describe learning from incidents.
- Managers told us learning from incidents was shared at team meetings. However, managers did not document minutes from staff meetings and therefore it was difficult to conclude the quality of the discussions or if managers shared learning.
- The division of integrated medicine reported 3023 clinical incidents from April 2015 to March 2016, 2885

(95%) were classed as no or low harm, 116 (4%) moderate harm, five severe and 14 resulted in death. Out of the 928 incidents that caused harm, 28% related to pressure ulcers and 21% related to falls.

- There were no never events reported between June 2015 and May 2016 the division of integrated medicine. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, be implemented by all healthcare providers.
- The trust held a teaching session called 'lessons learnt' which focussed on specific topics relating to learning from incidents. The staff we spoke to knew about this session but attend due to clinical duties on the ward.
- Senior medical staff held morbidity and mortality meetings to discuss unexpected deaths or adverse events that related to patients. Learning from these meetings was shared across divisions and included in the 'lessons learnt' teaching sessions. However, we did not see evidence this was shared with staff at ward level in team meetings.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with could explain the concepts of openness and transparency and some could give examples of how they or their colleagues had applied DoC. Staff told us about a patient who did not receive a blood thinning medicine on admission to hospital which caused complications after discharge. The hospital apologised to the patient and their family and provided opportunities for them to meet with senior doctors and nurses and review the final investigation report to understand how the mistake occurred.
- The trust provided training for all staff in the principles of DoC. The attendance was below the trust target of 90%, 89% of staff without direct patient contact and 72% of staff with direct patient contact had completed this training as of September 2016.

Safety thermometer

- The trust monitored its safety performance through the use of the safety thermometer. The NHS safety thermometer is a monthly snapshot of avoidable harms that can occur. This includes pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE or blood clots) and falls.
- Wards displayed safety thermometer information, including the number of harm free days on notice boards in the ward corridor. However, there was no explanation of the meaning of harm free care on display to support the data displayed.Results on ward 2a and the stroke unit showed from August 2015 to August 2016 there were between 76% and 100% of harm free care days.
- The lowest measurement of 76% was recorded on ward 9 in July 2016 and related to pressure ulcers and catheter-related urinary tract infections.The trust did not provide any action plans to show how they planned to address this.

Cleanliness, infection control and hygiene

- The trust required that all patients were screened for meticillin resistant staphylococcus aureus (MRSA is a bacterium which can lead to infection) prior to or on admission. Between April to July 2016, there had been no cases of MRSA reported in in the division of integrated medicine.
- Between April 2015 to March 2016, 38 patients acquired Clostridium difficile (C.difficile is a bacterium which can lead to infection) against a target of 32 cases. Twenty of the 38 cases were in division of integrated medicine. Out of these 20, four occurred on ward 9 and one on ward 2a. The root cause analysis identified delays in sending stool samples and commencing stool charts. The trust did not submit an action plan to show how they planned to address this. The major risk factor identified by the trust was antibiotics.
- The wards we visited were visibly clean and equipment displayed stickers to show staff had cleaned them and they were ready for use.
- In CSRU, the sink in the emergency bay had a crack in it and paint on the walls was peeling off and on ward 2a some areas of the floor had tape on cracked and uneven patches and was in need of repair. This posed

an infection control risk, as the areas could not be cleaned effectively. However, senior staff recognised the risk and included it on the integrated medicine risk register. In order to address this, the trust planned to put forward a business case to build a new cardiac ward. Staff told us that in order to minimise the risk of infection while the business case was being reviewed the cleaning team carried out more frequent cleaning in this area.

- Staff had access to personal protective equipment (PPE) such as gloves and aprons. However, on the Cardiac and Stroke Receiving unit (CSRU) and ward 2a we observed staff gave patients' commodes and cleaned them without wearing an apron. This could pose an infection control risk if bodily fluids were splashed onto staff skin or uniforms.
- Hand sanitisers were available throughout the wards, however on CSRU and ward 2a we observed staff entered the ward and did not use hand sanitiser on three occasions. Staff on ward 8 and 9 used hand sanitiser appropriately. Staff on all wards adhered to the trust policy for 'bare below the elbow'. This allowed for effective handwashing and helped minimise the risk of spreading infection.
- The trust carried out an audit on the use of PPE and hand hygiene in November 2015. Ward 2a and CSRU achieved 100% and the stroke wards achieved 99%.
- The hospital provided hand hygiene training for staff with direct patient contact and 81% of staff within the medicine division had attended this training. The hospital also provided infection control training, 82% of staff without direct patient contact and 75% of staff with patient contact had attended this training. This was below the trust target of 90%.
- Patient-led assessments of the care environment (PLACE) for September 2016 showed the hospital scored 98.6% for cleanliness this was slightly better than the England average of 98%. PLACE audits assess the quality of the patient environment against set criteria.
- Wards had single rooms which were used to isolate patients to control infection risks. However, staff told us there was constant pressure for these rooms as they were also used for other purposes such as end of life care. Senior staff used their clinical judgement to decide how best to use the rooms. Ward managers told us they would like more single rooms to provide isolation for infectious patients and patients receiving end of life care.

Environment and equipment

- Equipment on all the wards we visited was visibly clean. Staff had placed stickers on equipment to show it was clean and ready for use. All the equipment we observed also had a label detailing an asset number and service date to allow it to be tracked and show when the next service was due. All equipment we checked during our inspection had been serviced.
- The hospital did not provide security at night and staff told us this was a major concern for them. Staff described an incident where a patient assaulted a nurse and a male member of staff was asked to provide assistance. We heard staff had escalated this issue to the senior management team but had not received feedback. We highlighted security concern in our 2014 inspection report. The lead nurse told us they had minimised the risks on the stroke and cardiac wards by introducing security doors, cameras and conflict resolution training for staff. We observed the wards we visited had controlled entry and exit to ward to facilitate staff and patient security.
- In the CSRU, one cubicle did not have access to a nurse call bell. We observed staff told a patient to call out if they needed assistance. Staff told us the hospital planned to refurbish the ward and this would include installing a call bell.
- A double therapy room was located on ward 8 to provide physiotherapy and occupational therapy to patients recovering from a stroke. Staff told us they had good access to specialised equipment.
- The stroke unit had recently purchased a low bed which was used for patients at risk of falls. The unit previously had to order beds on loan from another company. Staff told us the low bed had improved patient care and reduced the risk of falls as the equipment was available immediately.
- The PLACE audit for September 2016 showed the trust scored 86.9% for condition, appearance and

maintenance. This was lower than the national average of 93.3%. The trust had identified actions to improve this score such as providing designated money to address the main issues of concern.

Medicines

- The hospital had an onsite pharmacy where staff dispensed medicines, however some wards experienced delays in supply, as the central medicine store was located at a different hospital within the trust.
- There were 13 whole time equivalent vacancies for the pharmacy service across the trust. This was having a significant impact on the service that pharmacy staff provided to the ward and for patients.
- Staff shortages in pharmacy meant the trust did not meet their own medicines reconciliation target in July and August 2016. National Institute for Health and Care Excellence (NICE) guidelines recommend all patients should receive medicines reconciliation within 24 hours of transfer of care. Medicines reconciliation is the process of identifying an accurate list of medicines for the patient on admission. Data from the trust showed 46% of patients medicines reconciliation had started within 24 hours in July 2016 and 49% in August 2016. This was significantly lower than the trust target of 60%. There was an increased risk that patients may not have been prescribed all their correct medicines. The trust told us they had not met their 60% target due to lack of pharmacy staff and this had been escalated to the risk register. The chief pharmacist had asked pharmacy staff to prioritise high-risk patients for medicines reconciliation and clinical pharmacy review.
- Wards stored medicines securely in locked medicines trolleys, treatment rooms and in patient lockers. The nurse in charge held the key to access medicines. However, staff did not always store unwanted and expired medicines separately from the main ward medicine stock. This posed a risk that patients could receive out of date medicine or medicine due to be returned to the pharmacy department.
- Staff managed controlled drugs (CDs) safely. We observed wards stored CDs in appropriate cupboards, carried out daily stock checks and pharmacy staff had completed audits. The audits were carried out to monitor compliance with legislation and safe working practices for storage, records and stock checks of CDs.
- On ward 9 we found a drawer of out of date intravenous fluid and medicines stored in a cupboard in the clinic room. We also found the medicines fridge on ward 9 contained insulin that had been dispensed in March and June with no date of opening recorded. Insulin vials must be discarded after four weeks of opening and therefore there was a risk patients' could receive out of date medicine. Insulin vials were not always labelled for patients and intravenous feed which had expired in August 2016 was still being stored in the fridge. We asked to see records of medicine stock checks, however, staff told us they did not complete these checks. There was a potential risk that patients could receive incorrect or expired medicine because the system for storage of medicines was not robust
- Staff did not always record the temperature of the fridge on a daily basis or take action when the temperature was out of the recommended range of 2 to 8 ˚C. From June 2016 to August 2016, the fridge temperature on ward 9 was recorded as out of range on 63 days, the minimum was recorded as 0.1 ˚C and the maximum 9.4 ˚C. There was no evidence that staff had taken action to resolve the issue or ensure the medicines stored in the fridge was safe to administer to patients. On 18 days from June 2016 to August 2016, staff had not recorded the fridge temperature. There was a risk that medicines had not been stored to manufacturers specifications which could reduce the efficacy of medicines when administered to patients
- Although staff had documented allergies on patient prescription charts, staff did not always sign and date this as per the chart instructions. The person who prescribed medicines was not always written on the prescription chart. This meant staff could not easily check the prescription with the person who had written it.
- The trust provided medicines management training to staff. In the cardiac and stroke speciality 68% of staff had completed this training, which was significantly lower than the trust target of 90%.

Medical care (including older people's care)

Records

- Patient records were in paper and electronic format. All professionals used the same records to ensure care was detailed in chronological order. The wards stored medical notes in the ward office or locked notes trolleys and nursing assessments and paperwork in files at the end of the patient's bed or outside their room. Although the wards had processes in place to keep patient information secure, staff did not always follow these processes. We observed notes trolleys were left unlocked and unattended in a public area on ward 2a and confidential information left on the desk where members of the public could view it on ward 2a and ward 9. This meant there was a risk that unauthorised people could access confidential information.
- Staff had signed and dated entries in a timely manner with a clear explanation of the care provided. All the records we looked at were written clearly in legible handwriting.
- Physiotherapists documented their notes using the subjective objective assessment and treatment plan (SOAP) method in line with the Chartered Society of Physiotherapy and Health and Care Professions Council (HCPC).

Safeguarding

- Safeguarding children and vulnerable adults training was part of the statutory training for all staff. The level staff needed to achieve was determined by their job role and in line with national guidance.
- Staff had a good understanding of safeguarding and gave examples of how they had dealt with concerns and made referrals to appropriate people. The trust had designated leads for safeguarding and staff knew how to contact them. We observed safeguarding guidance displayed on staff notice boards.
- As of August 2016, 91% of staff in the cardiac and stroke speciality had completed safeguarding vulnerable adults and safeguarding children level 1 training. This met the hospital target of 90%. However, only 87% of staff had completed safeguarding vulnerable adults level 2 training and 80% of staff had completed safeguarding children level 2 training. This did not meet the hospital target.
- The trust provided PREVENT (preventing people at risk of radicalisation) training for all staff which was completed every three years. The PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who are at greater risk of radicalisation. As of August 2016, 87% of staff in the stroke and cardiac speciality had completed this training and the trust was on target to meet the 90% government training target by 2018.

Mandatory training

- The hospital delivered statutory and mandatory training via online training or classroom based sessions. Topics covered included infection prevention and control, fire safety, information governance, summoning emergency help, health and safety, manual handling, conflict resolution and equality and diversity.
- Each member of staff was assigned a role-specific mandatory and statutory training plan via the online e-learning system used by the trust. This sent reminder emails to staff and their manager when they needed to renew a training module. Statutory training is training which staff are legally required to complete, such as fire safety. Mandatory training is training which staff must complete but is specific to the role they are completing, such as basic life support or advanced life support
- Although staff in the cardiac and stroke specialities met compliance for most of their mandatory training, there was a significant lack of compliance with some modules. For example, only 56% of staff had completed adult basic life support training and 64% had completed tissue viability training.

Assessing and responding to patient risk

- Staff did not always complete assessments in relation to malnutrition and pressure ulcers. Three of the eight patient records we looked at did not have a pressure ulcer risk assessment and five did not have a malnutrition risk assessment. This meant that plans were not in place that ensured risks to patients were minimised. However, in conversation with the dieticians they were aware of the patients who needed support for their nutrition and hydration needs.

- Staff completed falls risk assessments to identify patients at risk of falls. This enabled staff to respond and manage the risks associated with patient falls. For example providing a low bed or one to one nursing support.
- Medical staff completed venous thromboembolism (VTE) assessments and we saw evidence of this in patient records.
- Consultants reviewed patients within 12 hours of admission. However, in three out of eight records we looked at there was no formal diagnosis and management plan documented. This posed a risk that patients' care would not be delivered to support their diagnosis.
- The trust used a national early warning system (NEWS) to highlight significant changes in a patient's medical condition. Staff we spoke with had a good understanding of the actions they should take should a patients score increase above an agreed level. We reviewed eight patient records and saw staff had responded appropriately to changes in the NEWS score.
- The trust carried out a quarterly audit on compliance with NEWS scoring. The audit results showed ward 2a, CSRU and ward 8 consistently achieved over 94% compliance with recording and calculating the NEWS score. The audit highlighted that ward 9 had consistently lower compliance ranging from 75% to 89% from January 2016 to July 2016. A ward manager on the stroke unit told us they had recently implemented additional training such as scenarios and one-to-one training for staff to improve compliance with NEWS.
- The stroke unit had a clear pathway for patients admitted with a stroke. The stroke pathway had a clear progression and prompted staff to take specific actions such as imaging, swallow assessment and thrombolysis depending on the patient's condition. The cardiac unit also had a clear heart failure and chest pain admission assessment with clear protocols to follow.
- Resuscitation trolleys on all the wards we visited had a tamper proof seal. Wards kept medicines for use in an emergency in a separate drawer within the emergency trolley. The logbook for the emergency trolley stated the drawer required weekly checks, however on ward 9 the drawer had not been checked on one week in June and another in July. On ward 2a, we found emergency medicines that had expired and staff were not aware of this. We raised this to a senior member of staff who replaced the emergency medicines immediately.

Nursing staffing

- The trust used the safer nursing care tool to calculate the number of nurses needed on each ward to meet the needs of patients. Wards displayed staffing levels, which showed the actual number of nurses and healthcare assistants on duty, as well as the nurse in charge of the ward.
- The hospital provided planned versus actual staffing for each ward for atotal of 28 days. The data from 15 August to 11 September showed ward 2a were understaffed on 15 shifts which were a mixture of day and night shifts. Four shifts were understaffed by one qualified nurse and one healthcare assistant, nine shifts were understaffed by one qualified nurse and 2 shifts understaffed by one healthcare assistant On the stroke unit for the same period, six day and night shifts were understaffed by one healthcare assistant. Staff told us bank and agency staff were contacted to cover staffing shortages. However, on these shifts there was no bank or agency staff available. Patients told us nursing staff appeared busy and did not always answer the call bell in a timely way.
- On all the wards we visited, the nurse in charge was often required to provide nursing cover although they were not part of the nursing establishment. This meant they had reduced time to carry out their management and leadership roles.
- The stroke unit aimed to provide a stroke nurse on duty (SNOD) 24 hours a day to receive referrals and support the wards. Staff and managers told us this could not always be achieved and if there was no senior stroke nurse available then medical registrars provided cover for referrals.
- The transient ischaemic attack (TIA) clinic was consultant led and supported by a health care assistant. Staff told us that the lack of a dedicated registered nurse in this clinic could sometimes take

nurses away from clinical duties on the ward. The ward manager had recently submitted a business case to staff the clinic with an additional registered nurse. This was being reviewed at the time of our inspection.

- Ward managers on the stroke unit told us they had two vacancies for registered nurses. One manager told us they had recently had over 20 vacancies but had implemented a number of recruitment and retention initiatives to attract and retain staff to the unit.
- At the time of our inspection, the physiotherapy department had one vacancy for a full time member of staff and the occupational therapy team had vacancies for one full time member of staff and one part time member of staff. The dietetics there was one full time vacancy for a band 3 assistant. The trust told us they managed therapy staffing across two hospital sites to prioritise patients. Staff told us all patients had access to therapy when needed and we observed this on the ward and in patients' notes.

Medical staffing

- The trust had a higher proportion of junior doctors and middle career doctors than the national average (29% compared to 21% and 11% compared to 6%, respectively). There was a lower proportion of consultants and registrars than the national average (29% compared with 37% and 31% compared with 36%, respectively). However, junior doctors told us they had good support from consultants and registrars and could ask advice at any time.
- The stroke and cardiac unit were staffed with one consultant, one registrar and two junior doctors Monday to Friday from 9am to 5pm. From 5pm until 10pm there was one junior doctor supported by the on call team. The on call team of a consultant, junior doctor and registrar provide medical cover overnight from 9.30pm until 9am. On weekends, on call, consultants lead ward rounds supported by a junior doctor between 9am and 10pm and the on call team provide cover overnight.

Major incident awareness and training

- The Chief Operating Officer held the role of accountable emergency officer for emergency planning, resilience and response. The trust held resilience meetings every two months and had plans in place for emergency preparedness, resilience and response, mass fatalities, severe heat and hazardous materials with supporting action cards and triggers for escalation. Each ward also held a red folder with emergency plans specific to that ward.
- Staff could discuss how to access emergency and major incident plans and knew the protocol to follow if an incident took place.

Are medical care services effective?

Good

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

We rated effective as good because:

- The service used specific pathways and protocols for a range of conditions based on national guidance such as National Institute for Health and Care Excellence (NICE) guidelines.
- The trust participated in national and regional audits and undertook a local audit programme. The hospital had received an A grading in the Sentinel Stroke National Audit Programme (SSNAP) which is the highest possible grading.
- The hospital also performed better than the England average in the myocardial ischaemia national audit project (MINAP) for the treatment of patient with non-ST-elevation infarction (nSTEMI).
- The hospital employed stroke and cardiac research teams and there was evidence of research being implemented in practice to improve patient outcomes.
- The cardiology unit had a lower than expected relative risk of readmission rate. The average length of stay for non-elective cardiology patients was lower than the England average.
- Staff assessed and managed patient's pain appropriately and had access to the acute pain service for advice and support.

- Staff had good access to training and professional development. Nursing staff received regular appraisals and met the trust target.
- Multidisciplinary working was embedded across all the wards we visited and patient's medical records showed input from a range of professionals.
- Consultants carried out ward rounds seven days a week. Audit results showed that the hospital performed above the national and regional average for most standards set out in the NHS services, seven days a week guidance. However, there was limited access to occupational therapy at the weekends.

However,

- There was lack of consistently in care planning for patients. None of the records we reviewed at on ward 2a contained a care plan which posed a risk that staff may not provide consistent care. On the stoke unit, although all patients had a care plan, three of these did not have a documented diagnosis and management plan. This meant the care plan may not adequately reflect the patient's individual care needs. Three of the four records we reviewed on ward 2a at did not have a documented malnutrition assessment.
- Although staff had access to training for the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS), staff did not always recognise when a patient was being deprived of the liberty and apply for a DoLS order. We observed a patient who had received chemical restraint without the correct order in place.
- The trust performed worse than the England average in 11 of the 17 scored measures in the National Diabetes Inpatient Audit (NaDIA).
- The relative risk of readmission was higher than the national average on the stroke unit and the average length of stay for stroke patients was above the England average.
- The appraisal rate for medical staff within the integrated medicine division was 83%, which was below the trust target of 90%.

Evidence-based care and treatment

- The trust had specific pathways and protocols for a range of conditions. These included patients with heart failure, stroke, and acute coronary syndrome. Pathways were based on national guidance such as National Institute for Health and Care Excellence (NICE) guidelines. For patients who had heart failure or had suffered a stroke the care pathways were integrated and promoted effective care and treatment from the full multidisciplinary health team.
- The stroke unit used the National Institute of Health Stroke Scale (NIHSS) to assess the impairment caused by a stroke.
- The trust's sepsis group had developed a sepsis screening and treatment pathway based on the National Clinical Guideline No. 6. Doctors and nurses used this tool to assess the risk of sepsis in patients and to give clear guidance on what actions to take and when.
- The medical division participated in national clinical audits, to measure the effectiveness of care and treatment provided. These included a heart failure audit, the Myocardial Ischaemia National Audit Project (MINAP) and the Sentinel Stroke National Audit Programme (SSNAP).
- The trust employed a research team for the stroke and cardiac service and could describe examples of how the service had used research findings in practice. For example, on the stroke unit intermittent pneumatic compression sleeves had been introduced after the hospital took part in a trial which showed this reduced the risk of venous thromboembolism (VTE or blood clot) and improved survival in immobile patients after a stroke. The research team shared findings from research trials with staff via a newsletter.
- The stroke unit has recently developed a role for a practice development nurse who told us they developed teaching programmes in line with NICE guidance. For example, they had recently held a teaching session about oral hygiene for patients who had difficulty swallowing.
- We reviewed four patients' records on the stroke unit. All the records had care plans that reflected the needs of the patient. However, three records did not have a documented diagnosis or management plan. On ward 2a, we reviewed four patient records and although all had a diagnosis and initial management plan, none of the records had a nursing care plan written to reflect

the patient's needs in line with NICE guidance. Care plans outline how a patient's care needs will be met during their admission. Therefore lack of care plans posed a risk that staff would not provide consistent care and treatment to patients.

Pain relief

- Staff used a zero to three pain scoring tool to assess patients' pain and recorded this on the National Early Warning System (NEWS) charts. We observed staff asked patients' about their pain and offered pain relief at regular intervals.
- Therapy staff monitored the patient's pain level during treatment. We observed a therapy session where the physiotherapist asked the patient about their pain at regular intervals and liaised with nursing staff to administer pain medicine.
- The hospital had an acute pain team who provided advice and support to staff in managing patient's pain. Staff told us they had a good relationship with the team and felt able to ask for advice or request the team review a specific patient. We observed a patient who had been referred to the pain team to manage chronic pain. This was in line with the core standards for pain management services in the UK (Faculty of Pain Medicine, 2015).

Nutrition and hydration

- The hospital used a recognised tool to assess patients' risk of malnutrition. However, we reviewed four patients' medical records on ward 2a and none of these had a malnutrition assessment completed. However, on the stroke unit, we looked at four patients' medical records and three of these had a malnutrition assessment completed. There was evidence staff monitored and documented patient's food and fluid intake when required.
- On the stroke unit, speech and language therapists assessed patients' ability to swallow safely and documented clear guidance for ward staff on how to prepare their food and drink to the right consistency. Dieticians provided dietary advice and plans for patients who had specific dietary requirements or those identified at risk. We observed nursing staff, consultants, speech and language therapists and dieticians discussed individual patient's nutrition and hydration needs at ward rounds and board meetings.
- On all the wards we visited, patients had water jugs and we observed patients were offered food and fluids on admission to wards and the Cardiac and Stroke Receiving Unit (CSRU).
- The hospital used a red tray system to identify patients in need of assistance with meals. We observed this in place across all the wards we visited.
- The hospital had a protected mealtime policy in place across all wards and we observed signs in place to inform patients and visitors about the policy. The aim of this was to stop all non-urgent clinical activity during mealtimes to allow patients to eat their meals without interruptions. This also allowed nursing staff to provide assistance with meals to those who required it.
- Patient-led assessments of the care environment (PLACE) for September 2016 showed the hospital scored 91.6% for food. This was slightly higher than the England average of 88.2% and showed an increase since the 2015 audit.

Patient outcomes

- The stroke and cardiac unit took part in national audits. These included the sentinel stroke national audit (SSNAP), heart failure audit, myocardial ischaemia national audit project (MINAP) and diabetes inpatient audit.
- The SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. Results for all trusts carrying out the audit are reported quarterly. From April 2015 to March 2016, the hospital scored a level A which is the highest possible score.
- The hospital participated in the National Institute for Cardiovascular Outcomes Research (NICOR) heart failure audit for hospital care. The hospital performed better than the England average in seven of the twelve indicators including input from specialists, discharge planning and completing echocardiograms. The hospital performed worse than the England average for the remaining five indicators which related to patient discharge.
- Results of the myocardial ischaemia national audit project (MINAP) national audit 2013/14 showed the trust's outcomes were better than the England

average. Of 161 patients with non-ST-elevation infarction (nSTEMI), 98.8% were seen by a cardiologist or a member of the cardiology team. This was the higher than the national average of 94.3%. The audit showed 96.4% of these patients were admitted to a designated cardiac ward (against a national average of 55.6%). The trust performed slightly better than the national average for the proportion of nSTEMI patients referred for an angiogram, 79.5% against 77.9% nationally.

- Results of the National Diabetes Inpatient Audit (NaDIA) in September 2015 showed the trust performed worse than the England average percentage for 11 out of 17 scored measures. The trust performed worse than the England average for staff knowledge on diabetes care, foot risk assessments, meals and visits by the specialist diabetes team. The trust performed better than the England average on six of the 21 measures including patients able to take control of their diabetes care, patients admitted with foot disease, medicine, prescription and management errors.
- The overall relative risk of readmission was lower than expected for elective and non-elective cardiology but higher than expected for stroke patients from February 2015 to January 2016. A lower relative readmission rate is a positive indicator for patient outcomes.
- The average length of stay for non-elective medical patients was 6.7 days which was the same as the national average from March 2015 to February 2016. The average length of stay for non-elective stroke medicine was 13.5 days, which was above the national average of 11.2 days. For non-elective cardiology, the length of stay was 3.1 days, which was below the national average of 5.5 days.
- The stroke unit participated in early supported discharge for stroke patients in order for them to return home as soon as possible and continue to receive rehabilitation in their own homes. This was provided by the multidisciplinary team and was shown to improve functional outcomes and reduce the patient's acute length of stay.

Competent staff

- Nursing, therapy and medical staff told us they had good access to training and professional development.
- The trust employed specialist stroke and cardiac nurses who supported staff on the ward and arranged regular specialist study days with sessions delivered by therapists, consultants and research nurses.
- The stroke unit had recently employed a practice development nurse who was supported by an assistant practitioner to lead education across the stroke unit. The practice development nurse told us they planned to work clinically to support new staff for three days a week and provide teaching for the remaining two days a week. We observed teaching sessions with individual nurses focussed on specific subjects such as wound care, continence and oral hygiene.
- The stroke unit encouraged health care assistants and nursing staff to complete the Stroke Training and Awareness Resources (STARS), an online training package focussed on core stroke competencies. However, the hospital did not record or monitor which staff had completed the training. The practice development nurse told us they planned to start monitoring this.
- New staff underwent an induction programme during which time they were supernumerary. This allowed them to complete the corporate induction, core training and local induction to ensure they were familiar with the ward they were based on. The practice development nurse on the stroke unit told us they were in the process of developing a more robust stroke induction programme
- The trust provided a preceptorship course for all newly qualified nurses. New staff were assigned a mentor and an associate mentor. Staff were supervised until they had completed medicine administration and IV competency training.
- The stroke unit held specialist stroke study days with tuition from therapists, consultants and the stroke specialist nurse. Stroke nurses on duty (SNOD'S) were offered the opportunity to complete the specialist stroke course.

- Junior doctors told us they received good support from more experienced medical staff and consultants. The junior doctors we spoke with told us they felt there was always a senior doctor available for advice and support and senior staff answered questions in a way which supported learning rather than highlighting mistakes.
- Junior doctors across the stroke and cardiac wards received a ward-based induction led by a consultant. Junior doctors rotated to all areas of the stroke and cardiac ward to gain experience.
- The stroke and cardiac wards held lunchtime teaching sessions for junior doctors on a weekly basis. Staff told us they appreciated these sessions as they focussed on useful subjects such as how to interpret scans.
- The staff we spoke with told us they received regular appraisals, and commented appraisals had improved recently and now included a review of behaviours. The division of integrated medicine achieved an overall 90% completion rate for appraisals from September 2015 to August 2016 which met the trust target. However, the appraisal rate for medical staff in the integrated medicine division was 83%, which did not meet the trust target.

Multidisciplinary working

- On all the wards we visited, we saw evidence of good multidisciplinary team (MDT) working. Staff from different disciplines supported each other to co-ordinate patient care. Patient records showed that care planning for patients included assessments by different members of the MDT team. Patient records had entries from different disciplines including therapists, dieticians and the palliative care team.
- We attended a 'board round' on ward 8 where staff planned care or discharge arrangements for each patient on the ward. The meeting occurred daily and had good attendance from a physiotherapist, occupational therapist, consultant, the nurse in charge of the ward, dietician, stroke nurse, speech and language therapist and research nurse. Staff told us the ward round took place before the board round and each member of the MDT completed the MDT sheet detailing progress and treatment for the patient.
- The SSNAP audit from January 2016 to March 2016 showed the stroke unit achieved an overall B rating for MDT working. The unit performed better than the national average for patients to be assessed and receive treatment from physiotherapists and occupational therapists.
- The stroke unit displayed an MDT board for patients with information about different professionals who may be involved in their care. Staff reported they had good working relationships with other teams such as palliative care team, outreach and acute pain team.
- Paramedics could refer stroke and cardiac patients directly to the CSRU. For cardiac patients paramedics liaised with the nurse in charge of the ward and with the stroke nurse on duty for stroke patients. GP's were also able to refer into the cardiac and stroke unit by liaising with the registrar on duty.
- The senior stroke nurse on duty managed referrals from other hospitals for patients who required therapy or rehabilitation. They liaised with medical and therapy staff to ensure they were able to provide suitable care.

Seven-day services

- A stroke and cardiac consultant covered the wards on weekdays, and weekends on call. Consultants undertook ward rounds every day including weekends. Audit results produced by the hospital for April 2016 show the 65% of patients in a high care setting were reviewed by a consultant twice daily, on Saturdays this figure was 43% and on Sundays, 69%. This was above the regional and national average.
- Seven of the eight patients whose notes we reviewed had seen a consultant within 14 hours of arriving at hospital in line with NHS services, seven days a week guidance. The hospital participated in a national survey in April 2016 to monitor compliance. This showed that on weekdays the number of patients seen by a consultant was lower than the regional and national average. However, on weekends it was above the national and regional average.
- The diagnostic imaging department provided on call cover for computerised tomography (CT), and ultrasound 24 hours a day. A survey completed by the hospital in April 2016 showed 100% of patients accessed CT and echocardiograms and 50% of

patients received ultrasound and magnetic resonance imaging (MRI) scans within the designated timeframe for their clinical condition this included patients admitted out of hours.

- The stroke unit provided a stroke nurse on duty to cover the 24-hour period, seven days a week. The stroke nurse managed referrals to the unit from paramedics and other hospitals. Staff told us there were occasions where a stroke nurse was not on duty and therefore the medical registrar provided cover. The stroke unit provided thrombolysis for patients 24 hours a day.
- The cardiology unit provided a primary service from 8am to 6pm daily for patients who required cardiac interventions. Outside of these hours, patients were transferred to two other acute hospitals.
- The physiotherapy and occupational therapy teams provided cover Monday to Friday 8am to 4pm with a chest physiotherapist on call out of hours. Physiotherapy support was available at the weekends from an on call physiotherapist working across medicine, surgery and ITU.

Access to information

- Staff told us they had good access to patient-related information and records.
- The hospital provided discharge summaries to GP's to inform of them of patients care and treatment received in hospital.
- GPs had direct access to the cardiac registrar and stroke nurse on duty for advice and referrals.
- Referrals were faxed to the appropriate unit by secure fax after a telephone handover had been given. This ensured staff had access to appropriate information before the patient arrived at the hospital.
- Nurses handed over information when they transferred patients to a different ward. We observed a patient being transferred to the stroke unit from ward 8 with all relevant information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff asked for consent before providing any care or treatment for example taking blood, cannulation and therapy sessions.
- Staff received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). In the stroke and cardiac wards, 89% of staff had received MCA training and 82% of staff had received DoLS training. The hospital target was 90%.
- Staff on the ward 2a and CSRU had a good understanding of MCS and DoLS and could give examples of when they had needed to apply for urgent DoLS applications in order to safeguard a patient.
- On the stroke unit, staff were unclear about their roles and responsibilities in regard to MCA and DoLS. Staff told us the stroke specialist nurse managed all DoLS applications and they did not see this as part of their role. On the stroke unit, we observed one patient where sedation had been used on admission to manage the patient's behaviour, and medical staff had prescribed additional sedation to use when the patient was transferred. This is a form of chemical restraint and the ward had not made a DoLS application. We raised this with the senior nurse on the ward who was an independent prescriber. They sought advice from a doctor and cancelled the prescription for sedation. The nurse told us this would be reviewed based on the patient's condition at the time of transfer and DoLS application would be applied for if needed.

Are medical care services caring?

Good

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

We rated caring as good because:

- Patients and their relatives spoke positively about the kindness and compassion of the staff. Patients told us staff treated them with dignity and respect and we observed evidence of this in practice.
- Results from the NHS friends and family test from March to August 2016 showed 94.7% to 100% of patients would recommend the wards to friends and family based on the care they received.

- Staff took time to ensure patients and their relatives understood their care and treatment.
- Staff recognised the importance of patient's emotional well-being. They had developed a number of interventions to provide emotional support to patients.

However:

- The multidisciplinary team meetings were held in an open office behind the reception desk, which meant other patients, and visitors could overhear confidential and sensitive information

Compassionate care

- The patients we spoke with on the stroke and cardiac ward gave positive feedback about the staff. We received comments such as, 'wonderful care', 'amazing service', 'so grateful for the treatment', 'care is outstanding' and 'professionalism faultless'. We also observed thank you cards, which had been sent to the stroke unit with comments such as 'wonderful sensitive care', always kind, gentle and caring, and 'nurses really went the extra mile'.
- Overall, we observed staff behaved in a way to respect patients' privacy and dignity for example, they used curtains to ensure privacy and used blankets to maintain dignity when carrying out personal care or treatment. However, we observed a patient on ward 2a was not covered, which comprised his right to privacy and dignity. We highlighted this to staff who ensured additional blankets were provided to the patient immediately.
- The hospital Patient-Led Assessment of the Care Environment (PLACE) audit from August 2016 showed the hospital performed below the national average for privacy, dignity and wellbeing, scoring 70% against a national average of 84%.
- Friends and Family Test (FFT) results from March 2016 to August 2016 showed both the stroke and cardiac wards had low response rates for this survey. Ward 9 had the lowest response rate of 3.1% and ward 8 had the highest response rate of 33.3%. All wards received positive feedback, on wards 8 and 9, 100% of patients were likely to recommend the ward to their friends and family. On ward 2a, 97.8% of patients would recommend the ward and on CSRU 94.7% of patients would recommend the ward.
- The multidisciplinary team (MDT) board meeting was held in an open office behind the ward reception desk. This meant that patients and visitors could overhear confidential or sensitive information.

Understanding and involvement of patients and those close to them

- Patients told us staff took the time to explain their condition and treatment plan to them and they felt involved in decisions about their care. We observed a physiotherapy session where the therapist kept the patient informed of their treatment throughout the session.
- The multidisciplinary team on the stroke unit held family meetings during the first week of admission and prior to discharge. Staff told us they engaged with patients relatives throughout the patient journey and invited them to be part of therapy sessions.
- Staff on the stroke took time to talk through information with patients and allowed patients to ask questions to aid understanding. We observed a patient transferred from CSRU to ward 8 after suffering a stroke. The stroke nurse on duty spent time with the patient and family explaining the booklet and highlighting key information.

Emotional support

- Staff showed a good understanding of the emotional needs of patients. We observed two multidisciplinary team meetings where staff discussed a patient's mood and acknowledged their need for social interaction. It was evident staff considered the emotional and well-being needs of patients during their treatment and preparing them for discharge home.
- Although a psychologist was not available on the ward, the stroke unit could access support from a psychologist from another hospital if required. The stroke clinical nurse specialist (CNS) held a qualification in counselling and was able to prescribe antidepressants if required. The CNS also talked about

other methods of providing emotional support to patients such as showing them letters from patients who had completed their recovery, bringing in patient' dogs from home and using music.

- Staff used a mood assessment to assess patient's emotional well-being and placed a high priority on the emotional well-being of patients. Staff told us they could arrange for relatives to stay on the ward if needed and patients told us they felt able to express their feelings and obtain guidance from staff.

Are medical care services responsive?

Good

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

We rated responsive as good because,

- The hospital planned services to meet the needs of the local population such as merging stroke services to provide a single specialist provision to reduce patient transfer between two sites. The hospital was undertaking work within the local health and care system to design sustainability and transformation plans.
- Patient with chest pain or stroke had access to rapid assessment and treatment via the cardiac and stroke receiving unit (CSRU). The stroke unit held a transient ischaemic attack (TIA) clinic everyday prioritising the most urgent cases.These services took referrals directly from GP's and paramedics.
- The trust met the NHS 18-week referral to treatment time and performed significantly better than the England average.
- Patients within the stroke and cardiac specialities had limited bed moves after they received an initial assessment. The average length of stay was better than the England average for cardiology. However, for stroke patients this was higher than the England average.
- The hospital had access to specialist bariatric equipment such as chairs and hoists. We observed staff using alternative methods to communicate with non-verbal patients and making flexible arrangements for families to support patients living with dementia and learning disabilities. The hospital also had disability and dementia lead nurses.

However:

- There was no evidence that learning from complaints and concerns was shared with staff. Although complaints were a standard agenda item for cardiac and stroke clinical governance meetings, details of these were not documented. Staff told us learning from complaints was not always shared at ward meetings.

Service planning and delivery to meet the needs of local people

- Senior staff worked with the commissioners of local services such as GPs, the local authority, other providers and patient groups to plan and co-ordinate services to meet the needs of local people.
- The trust's Chief Executive chaired the Healthy Bucks Leaders Group and work on the local health and care system sustainability and transformation plans (STPs).
- The Cardiac and Stroke Receiving Unit (CSRU) accepted referrals for any patient who had suffered a stroke or suspected stroke. The CSRU also accepted referrals for patients who required primary cardiac interventions during the day Monday to Friday and had arrangements in place for out of hours cover.
- The trust had expanded the stroke unit at the hospital. They had merged the hyperacute stroke and acute stroke inpatient unit previously provided across two hospital sites. This provided a single specialist stroke unit for patients in Buckinghamshire and East Berkshire. This meant patients did not have to be transferred between hospitals for rehabilitation.
- The stroke unit provided thrombolysis 24 hours a day, seven days a week.

Access and flow

- The average length of stay for integrated medicine admissions at the hospital from March 2015 to February 2016 was 4.1 days for elective patients and 6.7 days for non-elective patients. This was higher than the England average for elective admissions, which was 3.9 days and the same as the national average non-elective admissions.

Medical care (including older people's care)

- The average length of stay for non-elective cardiac admissions from March 2015 to February 2016 was 3.1 days and better than the England average of 5.5 days. The average length of stay for stroke admissions was 13.5 days and higher than the England average of 11.2 days.
- The average bed occupancy across the trust was 91.3% from July 2015 to June 2016. Occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally.
- The capacity governance for July 2016 showed 100% of patients stayed on the same ward following their first bed move after assessment. The report showed there were 21 bed moves from January 2016 to July 2016, four of these occurred at night from 10pm to 6am. The data from CSRU showed 14 bed moves occurred between 10pm to 6am, however the majority of bed moves occurred in the day from 12pm to 7pm.
- The trust met the NHS 18-week referral to treatment (RTT) time and all medical specialities performed better than the England average from June 2015 to May 2016. For cardiology, 98.5% of patients were admitted for treatment within 18-weeks compared to the England average of 87%. This means waiting times for patients at the trust were better than the England average.
- On the stroke unit, planning for discharge started as soon as the patient was deemed medically fit. We observed a multidisciplinary board meeting where a range of professionals discussed patient's discharge and transport arrangements.
- The stroke unit had an early supported discharge initiative in place that involved the provision of rehabilitation for patients at home to reduce their length of stay in hospital.
- Although some staff felt patient transport was improving, staff across the wards we visited told us there had been a number of incidents where patients had waited for transport for over four hours and in some cases waited up to nine hours for transport home.
- The trust monitored patient transfer delays from September 2015 to August 2016. There were 17 which related to transfer delay failure, seven related to a discharge planning failure and 12 related to a lack of or delayed availability of beds. In total, this made up 3.9% of the incidents reported across the trust. There was no breakdown available specifically for integrated medicine at Wycombe hospital.
- Staff told us it could be difficult to transfer patients to another hospital managed by the same trust and after 7pm patients had to be admitted through the emergency department. Staff also told us although they were able to access transport for time critical patients, there were delays in accessing transport for other patients.
- The stroke unit held a transient ischaemic attack (TIA) clinic on ward 8 with availability of emergency appointments. The stroke nurse on duty took referrals from GPs and liaised with the consultant on duty to prioritise the most urgent cases. Patients' who attended the clinic saw the consultant both prior to, and after a range of diagnostic tests which included magnetic resonance imaging (MRI), electrocardiogram (ECG) and blood tests. This allowed the consultant to discuss results with patients within the same clinic and make decisions on their care and treatment.
- The hospital did not report any mixed sexed breeches in the last year.

Meeting people's individual needs

- We attended two multidisciplinary team meetings on the stroke unit and observed staff had a good understanding of patient's specific needs and preferences. For example, one patient admitted to the unit following a stroke also had terminal lung cancer. The team held a family meeting and discussed all options for rehabilitation and the patient's preference for going home instead of remaining in hospital. The team spent a considerable amount of time ensuring the patient and family had all the information to make a decision.
- The stroke unit gave patients and their families an information booklet designed to support patients and their relatives through the patient journey. Staff told us they explained the booklet to patients and relatives, breaking information down to aid understanding.
- The hospital had equipment for bariatric patients that included a bariatric chair and hoist.

Medical care (including older people's care)

- The stroke unit had two specialised stroke chairs that gave support to patients and helped them to sit upright with their heads supported and limbs in good positions. The chairs also had pressure-reliving areas to minimise the risk of pressure sores. We observed patients who had been transferred to these chairs and they appeared calmer and more relaxed.
- The physiotherapy team had started one-hour bedside teaching sessions for nurses to help patients wash independently after having a stroke. This encouraged the patients to be more independent.
- We observed a physiotherapy session with a patient who was unable to speak. The physiotherapist used signs such as head nods and shaking head to communicate with the patient.
- Staff told us they would request additional staffing to meet the needs of patients living with dementia and we saw evidence of additional staffing requested on the nursing rotas.
- Staff told us they would involve the families of patients with learning disabilities to assess and meet their needs. Staff had access to two learning disability liaison nurses to provide additional support if required.
- Ward were flexible with visiting hours if needed to meet the specific needs of individual patients for example, patients with dementia and learning disabilities or patients who were particularly anxious.
- The trust had a lead dementia nurse who offered specialist advice to all staff. They had developed a documentation booklet for staff use to improve dementia care. The booklet pilot would begin in October 2016. Eighty eight percent of staff had completed dementia awareness training, nearly achieving the trust target of 90%. Staff used the Abbey scale to measure pain in people living with dementia who could not verbalise their level of pain.
- Patient-led assessments of the care environment (PLACE) for September 2016 showed the hospital scored 57.5% for dementia care. This was significantly lower than the England average of 75.2%.The PLACE audit also showed the hospital scored 65% for disability, which was significantly lower than the national average of 78.8%. The trust had made recommendations to improve the situation that focussed on dementia and the appointment of PLACE divisional champions to monitor progress.
- The hospital had access to an interpreter service if needed for patients who did not speak English. Staff told us the service was rarely needed as they ask family or staff members to interpret. However, this is not considered best practice. If family members are used, staff cannot be assured that the correct information is being relayed to patients. Patient information leaflets were in English but contained information on how to request them in another language or format, such as large print.

Learning from complaints and concerns

- The integrated medicine division received 178 complaints from September 2015 to September 2016. The highest number of complaints (30) related to patients treatment or procedure.
- There was evidence learning from complaints was a standard agenda item on the stroke and cardiac governance and sisters meetings. However, these did not detail the information discussed or the learning resulting from complaints.
- Staff told us details of formal complaints were not always discussed at team meetings and staff could not describe learning or changes in practice from complaints.
- Staff knew how to deal with informal complaints on the ward and could give examples of this. However, staff did not always share this learning with colleagues or the wider team as it was not logged as a formal complaint.
- The hospital website had clear information on how to make a complaint and contact details of the patient advice and liaison service (PALS).

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

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

We rated well-led as requires improvement because:

- Whilst the hospital had made a number of improvements since our 2014 inspection report, overall we were not assured senior staff and governance processes effectively addressed safety concerns.
- We found a number of issues including medicines management, confidentiality of records and lack of robust documentation.These issues had not been identified through the hospital own quality monitoring system.
- Some risks to patients such as the environment in the cardiology ward area had been recognised and escalated through hospital governance processes. However, this risk had been on the risk register since December 2012 without any significant progress being made.
- There was no evidence learning from the governance meetings was always shared with staff. Ward meetings were not always formally documented meaning staff who could not attend did not have an accurate record of discussions.
- The hospital did not always involve patients in developing services. Although the cardiac and stroke service both had plans for design and improvement, patient views had not been sought in the planning stages. The stroke and cardiac services did not currently have a patient user group or patient forum.

However,

- Staff enjoyed working at the hospital and told us they found managers and their team supportive. There was a clear sense of teamwork and collaboration between wards and members of the multidisciplinary team.
- Staff told us there was an open and transparent culture within the hospital. Both nursing and medical staff felt they could raise concerns openly with ward or senior managers.There was a whistleblowing policy and helpline in place. Although the helpline number was not displayed in the clinical areas we visited.
- Staff knew about the trust values and plans for expansion in their own ward areas. The staff we spoke with told us they were passionate about providing safe and compassionate care. The trust mission and values were displayed in every ward area and integrated into the governance and quality processes.
- The division had a clear governance structure in place, which linked in with the trust's overall governance structure. Meetings took place at all levels of the division and were well attended by members of the multidisciplinary team (MDT) staff reported on quality, safety and performance.
- There was clear evidence the hospital had made improvements since our last inspection in 2014. These were evident across all services but most notably within the stroke unit on ward 8.
- The hospital had a local and national audit programme and staff had knowledge of audits that directly linked to their clinical area. The clinical governance teams had an oversight of audit performance and there was evidence of improvement in clinical audit results.
- The stroke and cardiac unit had a variety of projects to improve services. The cardiac unit had plans for refurbishment including building a second cardiac catheter laboratory. The stroke unit had plans to relocate within the hospital to increase capacity and expand the catchment area.

Leadership of service

- A divisional chair, divisional director and chief nurse led the integrated medicine division. At the time of our inspection, the chief nurse was on secondment the trust had not identified a replacement for this role. There were service delivery leads in place for each speciality.
- The stroke and cardiac unit had a lead nurse who managed both services. Staff described the lead nurse as 'proactive' and 'supportive'. At the time of our

inspection, the lead nurse directly managed 15 to 18 staff. However, they told us there were plans in place to recruit additional band 8 staff to provide support. Staff told us they had good access to senior support and the division and service leadership team were approachable and visible.There was only one ward manager on duty across the stroke and cardiac unit at the time of our visit. Staff told us the manager was well respected on the unit and had a good relationship with the multidisciplinary team (MDT). However, ward managers were frequently required to cover clinical shifts, which meant they did not always have allocated time to spend on management tasks.

Vision and strategy for this service

- The trust had a mission to provide safe and compassionate care, every time. This was supported by the trust vision to make patients, the community and staff at the centre of their work and creating a sustainable future. Ward managers displayed trust values on staff notice boards. Staff told us they were passionate about providing safe and compassionate care to patients.
- The integrated medicine division had a strategy to improve urgent and emergency care services for the local population and improve access to services to expand market share.
- The lead nurse for the stroke and cardiac service told us the focus for the service was to develop stroke services providing care to a bigger catchment area and make more rehabilitation beds available at the hospital. Ward managers and staff told us about plans to relocate the stroke unit and increase bed capacity but could not tell us when this would be achieved.
- The cardiac service also had plans to develop. Building work for a second cardiac catheter laboratory was due to commence the week after our inspection and was due to be completed by the end of 2016.
- Service leads linked the trust mission and goals into governance meetings and the minutes of these meetings reflected discussion around progress towards these goals in individual areas.

Governance, risk management and quality measurement

- Although we saw evidence of improvement from our last inspection in 2014 particularly in ward 8 on the stroke unit, we had concerns that risks were not always effectively managed.
- There was a clear governance structure in place for each division which linked in with the hospital governance structure. There was evidence of quality and risk review escalated throughout governance meetings to senior managers.
- The division lead for integrated medicine held overall responsibility for governance and was supported by service delivery units (SDU). Each SDU held monthly governance meetings chaired by a consultant lead and attended by senior members of the multidisciplinary team. An action log was produced from the meetings with actions allocated to an individual.
- Each SDU had an individual risk register and escalated risks up to the divisional risk register. Although, the lead nurse for stroke and cardiac had a good understanding of the risks in their SDU and these accurately reflected risks on the risk register, risks were not always dealt with in an effective manner. For example, in the cardiology department, the wards were in need of refurbishment and we had concerns the environment could pose an increased infection control risk. Although this risk had been recognised by senior staff, it had been on the risk register since December 2012 with no significant progress.
- We found concerns with the storage and administration of medicines across all the wards we visited. Leaders were not aware of these issues and had not yet developed an action plan to address this.
- Across all the wards we visited we found concerns with documentation, risk assessments and the security of information. Senior staff were not always aware of these issues and there was no plan in place to address this.
- Minutes of the SDU governance meetings showed discussion about learning from incidents, mortality, review of National Institute of Clinical Excellence

(NICE) guidelines, complaints and clinical audit. Staff did not document discussions in detail so it was difficult to assess the quality of the reviews which took place.

- The lead nurse for the stroke and cardiac service told us ward managers received feedback from governance meetings at their one-to-one sessions and they would feed this back to staff in monthly ward meetings. Junior doctors held monthly meetings and the lead nurse told us they attended these when required to explain specific feedback from the governance meetings.
- Staff told us wards held monthly team meetings, however minutes from these meetings were not always available. This meant staff who could not attend ward meetings did not always have an accurate record of the discussions. We were able to review some ward meeting minutes but these did not always include learning from governance meetings, incidents or complaints. We saw evidence of both local and national audit programmes to measure the safety and quality of service. The trust issued a monthly newsletter which informed staff of updates to NICE guidelines and there was evidence SDU's reviewed hospital policies to reflect these changes.
- Quality measures were included in the divisional monthly reports. These included narrative and data relating to key performance indicators, finance and celebrated areas of good practice, accolades and successes.

Culture within the service

- Throughout the inspection, we observed a strong sense of collaboration and team work across services. Staff told us they enjoyed working at the hospital and teams were welcoming and supportive.
- There was evidence of career progression and development within the stroke and cardiac services, for example, staff had been promoted to junior sisters, specialist nurses and practice development nurses.
- Staff had a good understanding of the principles of openness and transparency and some could give examples of where they had implemented duty of candour (DoC).
- The trust had a whistleblowing helpline and whistleblowing policy to support staff in raising concerns within the trust. Staff told us they would raise concerns with their manager or another senior manager and felt they would address concerns fairly. However, staff did not know there was a whistleblowing helpline or policy and information was not displayed to inform staff of this. This meant that if staff did require support from the helpline they may not have the information to do so.
- The staff sickness rate for all staff members across the trust from June 2015 to May 2016 ranged between 3.09% and 4.08%. This was consistently lower than the England average which was 3.84% to 4.49% between January 2016 and May 2016. However, staff on the Cardiac and Stroke Receiving Unit (CSRU) and stroke unit reported high staff sickness and turnover of staff. This was supported by senior managers who told us it was a high pressure area to work in. Senior staff told us they were addressing recruitment and retention issues and were making improvements based on staff surveys such as career progression, employing a practice development nurse and international recruitment.
- The National Training Scheme schedule published by the General Medical council in 2015 showed the general medicine division performed worse in for feedback and induction for junior doctors. The trust performed the same as expected for all remaining 12 areas including overall satisfaction, supportive environment, workload and supervision. Our previous inspection of the trust in 2014 showed the general medicine division performed worse in six out of the 14 areas.

Public engagement

- The trust encouraged patients and their relatives to give feedback on their care using the NHS Friends and Family Test (FFT). Although the responses were generally positive, the response rate was significantly low at times ranging between 0% and 62.5% across cardiac and stroke wards.
- Wards displayed feedback from patients and the action they had taken in response. For example on ward 2a patients had said they would like the water to be cooler and the ward had installed a water cooler and started to provide fresh fruit and ice creams.

- There had been a formal public consultation in the process of centralising the stroke and cardiac services to Wycombe. This programme of engagement and then later a public consultation was called "Better Healthcare in Buckinghamshire.

Staff engagement

- NHS staff survey results for 2015 showed the trust performed worse than average in 11 of the 20 areas. The five areas which scored lowest were staff recommendation, staff working extra hours, staff feeling pressure to attend work when unwell, staff confidence in security and reporting unsafe clinical practice and fairness and effectiveness of procedures for reporting errors, near misses and incidents. However, the trust performed better in nine of the areas and showed a general improvement from 2014.
- The trust held a yearly staff awards ceremony with patients and staff nominating staff or teams for awards. The stroke unit had won healthcare team of the year award in 2015 after being nominated by their manager for positive patient feedback which was backed up by the Sentinel Stroke National Audit Programme (SSNAP).

Innovation, improvement and sustainability

- Staff told us the hospital encouraged innovation and improvement. The hospital had well established stroke and cardiac research teams, which had grown in recent years and were well integrated into the multidisciplinary team (MDT). Both research teams had been recognised in national awards.
- The cardiac research team won the Patient Experience Network (PEN) award 2015 in the 'partnership working to improve the experience' category for their work to improve cardiac outcomes for cardiac patients through rehabilitation research.
- The cardiac and stroke service had plans to increase and refurbish clinical areas. The stroke unit had plans to extend the hyperacute stroke unit to incorporate the East Berkshire catchment area. The cardiac unit had plans in place to build a second cardiac catheter laboratory, which was due to open by the end of 2016.
- The cardiac service had developed a new role for an angiography nurse. Medical staff traditionally carried out this procedure, however the nurse was supported by senior and medical colleagues to develop her skills in this area and become the second nurse in England to carry out this role. The nurse has recently presented at the European Cardiology Conference.

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Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

Buckinghamshire Healthcare NHS Trust provides day case, elective and emergency surgical care at Wycombe Hospital. From March 2015 to February 2016, there were 14,066 admissions for surgery; 70% of the surgical activity was day case, 25% elective surgery and 5% emergency surgery. Over the same period, urology and trauma and orthopaedic surgery made up 62% of all surgical treatments performed, with 18% general surgery and 20% covered by other specialities.

The hospital has three theatre suites, with 11 theatres across these three areas. Four theatres have laminar airflow ventilation systems (a system of circulating filtered air to reduce the risk of airborne contamination). There is a dedicated recovery area for each theatre suite. There are three surgical wards (12 a, b and c) and a day surgery unit.

The surgery service is part of the Division of surgery and critical care, one of five divisions at the trust. The divisional leads have responsibility for leading and managing the surgery service at all relevant locations across the trust, including Wycombe hospital.

During our inspection, we inspected all the theatre suites and all the surgical wards. We spoke with 14 patients and 27 members of staff, including theatre and nursing staff, porters, housekeeping staff and medical staff and the divisional leads. We also reviewed five patient records, observed care on the ward, in the operating theatres and in the recovery area. We analysed data provided by the hospital before, during and after the inspection.

Summary of findings

We rated this service as requires improvement because:

- Staffing levels in the pharmacy service were not as planned and they could not deliver an effective service, including to the medicine division. Although the service prioritised patients with the greatest need, some key performance indicators were not achieved.
- Staff on the wards did not always dispose of out of date medicines promptly. They did not always follow the trust's controlled drugs policy when documenting receipt of controlled drugs.
- We found incomplete records for the anaesthetic machine logbooks in the operating departments and for the resuscitation equipment on the wards. It was not clear if staff completed the daily safety checks and the equipment was safe to use . While staff in theatres followed the World Health Organisation (WHO) surgical safety checklist, we observed staff who did not always pay full attention for each stage of the process to ensure patients' safety.
- Theatre staff did not always comply with the trust's uniform policy to minimise the risk of infection.
- Staff did not have a good understanding of the principles of Mental Capacity Act and associated

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Deprivation of Liberty Safeguards and their responsibilities in relation to these areas, to support people whose circumstances made them vulnerable and who could not always give consent.

- Patients' record keeping was not to a consistent standard. Although patients told us they made informed decisions about their surgery, medical staff did not always document the conversation fully.
- The division had not achieved the 18 week referral to treatment time indicator for 90% of patients admitted for an operation over the last five months.
- Three trust policies and standard operating procedures were out of date for review. .
- Departmental and managers' meetings did not record discussion and actions and there was not a formal record of decisions or assurance that concerns were addressed.

However:

- Staff knew the process for reporting incidents. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- Areas we visited were clean and tidy, we saw most staff following good infection prevention and control practices.
- There was good multidisciplinary working across teams at the hospital so patients received co-ordinated care and treatment. Staff planned and delivered patients' care and treatment using evidence based guidance and audited compliance with National Institute Health and Care excellence (NICE) guidelines.
- Nursing staff completed risk assessments for patients. If a patient became unwell, there were systems for staff to escalate these concerns and refer them to another hospital if necessary. The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
- We saw staff care and treat patients with compassion. They were kind and treated them with dignity, and respect. There were systems to support patients with additional or complex needs. Patients felt informed and involved in their care. They said they would recommend the service to others.
- Staff followed the governance processes to monitor the quality and risks of the surgical service. They completed audits and monitored patient outcomes, making changes to practice when necessary. Outcomes for patients were similar to the England average compared to data from national audits such as the bowel cancer audit. The divisional leads used the monthly quality reports and dashboards to support this.
- Feedback from patients and staff had been used to develop and improve the service. The divisional leads and executive team considered the sustainability of the service and had a strategy in place to support this.
- Staff told us the leadership across the service was good and the senior team were visible and accessible. Staff had an annual appraisal and could access additional training to develop in their role.

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Are surgery services safe?

Requires improvement

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

We rated this service as requires improvement for safe because:

- Staff were not following trust's policy and best practice guidance when controlled drugs orders were received by ward staff. Also, staffing shortages in the pharmacy department resulted in reduced support to departments and we found evidence of some unsafe practices in relation to medicines management, including out-of-date medicines or medicines belonging to discharged patients not segregated from current medicines. Not all medicines were stored securely on the wards.
- We found staff had not completed patients' records in full, including the signing of medicine charts and completion of an assessment of the patient's capacity.
- In the operating departments, the anaesthetic log books were not complete, to provide assurance the daily safety checks had been completed and equipment was fit for purpose, prior to patients having surgery. On some of the wards, staff had not completed the daily checks on the resuscitation equipment in line with the trust policy, to ensure it was ready for use in an emergency.
- Although staff completed the World Health Organisation Five Steps to Safer Surgery, we observed some members of the theatre team were not engaged for each step of the process, potentially placing patients at risk of harm. Although, the most recent trust patients' record and observational audit showed 95% compliance.
- Theatre staff did not always collect a new set of scrubs to change into when returning to the operating department from another area in the hospital, in line with the trust's uniform policy and as good infection control practice.
- Not all staff were up-to-date with their level 2 safeguarding children and vulnerable adults training.

However:

- The trust had made significant improvements to the culture when staff reported incidents. Staff felt confident and able to report incidents. The trust recognised the importance of learning from incidents to improve the care provided to patients. Staff demonstrated a good understanding of duty of candour and gave examples where they had used this to support patients.
- All clinical areas were visibly clean and staff had access to sufficient equipment to provide safe care and treatment. Staff in general adhered to infection prevention and control practice on the wards and in theatres. Patient's safety and daily staffing information was prominently displayed for patients, staff and visitors to read, as part of the trust's open and honest approach.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns. Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate.
- Overall, staffing levels met the planned levels for theatre, nursing and medical staffing. The trust achieved this using bank and agency staff for some shifts, particularly in the operating departments. There were escalation processes in place when staffing shortages were identified.

Incidents

- Staff knew how to and felt confident to report any incidents which occurred. They used an electronic reporting system and told us they normally received feedback. The divisional leads monitored on a monthly basis the total number of incidents reported, looked for trends and reviewed the time for managers to sign off that they had investigated incidents allocated to them.
- All staff we spoke with told us there had been a significant change in the culture around reporting of incidents compared to our previous inspection in 2014, this was particularly evident in the operating departments. Staff told us incidents were seen as an opportunity to learn and improve practice. The trust recognised the importance of everyone being open and honest.
- Nursing staff on the wards told us managers shared learning from incidents at daily meetings, through their

ward communication book and discussed incidents at team meetings. The trust told us minutes had not been taken at these meetings for us to confirm this. This was an additional concern as there was no formal record of decisions, which had been made in response to learning from incidents. In the operating department, fortnightly quality and safety meetings were held, with a delayed start to the operating lists to enable all staff to attend. The meetings covered learning from incidents, notes were taken and shared with staff unable to attend. The senior team hard worked hard to make positive changes to the reporting culture within the department. The anaesthetic team had introduced a pre-prescribed saline flush as a change to practice following an incident.

- From July 2015 to June 2016, staff in the division of surgery and critical care reported 1091 clinical incidents, the majority were graded no or low harm (1044). Fourteen of the incidents were considered serious incidents. Four of the serious incidents related to treatment delays and there were no particular themes for the remaining 10. One of the serious incidents was a never event, which had occurred in the operating department. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. A root cause analysis had been completed, debrief held with staff and learning shared locally and across other sites run by the trust, with an agreed action plan in place. The root causes were human error, staff not adhering to trust policy and poor communication. The department planned to audit compliance in six months' time.
- The operating departments introduced excellence reporting in July 2016. Staff were encouraged to report excellent practice, to enable positive learning to be shared between teams and improve the quality of care provided to patients, rather than only learning from mistakes. Staff who reported were recognised by the central governance team.
- Medical staff included mortality and morbidity, to discuss unexpected deaths or adverse incidents affecting patients and learning from these events as part of their speciality clinical governance meetings and audit days. Minutes were shared with staff unable to attend. Learning from significant events was shared across specialties and with the divisional managers where relevant.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support. Staff gave examples of where they had recently applied duty of candour and learning because of an incident.

Safety thermometer

- The trust monitored its safety performance through use of the safety thermometer. The safety thermometer provides a monthly snapshot audit of the prevalence of avoidable harms that occur including pressure ulcers, falls, venous thromboembolism (VTE) and catheter related urinary tract infections (UTI). Also included is the percentage of patients receiving harm free care.
- All wards we visited prominently displayed their safety thermometer results for patients and visitors to look at. They presented the number of days since, for example, a patient had a fall with harm, so the information was meaningful to patients.
- The safety thermometer data for the surgical wards across the trust showed 12 pressure ulcers, 10 falls and 15 catheter related urinary tract infections from August 2015 to August 2016. There were no identified trends in the data.
- Ward sisters explained the actions they took to minimise the risk of avoidable harms. They monitored the use of and completion of risk assessments and fluid charts. Where they found issues relating to care they raised them with staff directly. They also used the morning and evening safety brief to reinforce messages relating to patient's safety.

Cleanliness, infection control and hygiene

- All clinical areas we visited in theatres and on the ward were clean and tidy. We observed staff following good

infection control practices, to minimise the risk and spread of infection to patients such as cleaning their hands before and after patient contact and ensuring they were 'bare below elbows'. Staff also had access to personal protective equipment (PPE)such as gloves and aprons, which we observed them using appropriately. There were hand sanitiser points around the hospital for visitors to use, to reduce the spread of infection to patients.

- There was an infection prevention and control (IPC) lead for the trust and most departments had a staff member who was the lead for IPC. They promoted good IPC practice and helped to complete IPC audits. We saw wards included the outcome from hand hygiene audits on their public information boards and the number of days since they had any cases of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile. The trust IPC team produced monthly division reports which included results for each ward and department. The team audited a different IPC area each month, in addition to hand hygiene audits, such as use of PPE and safe use of sharps.
- Results from the most recent hand hygiene audit in August 2016, showed overall 98% compliance for the division, the target for compliance was 95%. Results were also recorded for each surgical ward and theatres. The division kept a log to show the action taken when staff members were observed not to comply with an element of the hand hygiene observational audit. This enabled the division to monitor and take further action where staff repeatedly did not comply with the trust policy. Staff were required to complete annual IPC training.
- From April 2015 to March 2016, across the division of surgery and critical care, there were no cases of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) and two cases of hospital acquired Methicillin-sensitive Staphylococcus Aureus (MSSA). There were 11 cases of Clostridium difficile and no cases hospital acquired E.Coli. The division monitored the incidence of hospital acquired MRSA and Clostridium difficile as part of the division scorecard, assessing compliance with the agreed local target of 1 case per month of Clostridium difficile and no cases of MRSA. For July 2016, there had been one case of Clostridium difficile and one case of MRSA.
- The trust hospital policy 'Methicillin resistant staphylococcus aureus' (2007), required all patients (elective and emergency) to be screened prior to or on admission other than for specific surgery cases as identified by the Department of Health. Elective patients with a positive result received treatment prior to the hospital admitting them for surgery. Emergency admitted patients considered at higher risk of having MRSA were cared for in side rooms, to minimise the spread of infection to other patients, until staff knew the swab results.
- The trust submitted data surgical site infection data, for patients having orthopaedic surgery to the Centre for Infection. From April 2015 to March 2016, the incidence of surgical site infections for patients having repair of fracture neck of femur was 0.7%, this was below (better than), the national average of 1.5%. No lapses in care had been identified during the trust investigation into the infections. There had been no infections for patients having hip or knee surgery.
- The decontamination and sterilisation of surgical instruments, took place on-site, meaning equipment was always available for routine surgical procedures.
- Each ward had a schedule of cleaning and checking for items such as bedpan washers, mattresses and furniture. All records we checked were complete. Curtains in patient bays were cloth and did not contain a date when they should be cleaned and changed. Staff told us this happened each time a bay was deep cleaned. Housekeepers worked hard to keep patient and staff areas clean and tidy. Staff valued having a housekeeper allocated to each ward.
- We observed some poor IPC practice by staff in the operating department in main theatres. Staff kept their bags in the anaesthetic room, operating theatres and recovery areas, due to their lockers being in a different theatre suite. This was a potential infection control risk. Also medical staff attended for the team brief without changing into scrubs. Theatre staff were seen to return to the operating department in scrubs and not collect a new set to change in to prior to returning to the operating theatre, creating infection control risks. This was also not in keeping with the trust 'Uniform and dress code policy' (2015). We also found intravenous fluids stored on the floor in the storage room, preventing staff from cleaning the floors properly.

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Environment and equipment

- Staff told us there was sufficient equipment for them to care for patients and we saw staff maintained stock levels well for both reusable and single use items. Equipment in general was stored appropriately, with clear labelling in storage rooms. However, staff had not completed daily checks on all the anaesthetic machines in the operating theatres and daily checks of the resuscitation trolley on some wards.
- Staff were not adhering to The Association of Anaesthetists of Great Britain and Ireland safety guidelines: Safe Management of Anaesthetic Related Equipment (2009) as the logbook with each anaesthetic machine had not been completed daily prior to the sessions starting to confirm the equipment was in working order and safe for use. This was a potential significant risk to patients if the equipment failed during an operation.
- We reviewed the records for daily and weekly checks of the resuscitation trolleys in the operating departments and on the wards for the week of our inspection and found these were complete, other than for ward 12a and 12c. There were five days when staff had not checked the trolley to ensure it was ready to use in an emergency. On ward 12b, to ensure staff correctly checked all the items on the trolley, a poster was placed above the trolley with photos of every item on the trolley.
- We checked about 20 items of single use equipment and found all were in date. In addition, we checked five pieces of clinical equipment and all were in date for servicing.
- Staff told us if equipment broke and needed replacing or they needed additional equipment they could obtain this through the central equipment library.
- Theatre staff raised concerns the sterile wraps for theatre instrument kits were sometimes damaged and prevented surgeons using the kit until it was sterilised again. They had reported this as an incident and investigations found kits were being stored on top of each other, with wraps damaged when staff moved the kits. Managers had contacted the manufacturer of the wraps to see if a heavier weight wrap was available.
- Staff told us and we saw there was suitable equipment available for bariatric patients. Staff completed training on using this equipment as part of their manual handling training. Staff completed manual handling training every two years. As of August 2016, division compliance was 88%, against the trust target of 90%. We observed staff in the operating theatre moving patients appropriately to minimise the risk of injury to the patient and staff.
- Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately. Clinical waste bins were clearly labelled and we observed staff kept the rooms used to store clinical waste clean and tidy to minimise infection risk.
- The theatre matron and maintenance team completed monthly safety walkabouts. There was a lack of storage for equipment, which had to be stored in corridors, making it more likely to be damaged. In the anaesthetic store rooms, some items were overstocked. Staff told us they tended to look at the level of stock, rather than monitoring the use to determine when they needed to order more supplies.

Medicines

- We had significant concerns about the effectiveness of medicines management systems in the operating departments and on the wards.
- There were 13 whole time equivalent vacancies for the pharmacy service across the trust. This was having a significant impact on the service that pharmacy staff could provide to the wards, operating departments and for patients.
- Staff shortages resulted in the pharmacy team not completing all medicine reconciliation checks within 24 hours of a patient being admitted to the hospital. This standard is part of National Institute for Health and Care Excellence Guidance (NICE) guideline 5- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. The trust target was for pharmacy staff to start 60% within 24 hours and 80% to be completed, the department achieved 49% and 62% respectively in August 2016. There was an increased risk of patients receiving the incorrect

medicine or delays to their normal medicine due to incomplete checks. The department had risk assessed and was trying to ensure the needs of acute patients with complex medical needs were addressed first.

- We found out-of-date British National Formulary (BNF) pharmaceutical reference books on the wards. This was unsafe practice as the advice and recommendations may no longer apply. There was access for staff to the on-line guide via the trust intranet, which contained current information but staff sometimes referred to the book instead.
- Across the three operating suites, staff had not completed the logbooks to confirm they had checked the temperatures of the fridges in the anaesthetic rooms, to ensure medicines were stored at the correct temperature, in accordance with trust policy. We found gaps of weeks and over a month in the logbooks, there was no assurance staff recognised the importance of these checks. Medicines stored at the wrong temperature and not according to the manufacturer's specifications could reduce the efficacy of medicines administered to patients.
- On ward 12b, the treatment room door was unlocked and intravenous fluids were stored in unlocked cupboards. This was a potential risk due to unauthorised access to the medicines, which were not stored securely. The treatment room door was also unlocked on the day surgery unit. Staff raised concerns that pharmacy delivered medicines and staff did not always put the medicines away immediately again creating a potential risk due to unsecure storage.
- Additionally on ward 12b, we found expired and unwanted medicines not separated from useable stock in the medicine fridge. Two were dispensed to patients in October 2015 and February 2016. There was a loose vial of insulin, dated July 2016, which staff should have removed due to it expiring one month after they first used it. The process for checking of medicines and stock rotation was not effective.
- Staff were reporting medicine incidents and minutes from the pharmacy governance meetings showed staff discussed outcomes and learning shared. Pharmacy staff also recorded dispensing errors and omitted doses. The divisional leads monitored the number of medicines errors as part of the monthly quality and safety report and whether harm had occurred to the patient. Nursing staff told us they discussed incidents and learning from medicines errors at team meetings but there was no record of this in the five sets of minutes we reviewed.
- Permanent nursing staff told us they completed online training and completed a medicine competency framework before they could administer medicines unsupervised. Agency staff had to supply evidence of completed training to their employment agency prior to being able to complete shifts at the trust, there were no additional checks completed by the trust to confirm staff were competent to administer medicines.
- In one recovery area, we observed staff following the correct procedures when administering controlled drugs to a patient. The two-person check was completed and the controlled drugs book completed and signed as per hospital policy. For all areas we visited controlled drugs were stored correctly and stock balance checks were as recorded.
- However, on two wards (12b and the Day surgery unit) the daily stock checks did not always take place and the received section was not always signed in the controlled drugs order book, this was against trust policy. Staff did not follow their procedure for discarding medicines. We found controlled drugs belonging to a patient who was discharged from the day surgery unit in July 2016 had not been returned to the pharmacy and they had not separated them from the useable stock for the ward. Pharmacy staff raised concerns on some wards the controlled drugs cupboard keys were kept with the main keys, which is against trust policy and good practice guidance. This was to ensure only staff authorised to administer the drugs had access to the medicines.
- Staff kept medicine trolleys locked and secure when not in use.
- In general, prescription charts we checked were complete. Medical staff recorded allergy information but did not always sign and date this information as stated on the chart. Also, they did not always sign each prescription. The hospital provided pre-printed day surgery prescription charts which listed possible medicines a patient might need; medical staff signed and dated against those relevant for that patient. Nursing staff told us anaesthetic staff did not always

record the time they gave pain-reliving medicines to patients or transfer this information to the main medicine chart. This caused delays in patients receiving pain control as nursing staff had to cross check to ensure they did not give too much medicine.

- Patients told us nursing staff usually gave them their medicines on time. Staff had given them clear instructions and advice about any medicine they needed to use at home, prior to discharge from the ward. However, nursing staff on the day surgery unit raised concerns there were sometimes delays of up to four hours for patients receiving their discharge medicines that delayed their discharge from the ward. Also due to the pharmacy closing at 5pm, there had been occasions when patients had to return to collect their medicines the next day.
- Medical staff followed the trust's microbiology protocols for the administration of antibiotics.

Records

- Patients' care records were in paper and electronic format. Paper records were stored on the wards in lockable trolleys. Staff did not raise any concerns about the availability of patients' records. The standard of record keeping was inconsistent, as records we reviewed were not all completed in full.
- On all the wards we visited, the records trolley was either kept locked at all times or when unlocked kept by the nurses station or in the treatment room to prevent unauthorised access to patients' records. Ward 12b had a keypad entry trolley, which ensured the trolley remained, locked and prevented staff from having to find the key each time they needed access.
- The care records contained pre-operative assessments, risk assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and medical staff notes and discharge checklists and assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists where relevant.
- We reviewed the care and surgery records for five patients who had undergone surgery. Whilst the notes were legible, none of the records were complete. Staff had consistently omitted to record they had completed an assessment of the patient's capacity. Other errors were the start and finish time of the operation not recorded, the operation note not signed, no falls assessment completed, unable to find the pre-assessment record, no care plan or goals or documentation of how the patient had been involved in this, no risk assessments and no discharge planning.
- Ward managers told us they completed patients' record audits and discussed the findings at team meetings. Some wards displayed the results from the most recent audit. In general surgery, doctors completed an audit of the quality of the operation notes (July 2015), comparing findings to the audit from April 2015 and compliance with guidelines from the Royal College of Surgeons. They found improved compliance for 14 of the 20 areas reviewed but the majority remained below 100%, including recording the time (20%), responsible consultant (20%), blood loss (30%) and DVT prophylaxis (13%). They planned to re-audit and consider a more specific operation note pro-forma.

Safeguarding

- Safeguarding was part of the statutory training for all staff, the level of training required determined by their clinical role. Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and how to seek support if they needed to.
- Staff in the operating department described two occasions when they had needed to raise a safeguarding concern and the process the department had followed.
- Flowcharts of the safeguarding process were on display on the wards and in operating department, including all the relevant local telephone numbers. Staff could access the trust safeguarding policy on the intranet for reference. Not all the staff we spoke with could name the safeguarding leads but knew where to find their contact details if the needed them.
- As of August 2016, 78% of staff in the division of surgery and critical care had completed safeguarding adults (level 1) training and 81% had completed safeguarding children (level 1) training, against the trust target of 90%. For those staff required to complete level 2 adults

training compliance was 70% and for level 2 children training 72%. Departments were compliance were low had taken action and the trust told us staff had a due date for completion of the required training.

- All staff had to complete PREVENT (Protecting people at risk of radicalisation) training every three years. The PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who are at greater risk of radicalisation. The Department of Health required trusts to have 90% of staff compliant with this training by 2018, the trust were on track to meet this target.

Mandatory training

- Staff we spoke with understood the importance of completing their mandatory and statutory training but raised concerns they did not always have specific time allocated at work to complete the training or sometimes had to complete the online training at home in their own time. This was of particular concern for staff working in the operating department.
- Each member of staff was assigned a role-specific mandatory and statutory training plan via the online e-learning system used by the trust. This sent reminder emails to staff and their manager when they needed to renew a training module. Staff completed most training electronically but the trust provider practical training where appropriate, such as for manual handling and infection prevention and control.
- As of August 2016, overall compliance with statutory and mandatory training for staff working in the division of surgery and critical care was 82% against the trust target of 90%. Statutory training is training which staff are legally required to complete, such as fire safety. Mandatory training is training which staff must complete but is specific to the role they are completing, such as basic life support or advanced life support.

Assessing and responding to patient risk

- Staff assessed patients for key risks on admissions and continued to monitor these before and after their surgery. These included risks about mobility, medical history, skin damage and venous thromboembolism (VTE). There were systems and processes in place to support staff to complete these assessments.
- All elective surgery patients had a pre-operative assessment to identify and plan the management of any concerns around their health and wellbeing, including the need for additional tests. Nursing staff also completed assessments to identify those patients at risk of falls, malnutrition and developing a pressure ulcer. Where relevant staff transferred this information to the theatre list to ensure the correct grade of medical staff was present in the operating theatre; this was particularly important for patients with a greater risk of anaesthetic complications. Theatre staff raised concerns some patients did not have all their pre-operative tests completed, such as bloods and X-rays prior to surgery and this caused delays in theatres. They felt this was related to the staffing shortages for the pre-assessment clinics.
- The trust told us the endeavoured to screen all emergency admissions over the age of 75 for dementia as part of the Commissioning for Quality and Innovation (CQUIN) payment. They had plans in place to include the screening tool as part of the surgical care pathway to improve compliance.
- National Institute for Health and Care Excellence (NICE) quality standard 3- Venous thromboembolism in adults: reducing the risk in hospital recommends all patients on admission, receive an assessment of their venous thromboembolism (VTE) risk so appropriate treatment can be given to patients, such as prophylactic medicines. The division achieved the trust target of 95% compliance for April to June 2016. There was no data for January to March 2016, which the trust had recognised as a risk and taken action.
- Staff used the National Early Warning System (NEWS) to monitor patients and identify deterioration in their health. This is a series of observations that produce an overall score. An increase in the score showed a deterioration in a patient's condition. Results from the most recent quarterly surgery and critical care division audit (July 2016) on completion of the chart showed 97% compliance overall but with slightly reduced compliance of 88% on ward 12b, against the trust target of 95%. The division action plan included ensuring all staff had completed the mandatory training module and senior staff completing random observational spot checks.

- If a patient's condition deteriorated, staff followed the trust 'NEWS escalation process' guidelines (2014), which stated the steps staff must take depending on the score recorded. If a patient did not recover as expected after day case surgery, medical staff arranged a transfer to a surgical inpatient ward. On the day surgery unit we saw a poster reminding staff to follow the situation, background, assessment and recommendation (SBAR) technique when monitoring patients who were showing signs of deterioration.
- The majority of staff we spoke told us they had completed sepsis training, could describe the symptoms and the action they needed to take. We saw sepsis information and treatment pathways on display on the wards. Staff used a screening and action tool and trust guidelines were in place for treatment of patients with suspected sepsis. The trust monitored the percentage of patients who had received treatment in line with the NICE guideline 51- Sepsis: recognition, diagnosis and early management.
- Staff completed adult basic life support, immediate or advanced life support training depending on their role. As of September 2016, 93% of staff had completed the adult basic life support training. Staff working in theatres were required to complete immediate life support training.
- For patients having bilateral breast surgery, two surgeons were present for the operation. This was to reduce the operation time and time under general anaesthesia, improving the recovery for the patient.
- Theatre, staff followed the Five Steps to Safer Surgery checklist based on the World Health Organisation. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning and end of each theatre list and the WHO surgical safety checklist, which included sign in, time out and sign out. We observed three operations.The team brief and time out were completed appropriately and there was good engagement from all staff. For the sign in, for one procedure some members of the theatre team continued talking and for another staff did not clearly define the sign in had started. During the sign out, for one procedure staff continued talking whilst the scrub nurse and circulator were completing the final instrument count. There was a potential risk that staff may miss count due to the background distraction and there was no confirmation with the rest of the team that the count was correct.
- Theatre staff told us and we observed that additional time was taken up completing the Five Steps to Safer Surgery checklist in the patient's record and on the electronic record. The trust had not yet transferred to complete electronic patient's records. Staff were concerned of making errors when they uploaded the information. This trust used this data for audit purposes. Results from the most recent patient records review and observational audit for May 2016 showed compliance of 95% or above for all the different stages of the Five Steps to Safer Surgery. An action plan was in place to address areas of non-compliance, with a repeat audit planned for November 2016.
- There were adapted version of the WHO surgical safety checklist in use in ophthalmology and urology, in keeping with best practice guidance.

Nursing and theatre staffing

- Staff working on the surgical wards and in the operating department told us and we saw from rotas that in general shifts were staffed appropriately based on the number of patients and the needs of these patients. An electronic staffing tool was used that highlighted were shifts did not meet the minimum staffing for the ward, so managers could address this.
- Ward and theatre managers described the escalation process if the staffing levels for their area dropped below the minimum safe staffing. They told us senior staff were responsive and where possible reallocated staff to another ward or tried to recruit bank and agency staff at short notice. The electronic rostering system highlighted when shifts were below the minimum level, with managers recording any mitigating actions they had taken. The trust also held daily bed occupancy meetings to monitor staffing levels due to changes to the needs or number of patients.
- All wards we visited, displayed their planned and actual registered nurses and health care assistants for the day, for patients and visitors to refer to. Patients told us although staff were busy, the care they received felt safe.

The trust also reported their actual nurse staffing hours against planned nurse staffing hours on their website, however, they had not updated this information since March 2016.

- We reviewed the rotas for the day surgery unit and ward 12c, for the week of our unannounced inspection all shifts had been filled so staffing on the ward met the planned level. The coordinator had used agency staff to fill two vacant shifts on the day surgery unit.
- Nursing staff on the day surgery unit told us the late shift often overran due to delays in theatre, with patients returning later than planned to the ward. Some staff kept a log but had not specifically requested the time back as they considered it part of their role.
- On ward 12b, extra nursing staff were on duty for the night shift on a Wednesday and Thursday, due to the number of patients having had hip and knee surgery on these days and needing assistance with mobilising.
- We reviewed the staffing rotas for the operating theatres for the week of our unannounced inspection and all theatres were staffed in line with the trust standard operating procedure 'Safe staffing in theatres' (2015). This SOP followed the staffing guidance from the Association for Perioperative Practice (AfPP).
- There remained a high use of bank and agency nursing staff and operating department practitioners in the operating department due to staff vacancies, with 41% of nursing shifts filled by agency staff in August 2016. The division considered this department a 'hotspot' area and monitored staffing closely. There was a 10% nurse vacancy rate at the time of our inspection, with six staff recently recruited and due to start in the next two months.
- The theatre matron allocated shifts 10 weeks in advance but had to review the rotas at six, four and two weeks after they had attended the theatre scheduling meetings, to accommodate changes to planned theatre sessions.
- Consultants raised concerns about the shortage of pre-assessment nurses and the backlog of surgical patients needing a pre-assessment. The trust estimated there to be a backlog of 600 patients and already had taken some action to reduce this, including offering linked outpatient and pre-assessment appointments and more anaesthetist led pre-assessment clinics for patients with complex conditions.

Surgical staffing

- Each speciality had a system in place to ensure there was consultant led care available all day every day. Other medical staff in their team supported the consultants and provided care to patients on the surgical wards.
- Consultants were on-call for a week at a time and during this time, the majority undertook no elective surgery work. They ran dedicated daily emergency operating lists and we saw these were staffed appropriately, including anaesthetic cover. Medical staff held daily handover meetings to discuss elective and emergency surgical admissions.
- There was 24-hour medical cover to the wards provided by the junior and specialist grade medical staff.
- The trust had slightly fewer consultant grade medical staff (39%) compared to the England average of 43% as of February 2016. They had slightly more middle career medical staff (13%) and a similar percentage of registrar grade staff (34%) compared to the England average of 10% and 35% respectively. The trust had slightly more junior grade doctors (14%) compared to the England average of 11%.
- One concern raised by medical staff was the difficulty with recruitment and retention of non-consultant grade posts due to the high cost of living in the area.
- Vacancy data provide by the trust for August 2016 showed there were 9.9 whole time equivalent medical staff vacancies across the division of surgery and critical care. Divisional managers monitored and reported on progress with recruitment to these posts as part of the monthly divisional workforce report. There had been a significantly greater use of agency and locum medical staff than budgeted for.
- Nursing staff on the ward and in theatres told us there was good access to support and advice from medical staff, during the day, night and at weekends. They told us they had a good working relationship with the medical staff.

Surgery

Major incident awareness and training

- The trust had business continuity plans for use in situations such as seasonal fluctuations in demand, a power failure or adverse weather conditions. There were corporate business continuity strategies in place, showing how senior management should manage an emergency at each site, depending on the level of impact.
- There was a trust 'Incident response policy' for staff to follow should a significant event occur at the hospital or in the local area. Staff knew where to find this policy on the intranet and senior staff understood their responsibilities if a major incident occurred.
- All staff completed annual fire safety awareness training as part of their statutory training. Theatre staff practised the fire evacuation procedure as part of their departmental audit days.

The trust followed a defined process for deferring elective surgery to prioritise unscheduled emergency procedures.

Are surgery services effective?

Good

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

We rated this service as good for effective because:

- Staff planned and delivered people's care and treatment in line with current evidence based guidance, standards and best practice. There was good monitoring of compliance with these standards at departmental and division level.
- Across the surgery service, departments monitored patient outcome data at a local level and submitted data to national audits to enable benchmarking to similar services. Results from these audits showed patient outcomes were in keeping with the national average. Staff used outcome data to identify ways to improve patient care and treatment.
- Patients told us they had made an informed decision to give consent for surgery. They could access pain-relieving medicine as needed during their stay in hospital.
- The hospital had systems in place to ensure they provided care for inpatients seven days a week, including access to on-call theatre and diagnostic imaging staff in an emergency. Planned operations were performed mainly during the week.
- Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs. Staff in general could access the information they needed to provide care for patients once they were admitted to hospital.
- The trust supported staff to become competent in their roles and provided specific training programmes. Staff told us they had received a recent appraisal and felt able to progress in the career, although some theatre staff felt there were limited opportunities for development.

However:

- Staff did not have a clear understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards to enable them to support and make best interest decisions for patients who were unable to give informed consent.
- The most recent informed consent audit showed medical staff were not completing all consent forms and patient care records to the expected trust and national standards.

Evidence-based care and treatment

- Staff working across the surgery service told us and the trust provided evidence to show how they used national guidance (for example, from the National Institute for Health and Care Excellence (NICE)) and from relevant professional bodies for the care and treatment they provided for patients.
- Services had written local policies to reflect this guidance and some departmental meetings covered changes to national guidance and the need for policy amendments. The division had a robust audit programme in place, with submission to a number of national benchmarking audits, so service delivery leads

could monitor the quality of their service. Also, audits were completed to monitor compliance with NICE guidance. The trust sent a monthly email to key lead staff to make them aware of NICE guidance released each month.

- The trauma and orthopaedic service published an audit in May 2016, auditing compliance with NICE Clinical guidelines (CG3)- Pre-operative tests for elective surgery. Results showed some patients were having additional investigations prior to surgery compared with the guidance. There was an impact on patient's time, costs and stress for patients. The service planned to liaise with the anaesthetic team to confirm which tests were required and produce additional guidance for staff.
- The division had reviewed and reported in August 2016 about compliance with key sepsis screening and treatment targets in line with NICE guidance. They had identified areas of reduced compliance and action plans put in place to ensure patients received treatment within the recommended treatment time.
- Theatre staff followed NICE guidance Quality Standard 49- Surgical site infection. This included steps to follow to minimise the risk of infection during surgery. The team has also re-audited compliance with NICE Clinical Guidelines (CG65)- Hypothermia- prevention and management in adults having surgery. The results found improved compliance with monitoring and maintaining of core body temperature but would continue to improve staff knowledge and understanding of the importance of maintaining normal body temperature at all stages of the surgery process. The department would keep a record of any patients who did experience hypothermia and the reasons for this.
- The trust monitored for any new or updated technology appraisals from NICE. These are recommendations from NICE on the use of new and existing medicines and treatments within the NHS. The action log included whether staff needed to update local clinical guidelines in response to the update. The trust held joint monthly meetings with the local clinical commissioning groups (CCG) to discuss these guidelines and other areas of concerns relating to safe, cost effective prescribing in the local area.
- To improve patient outcomes for patients having elective orthopaedics and colorectal surgery, staff followed evidence based enhanced recovery pathways. Staff prepared patients for surgery and provided a structured post-operative recovery plan, including pain relief and early mobilisation. This involved physiotherapists and occupational therapists where appropriate to help patients with recovery and discharge arrangements.

Pain relief

- Nursing staff assessed patients' level of pain using a numerical scale and recorded this on the patients' New Early Warning Score (NEWS) chart. Records we reviewed showed staff had acted appropriately to the score recorded, with pain reliving medicine given to patients.
- A staff member told us they used specific tools such as the faces visual pain scale pictures, either for patients unable to verbalise their level of pain, due to the effects of the anaesthetic or for patients with communication difficulties.
- We observed a handover between the anaesthetist to the recovery team, this included information around ongoing pain management for the patient, to ensure they remained comfortable.
- On ward 12a, staff asked colorectal patients how happy they were with the level of pain control provided, as part the departmental audit on the enhanced recovery programme. The most recent data from 2015, showed 98% were happy with the pain management they received.
- Patients and staff could access specialist advice from the pain management team. The team supported patients with acute and chronic pain and provided a daily weekday service to the wards and an on-call system out of hours.
- Thirteen out of 14 patients, told us they have received adequate pain relief and staff responded quickly when they were in pain.

Nutrition and hydration

- Nursing staff advised patients about fasting times prior to surgery at pre-assessment. They also completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments during their

pre-assessment and staff repeated this when they admitted the patient to hospital. The MUST was used to identify patients at risk of malnutrition. Staff could contact a dietician for additional advice if needed.

- Patients' specific dietary needs were also recorded at pre-assessment, so the catering team could be informed and provide suitable food for the patient during their stay.
- Staff monitored patients for post-operative nausea and vomiting. Staff gave anti-sickness medicine to patients as needed, which medical staff had written up prior to surgery.
- Patients had access to drinks by their bedside. Nursing staff checked that patients had regular drinks and where relevant monitored and recorded their fluid balance levels.

Patient outcomes

- Surgical specialities collected service specific data on patient outcomes and submitted this to a number of national audits to enable them to compare and benchmark patient outcomes against those achieved nationally. There was also a robust divisional audit programme in place for local monitoring of patient outcomes. Staff presented the results at speciality clinical governance meetings, to enable discussion and changes to practise.
- The trust participated in the National bowel cancer audit (2015), with results showing the trust was within the expected range when compared to other hospitals.
- For the National oesophago-gastric cancer audit (2015), the trust performed better than the national average for two indicators and within the expected range for the remaining two indicators.
- Results from the Vascular audit (2015) showed variable performance; one indicator was above the expected range, two were within and two below.
- Patient Reported Outcomes Measures (PROMs) are a national tool used to measure health gain in patients following hip replacement, knee replacement, varicose vein and groin hernia surgery in England. The measures are reflective of patients' responses to questionnaires before and after surgery. Data for April 2014 to March 2015, showed the trust had similar PROMs to the England average for groin, hip and knee surgery, with better PROMS for patient having varicose vein surgery, compared to the England average.
- The overall standardised relative risk of readmission at the hospital was better than the England average for elective and non-elective admissions other than for general surgery. This figure considers the actual number of readmissions against the expected number.
- The average length of stay for elective patients at Wycombe Hospital was 3.2 days, similar to the national average of 3.2 days (March 2015 to February 2016). The length of stay for trauma and orthopaedic patients was slightly worse than the national average 3.8 days compared to 3.4 days respectively. However, the length of stay for urology patients was the same as the national average (2.1 days) and better for general surgery patients, 3.1 days, compared to the national average of 3.4 days. On average, non-elective patients stayed at the hospital for 2.4 days, much better than the national average (5.1 days), however, trauma and orthopaedic patients stayed much longer, 14.8 days compared with the national average of 8.7 days.
- At the time of out inspection, the surgery service had not achieved Anaesthesia Clinical Services Accreditation (ACSA) but planned to work towards this as part of the theatre improvement programme.

Competent staff

- Staff told us they had received a recent annual and the majority felt supported to complete additional training to enable them to develop in their role.
- Data provide by the trust showed as of August 2016, compliance with appraisals for medical staff in the division of surgery and critical care was 81% and for non-medical staff 90%, against the trust target of 90%.
- Most staff commented positively about the access to training opportunities for continuing professional development. Some healthcare assistants told us the trust had financially supported them to complete a National Vocational Qualification (NVQ) as part of the 'Itchy feet' programme to encourage staff to stay and develop their role. However, nursing staff in theatres felt

there was limited career development for staff of grade Band 5 or below. They also told us they felt there was greater difficulty in accessing courses compared to their colleagues working on the surgical wards.

- Staff did not receive formal clinical supervision, however, staff told us their managers did observe them when working and issues around performance were discussed with them. We saw evidence in meeting minutes showing the trust had taken action when staff performance was not as expected or in line with trust's policy.
- Theatre staff attended monthly training meetings, which covered mandatory training, equipment updates and audit outcomes.
- We saw completed records showing permanent staff undertook competency tests, relevant to their area of work, to ensure they had the necessary skills to carry out their role. Staff who worked as 'link nurses' such as for pressure ulcers or dementia, told us they did feel they always had sufficient additional knowledge to be able to confidently support their colleagues.
- Students completed placements on some of the surgical wards. Staff who were mentors told us they completed an annual update to their training, which was a requirement of the universities sending students on placement. There were separate information boards for students, advising them of relevant trust policies, useful contacts and the learning opportunities and expectations for the ward they were working on.
- In the General Medical Council National Training Scheme Survey 2016, the trainee doctors rated their overall satisfaction with training as similar to other trusts. Trainee doctors told us they felt supported and enjoyed working at the trust.
- Patients could review and compare the clinical outcomes for surgeons working at the trust via a link from the trust website to the My NHS website.

Multidisciplinary working

- Throughout the inspection, our observations of practice, review of records and discussions with staff confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment.
- There was clear communication between staff from different teams, such as theatre staff to ward staff and between the ward staff and physiotherapists. We observed safe and effective handovers of care, between the ward, theatre and recovery staff. There was good communication between all members of the theatre team when they mad a change to the order of patients on the operating list.
- Daily ward round took place seven days a week on the surgical inpatient wards. Medical and nursing staff were involved in these, together with staff from other specialities as needed.
- Nursing, theatre staff and junior medical staff told us it was easy to contact a consultant if they needed advice. The consultant had overall responsibility for a patient's care.
- If a patient needed to be transferred to another hospital, medical staff were responsible for liaising with the hospital and arranging for the transfer, after discussion with the patient's consultant.
- Staff were aware of who to contact if they needed to arrange an urgent review for a patient with sepsis. The trust monitored compliance with all aspects of the sepsis pathway.
- When the hospital discharged a patient, they sent a letter to the patient's GP.
- Nursing staff on the ward told us there were sometimes delays to patients being discharged as their to take out (TTOs) medicine were not always ready and they had to chase this with the pharmacy department. Dispensing audits showed the pharmacy department had not met the trust key performance indicators (KPIs) of 95% of TTOs dispensed within 90 minutes, for April to August 2016, which supports the comments from staff. Compliance ranged from 69% to 81%.

Seven-day services

- The trust were working towards being compliant with all four of the key priority clinical standards of the NHS services, seven days a week framework, which ensured high quality care for patients every day of the week. The trust had participated in the NHS national sustainable improvement survey in April 2016 and devised an action plan in response to the findings from the survey, where they were fully compliant for two standards (Access to

diagnostics and consultant directed interventions) and partially compliant for two (Time to first consultant review andon-going intervention). The action plan included review of consultant job plans and ensuring staff provided information to patients and families of the diagnosis and treatment plan, within 48 hours of admission.

- All specialities had a consultant on-site seven days a week, normally 8am-6pm during the week and varying daytime hours at weekends. Services held daily ward rounds for all patients and had daily handover meetings to discuss new admissions or complex patients. There were rotas in place to provide medical cover to the wards out of hours and at weekends. A specialist registrar was always on duty to support more junior medical staff.
- A 'hospital at night' team was used to co-ordinate care provided by medical staff as they changed shifts, discuss any patients of concern and make staff aware of bed capacity issues.
- We saw the on-call rotas for the operating department, theatre staff and anaesthetic staff were available if there were any unplanned returns to theatre or emergency admissions.
- The pharmacy department ran an on-call rota so staff could access clinical pharmacy advice seven days a week, at any time.
- The radiology department provided an on-call service outside of normal working hours and at weekends so patients had access to key diagnostic tests such as X-ray and computerised tomography (CT) scans.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends. However, nursing staff on the day surgery ward told us the physiotherapists had sometimes gone home, if patients returned late from theatre. They gave patients an information leaflet and the physiotherapist called them the next day.

Access to information

- Nursing, theatre and medical staff raised some concerns around access to patient records; however, they told us these were normally available when they admitted a patient for surgery. Bank and agency staff had access to all patients' records to enable them to care for patients effectively.
- Staff raised concerns that patients arrived on the wards from the Minor Injuries Unit or their GP who had referred them did not bring any paperwork with them. Staff had to spend time chasing this information and the reason for admission.
- Theatre and ward staff commented there were errors on the operating lists, which resulted in issues such as patients arriving at the wrong time affecting the flow of patients between the ward and operating departments. This disrupted bed management plans on the wards. Staff had reported these incidents and the division recognised this as a key risk. The administration and theatre teams were reviewing the standard operating procedure for in-patient bookings.
- Nursing staff told us when transferring patients between wards or teams, staff received a handover of the patient's medical condition and on-going care information was shared. We observed informative and effective handovers between theatre and recovery staff. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.
- A discharge letter was sent to the patients' GP, staff placed a copy of this in the patients' file for reference. The letter contained information on the operation performed and any support or medicines needed post-surgery so the patients' GP was aware.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the importance of seeking consent for procedures but could not describe with confidence the use of mental capacity assessments, where there was a risk a patient did not have the capacity to consent, in accordance with the Mental Capacity Act (2005). Staff understanding of the use of deprivation of liberty safeguards was limited which may impact on patients' care.
- Staff completed Mental Capacity Act training on induction but were not required to renew this. In addition, all staff completed Deprivation of Liberty

Safeguards awareness training every three years. As of September 2016, 88% of staff had completed Mental Capacity Act training and 79% of staff had Deprivation of Liberty Safeguards training, against the trust target of 90%.

- Senior staff told us ward staff did not always monitor Deprivation of Liberty Safeguards applications that staff had made for patients on their ward. This could result in staff unlawfully depriving patients of their liberty without the appropriate safeguards in place. Senior staff were working with the county council to improve access to the Deprivation of Liberty Safeguards application system. Also, the trust planned to introduce from October 2016, a new patient care record, which included an assessment of capacity for all patients. They recognised the need for additional training to ensure staff felt confident to complete the assessment and take action to safeguard patients..
- Patients told us they had been able to make an informed decision about surgery, before signing the consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The five consent forms we checked confirmed this.
- The trust carried out an audit of consent forms in 2015 and found completed consent form for 98% of clinical procedures. 100% of consent forms audited were signed by a clinician. However in 11% of cases this information was either illegible or difficult to read. We saw an action plan for clinicians to improve and a repeat audit was planned end of November 2016.

Are surgery services caring?

Good

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

We rated this service as good for caring because:

- Patients were positive about the caring attitude of staff, their kindness and their compassion. All patients we spoke with would recommend the service to their friends and family and this was supported by data collected for the Friends and Family Test.
- Staff treated patients as individuals and respected their personal, cultural, social and religious needs. Staff involved patients, and those close to them, with decisions about their care and treatment. Patients told us they felt involved in their care and understood their treatment plans.
- Staff gave patients appropriate support and information to cope emotionally with their care and treatment.

However:

- Patient names were displayed in areas accessible to other patients and visitors. Also, staff did not maintain patients' privacy and dignity at all times when providing care and treatment in the operating department.

Compassionate care

- All patients we spoke with were positive about the caring attitude of staff and pleased with the quality of care and treatment they had received. Patients described staff on the surgical wards as "extremely welcoming", "outstanding in all areas" and "professional" in their approach.
- We observed compassionate and caring interactions from all staff. Staff spoke to patients in a kind manner and treated them with respect. We saw staff treated patients as individuals and that staff had an understanding of a patient's personal, cultural, social and religious needs.
- Staff providing care to patients introduced themselves and explained their role and how they would be involved in the patients' care.
- The surgical wards and day surgery unit collected FFT results and displayed the results for patients and relatives to view. The Friends and Family Test (FFT) measures how likely patients would be to recommend the hospital to their friends and family, based on their experience. The results of the FFT in July 2016 showed 95% of patients would recommend the surgery service to their friends and family, this was in keeping with the national average. Across the division, the response rate for the surgical wards at the hospital ranged from 26% to 54%, against the national average of 25%.
- During our observations on the wards and in the operating department, we saw and heard staff maintaining the confidentiality of patient's information.

However, staff did not always maintain patient's privacy and dignity. We observed staff in the recovery area in main theatres not always closing the curtain fully prior to providing care and treatment to patients. Other staff coming into the department or who were based in this area could see the care being provided to patients. In the same area, we found staff only partly closed the blinds on the recovery area windows and there was no frosting on the lower section of the windows to mitigate this. The windows looked out onto other departments, therefore staff and visitors could potentially see care and treatment being provided to patients. In the operating theatres in this same area, staff were able to see into the three theatres when accessing the storage corridor as staff did not close the blinds or place a screen in front of the theatre windows.

- Patient names were displayed (initial and surname) on the whiteboard at the nurses station on the wards. There was no screen on the whiteboard to cover patient identifiable information.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. The hospital's PLACE score in 2016, for privacy, dignity and well-being was 70.2%. The hospital has consistently achieved below the national average (84.2%) for this outcome. The trust scored similar to other trusts in the 2015 CQC inpatient survey for all key areas relating to care and dignity.
- Despite these concerns, all 14 patients we spoke with felt they had enough privacy and staff maintained their dignity throughout their care and treatment.

Understanding and involvement of patients and those close to them

- Staff gave patients the opportunity to ask questions about their care and treatment. We observed staff involving patients, and those close to them, with the decisions about their care and treatment.
- Patients told us all staff had given clear explanations and sufficient detail to inform them about each stage of their care and treatment, from initial consultation through to discharge. Staff gave patients information leaflets to support the discussions that had taken place.
- Medical staff were clear about the risks and benefits of the planned treatment and patients understood how their recovery would progress.
- If a patient's surgery was delayed, staff provided thorough explanations as to why this delay had occurred. For example, we observed staff explaining to a patient they were currently not well enough to attend theatre and staff would complete regular observations to determine if the patient was well enough for surgery on their planned date.

Emotional support

- Staff in all surgical areas showed sensitivity and support to patients, understanding the emotional impact of surgery admission and discharge. Staff offered plenty of reassurance when providing care to anxious patients. We also observed staff offering emotional support and information to patient relatives.
- The recovery staff in particular had a gentle and calm approach, which helped patients to relax before surgery. Staff in recovery were mindful that patients may be aggressive or present complex behaviour post-surgery and were able to support this.
- Patients spoke positively about the emotional support that staff provided. Patient comments included "staff were excellent calming my nerves" and "nurses are reassuring".
- The trust multi-faith chaplaincy service was on call 24 hours a day to provide spiritual and emotional support for patients and their relatives. The chaplaincy team had links with other local faith leaders if needed.
- Specialist nurses provided emotional and practical support for patients with specific condition, such as cancer.
- Staff supported patients to keep their independence and maintain contact with family and friends.

Are surgery services responsive?

Requires improvement 

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

Surgery

We rated this service as requires improvement for responsive because:

- Division of surgery and critical care did not achieve the referral to treatment time (RTT) indicator for surgical patients from April to July 2016.
- The service had a significant backlog of patients requiring pre-operative assessment. The division had not achieved 90% of patients being seen and admitted within 18 weeks of referral.
- The layout within the main operating theatres did not contribute positively to the patient's experience when patients arrived and were taken for surgery.

However:

- The trust worked in partnership with local commissioners to plan and deliver services, to meet the needs of local people. Some elective surgery such as for ear, nose and throat (ENT) and breast surgery had been relocated to the hospital to improve efficiency and a prompter service for patients.
- Staff took account of the needs of different people, including those with complex needs, when planning and delivering services. Staff showed good understanding and made reasonable adjustments to meet patients' individual needs.
- The trust dealt with the majority of complaints within the agreed response time. There was evidence the division leads and frontline staff discussed complaints and used these to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Senior staff worked with the commissioners of local services such as GPs, the local authority, other providers and patient groups to plan and co-ordinate services to meet the needs of local people.
- Wycombe Hospital was primarily an elective surgical site with inpatient and day surgery facilities. There were 11 theatres, across three departments. Theatre utilisation rates for the trust, for April to August 2016, averaged 76%. The division planned to monitor theatres utilisation and report on this monthly, linking with managers to identify ways to improve efficiency and utilisation.
- Elective ear, nose and throat (ENT) surgery had been transferred to Wycombe hospital to provide a prompter service. The trust planned to move pain surgery there as well and transfer all eye surgery to Stoke Mandeville Hospital, to maximise efficiency and utilisation of theatres. Staff working in ophthalmology theatres were concerned there was not sufficient capacity to manage all eye surgery at one site.
- The layout of the hospital meant that most areas were accessible for people using a wheelchair.
- Patients had access to free Wi-Fi. The majority of wards we visited had a day room with a television, however, patients did not have their own television at their bedside. Staff told us that this was due to the high cost of the service and that patients often brought in their own electronic device.
- The layout within main theatres hindered the 'patient experience'. As patients entered the department, the first thing visible were the large yellow waste bins. There were no screens in place to shield these from view. Additionally, when staff took the patient from the pre-operative admission area into theatre, they passed equipment stored in corridors and staff desks. Again, staff had not considered the impact of this as part of the patients experience during their stay in hospital.

Access and flow

- The hospital admitted surgical patients through a number of routes, including elective inpatient admission, pre-planned day surgery or from a GP referral. The division monitored the percentage of patients admitted within 18 weeks of referral as part of their monthly surgical quality report. It is expected that 90% of patients are admitted within this timescale. The division overall did not achieve the referral to treatment time (RTT) indicator, for patients on an admitted pathway from April to July 2016, with performance ranging from 58% to 63%.
- Staff carried out a pre-operative assessment for patients undergoing elective surgery. The trust had a significant backlog of patients requiring pre-operative assessment (approximately 600). Staff told us the backlog was due to various reasons including nursing and consultant shortages. A pre-operative assessment work stream were working to reduce the backlog of patients for pre-assessment. Staff now completed some pre-assessment appointments on the same day as the patients' outpatient appointment so the trust could

provide the patient with a date for surgery as soon as possible. The hospital had also introduced filter clinics for orthopaedic patients (in addition to booked pre-operation assessment slots) to improve pre-assessment workflow and facilitate urgent cases. The filter clinics ran between 9am and 6pm during weekdays. The clinics were not suitable for patients with a complex medical history.

- All breast surgery took place at the hospital. The service aimed to see all suspected breast cancer referrals within a week, as part of a one-stop clinic. A number of clinicians saw patients on the same day, with additional investigations also carried out. This helped to reduce patient anxiety and concern, as staff could give the patient a diagnosis promptly and start them on any treatment. The consultants reported that moving all breast surgery to Wycombe Hospital had improved access to beds, increased patient flow and worked better for both patients and staff.
- A weekly theatres scheduling meeting was held, with staff attending from all teams involved in managing admissions lists plus staff from theatres to ensure sufficient staff would be available for the planned lists. The teams reviewed the planned lists at six, four and two weeks in advance. We saw lists were amended based on changes to medical staff availability. Spaces in lists were also identified, with administrative staff contacting patients on the waiting list to see if they could attend at short notice.
- Elective surgery operating sessions ran from 8am to 6pm, Monday to Friday.
- From April to August 2016, the hospital cancelled 44 operations for clinical reasons and 37 operations for non-clinical reasons. As part of the theatre improvement programme, administrative staff called patients three days before admission to remind them of their date for surgery and check patient welfare, with the hope of reducing patient cancellations or patients not attending for surgery. The trust rebooked all cancelled operations within 28 days as per the agreed local target.
- From March to May 2016, bed occupancy on the surgical wards varied from 24% to 100%. It is accepted that at 85% and above, bed occupancy can start to affect the quality of care provided to patients, and the running of the hospital. Bed occupancy rose above the 85% national target on 18 occasions (March to May 2016). During this same period, the hospital reported no medical outliers on the surgical wards. Medical outliers are patients who should be cared for on a medical ward but due to bed capacity issues have to be admitted to another ward.
- In August 2016, the trust temporarily closed ward 12a due to limited patient numbers, patients that were on the ward were transferred to 12C. The staff on 12a also transferred temporarily to 12c to maintain expected staffing levels.
- In an attempt to increase discharge rates and prevent patients staying in hospital longer than necessary, the hospital aimed to discharge 10 patients by 11am each day. From March to May 2016, the hospital did not meet this target once. The main cause of delayed transfer of care residential home availability, accounting for 44.2% of delays.

Meeting people's individual needs

- The majority of staff on the wards demonstrated a good understanding of providing care, support and accommodating patient's individual needs.
- During the patient's pre-assessment, staff recorded information on patients' additional needs. This included information about any translation or interpreter services required, the patient's vision and hearing needs, and any social support needed.
- Patients reported receiving adequate information about their treatment and stay in hospital. Staff gave patients information leaflets about their planned procedure during their pre-assessment appointment or patients could print off patient leaflets from the trust website. Patient information leaflets were in English but contained information on how to request them in another language or format, such as large print.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. The hospital's PLACE score, for the suitability of the environment for people living with dementia, was 57.5% in 2016. This was significantly lower than the national average of 75.3%.
- On admission, the trust should screen all emergency patients aged 75 and above for dementia. From April to

June 2016, the trust reported approximately 89% of patients had been asked the dementia screening question within 72 hours of admission, in line with national targets. However, in for July and August 2016 there had been a significant drop in the number of emergency patients screened for dementia of 79% and 58% respectively.

- In spite of this, we saw evidence the trust was improving their delivery of services to meet the needs of people living with dementia. For example, the dementia lead had developed a documentation booklet for staff use to improve dementia care. The booklet pilot would begin in October 2016. Eighty eight percent of staff had completed dementia awareness training, nearly achieving the trust target of 90%.
- The trust had a lead dementia nurse who could offer specialist advice to all staff. On ward 12c, the senior nurse had requested an environment assessment with a dementia nurse to identify areas that could be improved for patients living with dementia. Since the assessment, more clocks had been placed on the ward.
- People living with dementia have a high risk of experiencing a fall. To mitigate this, there were designated priority beds for patients with complex needs, so staff could observe them from the nursing station. Ward 12b and ward 12c used stay in the bay workstations, which provided facilities to increase the time staff spent in sight of the patient and thus reducing the number of unobserved falls. In addition, the trust were considering a separate ward/area for patients who had complex orbehaviour that may challenge.
- Staff on the surgical wards and theatres had lead link roles, which meant they normally received extra training on an aspect of patient's care and acted as a resource for other staff. Staff link roles included manual handling, nutrition, diabetes and dementia care.
- The trust had two learning disability liaison nurses who were available to help both people with a learning disability and their carers during their time in hospital. The surgical department would contact the liaison nurses for advice and support when admitting people with a learning disability. The hospital's PLACE score, for the suitability of the environment for people with a learning disability was significantly lower than the national average (65% compared to 78.8%). As a result, the Chief Nurse proposed designating a PLACE link in the surgical division to manage outstanding actions identified in the assessments.
- Any patients with a body mass index (BMI) of 30 or above were flagged on the hospital's electronic system, allowing the ward to prepare for the patient's admission. We saw on one ward a bariatric patient had accessto suitable equipment during their stay. Staff told us equipment was available from central store within four hours.
- In the 2016 PLACE assessments, the hospital scored 91.7% for ward food, slightly above the national average of 88.2%. During our inspection, patients we spoke with praised the quality of the food and were impressed with the choices and quantity available. The service provided alternative menu options when patients had special dietary requirements, for religious or cultural reasons.

Learning from complaints and concerns

- The hospital had a(2012), which provided staff with a clear process to investigate, report and learn from complaints. At the time of our inspection, the trust was conducting a review of the complaints policy, to develop the policy further with staff engagement and feedback.
- Staff recognised that early resolution of patient concerns prevented the concern from escalating into a formal complaint. When a concern was first raised, it was highlighted to a senior nurse. If the senior nurse was unable to deal with the concern directly, they would direct the patient to the Patient Advice and Liaison Service (PALS) to formalise the complaint.
- From May to August 2016, the trust received 77 formal complaints concerning surgery, of which 15 related to Wycombe Hospital. The Chief Executive had overall accountability for formal complaints. The Medical Director and Chief Nurse and Director of Patient Care Standards had responsibility for ensuring complaints were processed and responded to in a timely fashion, and discussed across the trust. They also ensured the surgery service took action because of a complaint to improve the quality of care. An investigating officer was assigned complete a full investigation of any formal complaints.

- According to the trust's complaints policy, complainants should receive a to their complaint within 25 working days (In July 2016, the trust contacted 82% of complainants with a completed written response within 25 days. Although slightly below the trust target of 85%, this result was a significant improvement from the previous month (62%).
- There were procedures for sharing and learning from complaints across the hospital. a senior level at the
- We saw evidence that departments acted upon patient feedback. Wards used 'you said, we did' wall displays to show patients how they responded to patient feedback. For example, a patient on ward 12a complained that the waiting time for TTO (to take out) medicine was too long. Consequently, the ward had a meeting with pharmacy and staff now ensured TTO medicine was written up the day prior to surgery to avoid delays. Staff said they were proud of patient feedback and we saw examples of positive feedback displayed on the wards, such as "many thanks for giving me my life back".
- Information for patients on how to leave feedback or make a compliant was provided throughout the hospital. We saw a feedback boxes in use on the wards. Patients told us they would speak to a member of staff if they had any concerns. All of the patients we spoke with said they had no reason to complain, as their care had been good.

Are surgery services well-led?

Good

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

We rated this service as good for well-led because:

- Staff felt valued by their line manager and the trust as a whole. Staff felt able to raise concerns and described the positive change in the culture over the last two years, with openness and honesty encouraged. The majority of staff enjoyed coming to work at the trust and felt the team working was a particular strength.
- There were effective governance arrangements in place to monitor the quality, risk and performance of the surgical service. Actions plans were used to address areas of concerns. There were processes in place to escalate identified risks, both within the division and to the trust executive team. Service leads and departmental managers were encouraged and supported to monitor their own service and implement improvements.
- Systems were in place to gather patient feedback and we saw how departments and the division had used this feedback make changes to services.
- Staff were encouraged to make suggestions on how services could be improved to help with innovation and sustainability. Most staff felt the leadership of the trust and within the division were visible and supportive.

However:

- Staff could not describe the vision for the trust or the service where they worked.
- Three trust polices and standard operating procedures (SOPs) that staff were using were out of date for review by one to two years. There was a risk that staff were not following current best practice. Staff did not always follow the trust's medicines policy and SOPs; although audits had taken place, we did not see evidence of continued improved performance.
- There were no minutes or actions recorded for the matron and ward sister meetings, although the trust had addressed this following our inspection. In addition, there were no minutes for any of the surgical wards departmental meetings to provide a formal record of discussions and agreed decisions.
- We identified a number of concerns around staff not following practices that kept patients safe. The trust or surgery service had not identified these concerns.
- Staff in the operating departments had raised concern about morale. The trust had looked in to these concerns but there were no formal action plans in place to support the work which staff had completed.

Leadership of service

- A director, chair and divisional chief nurse led the division of surgery and critical care. At the time of our

inspection, there had been a recent change to the director and an interim chief nurse was in post. There were service delivery unit leads in place for each clinical speciality.

- Staff spoke positively about their manager and felt able to raise concerns with them. Staff had confidence in the leaders at all levels within the division and felt they were competent to undertake their role.
- The executive team and divisional leads completed observational visits to the wards and theatres, which staff valued. They felt issues they raised were recognised and where possible the trust had taken action. Some clinically trained senior staff completed shifts on the wards, with feedback provided to the team.
- Consultants valued the positive change in the approach of the senior management teams over the last two years. They felt the focus had moved positively towards improving services and outcomes for patients, looking at efficiency and quality. They felt the management, in particular the deputy divisional director, were responsive to suggestions from clinicians, which resulted in improved efficiency for their individual service.

Vision and strategy for this service

- The trust vision was to provide safe and compassionate care, every time. There was a strategy in place to support the achievement of this vision, as part of the trust's five-year plan (2015-2020).
- Senior leaders in the division of surgery and critical care were reconsidering the vision and strategy for the service to ensure it was in line with the trust's vision. The focus for the division was around providing safe and best care for all patients and to become the regional provider of choice for healthcare professionals across all specialities in the surgical service.
- Some managers we spoke with had a local vision for their area, however, the majority of frontline staff we spoke with could not describe the vision for the trust or the department they worked in. However, staff were passionate about improving services and providing a high quality service to patients.

Governance, risk management and quality measurement

- There was a clear governance structure and framework in place within the division, which linked into the overall trust governance structure. Staff followed processes to support them to achieve good quality care for patients, with senior staff monitoring and reporting on risks, quality and performance monthly.
- The divisional leads had overall responsibility for governance for the surgical services. A divisional quality group supported them, with each service delivery unit (SDU) having a clinical governance group and management meetings to monitor quality at a more local level. Minutes we reviewed showed these systems were working well.
- Minutes from the division and SDU governance meetings showed review of incidents and complaints, trend analysis for both of these areas; feedback from patients including monitoring response rates to the Friends and Family Test (FFT) and consideration of patient clinical outcomes. In addition, the division produced a monthly quality report that reported on these areas in more detail and included consideration of key risks. This was supported by the use of a division quality dashboard, providing at a glance information on performance for key quality measures, such as referral to treatment time performance and unplanned readmissions, on a monthly and year to date basis.
- There was a divisional risk register in place, with departmental and SDU risk registers completed to link into these. The top three divisional risks, aligned with concerns raised by staff during the inspection. These were the infrastructure of the operating departments, errors on the theatre lists and delays with pre-assessments. A lead was responsible for each risk and we saw they were effectively monitoring their risks on the register.
- In response to the number of never events in theatres at the trust, the medical director had arranged for an external review of theatres, in addition to the internal investigations that had taken place, to see if there were any further changes to practice. The external company had not completed the report at the time of our inspection.

- There was a sepsis lead for the trust. Recent trust wide audits on sepsis management had identified actions that staff needed to take to improve the promptness of treatment. Further audits were planned to monitor compliance.
- Staff working on the wards told us they attended regular team meetings, which provided an opportunity for them to raise concerns and discuss recent incidents, there were no minutes taken at these meetings. There was no formal record of the meeting, as a way to track actions that staff had taken and so staff unable to attend the meeting could see what their team had discussed and agreed. There were also no minutes from the matron and ward sister meetings, which took place on a monthly basis. The trust acknowledged this as a concern, told us there would be a standard agenda for the meetings, and provided the minutes from the first meeting.
- We saw good use of clinical audit programmes across the division to monitor quality and systems, with audit leads identifying actions that staff needed to take. The operating departments held quality and safety meetings every two weeks, which included discussing learning from incidents. They provided minutes for staff unable to attend the meeting.
- Theatre managers and the anaesthetists were developing local safety standards for invasive procedures, in response to the National Safety Standards for Invasive Procedures document. This document supports the delivery of safe care to patients having an operation.
- Staff had access to trust policies and standard operating procedures (SOPs). Most that we read were in date, however, there were some that had gone beyond their review date. The 'Correct site surgery' policy and the 'WHO surgical safety checklist' policy were due for review in 2014. Also, the 'Thromboprohylaxis in adults' was due review in 2015. There was a potential risk to staff and patients due to current best practice not being used and followed. Also, staff were not consistently following the trusts medicines policy and procedures, potentially placing patients at risk. Pharmacy staff had completed audits to monitor compliance but there had not been a sustained improvement in performance.

Culture within the service

- Staff told us they enjoyed working at the hospital and the team working was a particular strength.
- One member of staff told us they loved their job, they felt able to make a difference and make patients smile.
- A number of staff we spoke with had worked at the trust for over 10 years. Staff told us they felt the trust recognised the skills of all staff and what each individual could contribute by working at the hospital. They felt there had been a move towards staff at all levels of the organisation being more open and honest which they felt was important; staff felt able to raise safety concerns.
- The division monitored staff sickness and turnover rates on a monthly and rolling yearly basis. For July 2016, the sickness rate averaged 3% (range 0% to 6%), against the trust target of 3.5%. Actions were in place for areas with high rates or were changes occurred. Staff were supported in line with the trust sickness absence policy. The rolling 12-month turnover rate was variable depending on the staff group, ranging from 9% to 31%. Retention of staff was a challenge due to the high cost of living in the local area and the proximity to London hospitals that could offer a high cost area supplement.
- A couple of staff raised concerns about morale in the operating departments. The trust had completed a review and found concerns in seven areas, including rotas, training and education and respect. Although the service had considered suggested solutions and had already implemented some of these, there was no formal action plan in place to support this and offer assurance they would make all the changes. The trust had completed 'temperature checks' via a specific theatre staff survey completed in June 2016, to gain further feedback how staff felt about working in theatres, the best things about where they worked and how things could be made better. Again, it was not clear how the service would use this feedback to improve staff morale.

Public engagement

- The division asked patients and carers for feedback using the Friends and Family Test (FFT) and they monitored on a monthly basis the results from the survey and also the reasons for patients contacting the Patient advice and liaison service (PALS).

Surgery

- The trust had trialled text messaging inpatient surveys in April 2016 and had seen an increase in the response rate for May 2016, providing a more accurate reflection of patients' experience.
- Positive feedback from patients about the quality of care staff had provided was shared and acknowledged at all levels within the trust. The Chief Executive wrote to both the patient and the staff member to thank them.
- On a number of wards we saw boards displaying 'You said, We did'. Changes made included the aim to introduce free Wifi to one ward and requesting staff to wear quiet soled shoes and keep their voices down when working on the wards at night.
- The trust introduced in May 2016, a review of a specific department by the divisional chief nurse, which included speaking with three patients once a month, to seek their views about leadership, safety, environment, clinical effectiveness and experience. They shared the results with the team to enable them to make changes and so positive feedback could be shared.

Staff engagement

- The trust had a number of schemes in place to recognise and acknowledge the contribution made by staff, to seek their feedback and ideas for service development.
- Staff were encouraged to give positive feedback and express thanks to a staff member or team, for example, if they helped achieve a good outcome for a patient in challenging circumstances. This information was shared at division meetings and included in the monthly division quality report.
- The trust also held an annual staff awards ceremony, with patients and staff able to nominate a team or staff member for an award.
- Information was cascaded to staff through newsletters, emails and staff noticeboards. All departments we visited held team meetings for sharing of information and to provide an opportunity for staff to raise concerns.
- The division introduced in May 2016, a review of a department by the divisional chief nurse, which included speaking with three staff members to seek their views about leadership, safety, environment, clinical effectiveness and experience where they worked. The divisional chief nurse shared the results with the team to enable them to make changes and so positive feedback could be shared.
- Results from the staff friends and family test showed 81% of staff working in the division would recommend the trust for care and treatment and 62% would recommend the trust as a place to work.
- The division results from the 2015 staff survey showed a better response than the trust average for seven of the 32 key questions and a worse response for the remainder, although for some the difference was not statistically significant. A local action plan had been produced for the operating departments, addressing staff concerns including effective team working, support from line managers and improving staff engagement. The action plan included who was leading on each action, date for completion and how the service would monitor the impact.

Innovation, improvement and sustainability

- Staff said the trust supported innovative and new ideas. The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service.
- The division had completed a workforce review, which include succession planning, to enable the service to continue to deliver the desired standard of care.
- A theatre management group was considering five different areas, including the efficiency of the service. The group reported to the divisional leads and the trust board.
- The trauma and orthopaedic service planned to introduce a nurse practitioner role, to provide additional support to medical staff, acting as link for patients from their initial appointment to discharge from hospital.
- The division was working to a cost improvement programme as part of the trust's planned financial savings. Senior division staff monitored compliance with this on a monthly basis, with additional support offered to areas that were struggling to make savings.

End of life care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good
Overall	Requires improvement

Information about the service

End of life care in the acute setting in Buckinghamshire Healthcare NHS Trust is provided on all general wards across two hospital sites, Stoke Mandeville and Wycombe Hospital supported by a consultant-led palliative care team. The Florence Nightingale Hospice has 12 beds and offers a day hospice for up to 12 patients a day for pain and symptom relief, psychological and spiritual support. The hospice is situated on the Stoke Mandeville site. The report relates to the services provided at Wycombe Hospital.

The consultant led team included palliative care nurses who worked in the hospital and end of life care nurse specialists based in the hospice. Between March 2015 and February 2016 there were 1128 in-hospital deaths within the trust.

During our inspection we visited six wards where end of life care was provided, the bereavement centre, the chapel and the mortuary. We spoke with 5 patients, 2 relatives and 18 staff, including consultants, doctors, staff nurses, health care assistants, ward sisters, members of the palliative care team, and end of life care nurse specialists, porters, bereavement, chaplaincy, and mortuary staff.

We observed interactions between staff and patients, and their relatives. We looked at 8 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and 14 medical and nursing care records. Before and after our inspection, we reviewed performance information from and about the hospital.

Summary of findings

Overall this core service was rated as 'requires improvement' because:

- Advance care plans were not fully documented for some patients, so staff and families were not routinely aware of patient's care preferences before and after death.
- DNACPR forms were not completed according to national guidelines, which include the need to document discussions with patients and families and that Mental Capacity Act decisions were documented.
- Infection prevention and control practices were not all being followed. We observed in the bereavement office deceased patients' belongings were stored in cupboards in open plastic carrier bags; this has the potential for cross infection.
- There was no protocol for withdrawing treatment as recommended in the 2015 National Institute of Clinical Excellence guidelines. However, the trust said that they were prioritising this guidance for completion in 2017.
- The hospital did not classify end of life care training as a mandatory subject as recommended by of the National Care of the Dying Audit 2013/14
- There were governance processes, including evidence of investigation of incidents and audits and lessons learnt for staff to improve patient care.

End of life care

- Patients' needs were mostly met through the way end of life care was organised and delivered. However, a rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way due to external delays with funding and care packages for complex needs

However

- Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was consistently positive. We saw good examples of staff providing care that maintained respect and dignity for individuals. There was good care for the relatives of dying patients, and staff showed sensitivity to their needs.
- The trust had on going engagement with a people panel to ask for opinions and suggestions in what mattered to them regarding developing plans for end of life care. The panel were consulted regarding the trust wide end of life patient care plans called "Getting it right for me" We saw that the care plans were not consistently used for end of life care patients during the inspection. The trust wereaware of the concern and had appointed an end of life care facilitator to improve end of life care education for clinical staff and to ensure the care plans wereused correctly.
- The people panel were consulted on the trust wide end of life care strategy, which was complete but not published at time of inspection. Staff we spoke with was aware of end of life care priorities and described high quality patient care as the key component of the trust's vision.

Are end of life care services safe?

Requires improvement

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

We rated safe as 'requires improvement' because:

- Systems in place to prevent and protect people from infection were not robust. For example, staff were not clear who had responsibility for cleaning the trolley used to transport deceased patients.This meant there was no assurance that cleaning occurred.
- Medical and nursing notes were stored securely. On two wards the notes trollies were unlocked in the main corridor of the ward and could be accessed by the public. However, the lids were shut closed.
- The vacancy rate in the pharmacy meant some end of life care patients sometimes experienced a delay in medicine supply because the central stores were held in the trust's other hospital site.
- Medical staffing did not meet national guidance.

However,

- The palliative care team understood their responsibilities to raise concerns and report incidents
- The trust monitored duty of candour through their online incident reporting system. We were given examples of these from the clinical leads. The specialist palliative care team and ward staff had a variable understanding of the duty of candour. However, when prompted all staff gave satisfactory responses.
- Medicines were stored and managed safely for end of life patients.
- There was access to syringe pump equipment in all clinical departments, which were in line with national standards.
- Safeguarding vulnerable adults was given sufficient priority and staff were able to identify safeguarding concerns as they arose.

Incidents

End of life care

- There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- Incidents were reported through the trust's electronic reporting system. All clinical staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. Mortuary staff and porters stated they were encouraged to report incidents particularly for end of life care patients.
- There were no never events and no serious incidents reported by the palliative care team between June 2015 and May 2016. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, be implemented by all healthcare providers.
- There were 50 incidents relating to end of life care across the trust. All of these incidents were classed as low risk incidents, such as minor skin injury, trip, slip or a fall or missed medicines resulting in no harm to the patient.
- All incidents were reviewed by a senior staff member such as a team lead or ward manager. Staff told us they felt confident to problem solve incidents themselves without their managers wherever appropriate.
- Incidents reviewed during our inspection demonstrated that investigations had taken place and action plans were developed to reduce the risk of a similar incident re-occurring. A senior staff member discussed a shared learning incident regarding a pressure ulcer developing across a patient's bridge of nose in the intensive care unit from an oxygen mask, which had occurred at another of the trust hospital sites. All clinical staff were informed of the incident and corresponding action plan to prevent further incidents occurring in future.
- Staff told us they received feedback on the incidents they had reported. Minutes of monthly team meetings confirmed that the themes of incidents were fed back to staff. Learning from incidents and complaints was also shared across the trust via the route of trust's recently introduced monthly bulletin. An example of this was highlighting the prevention of patient falls information for staff awareness.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust monitored duty of candour through their online incident reporting system. Staff could describe the requirement to be open and transparent with patients following a patient safety incident. All four staff members we spoke with understood specific actions to meet the duty of candour requirements such as a letter detailing the incident and actions taken. All four staff knew how to escalate concerns if they thought duty of candour should be triggered and we saw examples of when incidents were investigated

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing harm to patients and 'harm-free' care. Harm includes new pressure ulcers, and falls. All the wards displayed their results to ensure all staff and visitors were aware of how the ward had performed. On two wards that we visited results displayed showed there had been no grade 3 or 4 pressure ulcers or serious falls in over 365 days.
- The trust reported 11 pressure ulcers grade 3 or 4 from 1st Dec 2015 to September 1st 2016.This number was lower than the 30 pressure ulcer incidents in 2014/15. Some pressure ulcers in end of life patients were deemed unavoidable, as reflected in the trust's own guidance. This guidance referenced the national 'skin changes at life's end' (SCALE) wound research document (2009) that explained why patients in the last days of life would often develop pressure ulcers even with the best possible care.

Cleanliness, infection control and hygiene

- During our two previous inspections conducted in 2014 and 2015 we highlighted there was a potential risk of cross infection in the bereavement office. Deceased patient's property was being kept in open bags in the office. During this inspection two deceased patients' belongings, were being stored in open cupboards in open plastic carrier bags while awaiting collection from

relatives. Staff told us that the specialist infection control nurse had visited the bereavement offices to advice on best practice and suitable storage had been ordered but had not arrived.

- The trolley for transferring deceased patients to the mortuary was stored inside the mortuary. We saw the trolley had a cover that was old and required washing and the legs and underneath side of the trolley had a build-up of dust and debris The mortuary staff we spoke with were unclear whose responsibility it was to clean it.
- The trust employed a team of infection control staff, which included a microbiologist who assessed and monitored levels of hygiene and infection control within the trust and reported on infection rates on a monthly basis within the hospital. From April 2015 to March 2016 there had been one patient case of Clostridium difficile. The patient had been nursed in a side room to prevent cross contamination to other patients.
- The hospital wards were visibly clean and well maintained. Staff followed the trust bare below the elbow policy and was seen washing their hands and using hand sanitiser appropriately. The hospital scored 96.97% for cleanliness in the 2016 patient-led assessments of the care environment. This was below the national average of 98.06%. The infection control nurse's action plan included reminding staff not to wear rings with stones as these cannot be cleaned properly.
- Every ward displayed their hand hygiene audit results. The results displayed during our inspection showed the wards had scored 97% in the audit. Personal protective equipment was available and staff were seen changing gloves and aprons in between patients to prevent the risk of cross infection. We observed equipment was clearly labelled with green 'I am clean stickers' to show equipment had been cleaned and was ready for use.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps on the wards.

Environment and equipment

- Syringe pump equipment met the requirements of the Medicines and Healthcare Regulatory Agency (MHRA). There was one type of syringe pump used in the hospital as per national guidance. This prevented the risk of potential confusion with medicine administration. Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medicine, because the syringe drivers used were tamperproof and had the recommended alarm features.
- The hospital had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure it continued to be safe for use. Equipment was clearly labelled with the date when the next service was due.
- The mortuary facilities were clean and well maintained and had fridge space for twenty six bodies. There was no fridge or bariatric equipment (equipment to support the care of obese people) at Wycombe hospital. All bariatric patient bodies would be transferred to the Stoke Mandeville Hospital.
- Ward staff told us they had good access to equipment needed for pressure area care. Pressure relieving mattresses were delivered from the hospital store and were available the same day when required.
- Patients who received end of life care in their own homes were given priority if equipment such as pressure relieving mattresses were required. This equipment was hired and delivered promptly by an external community equipment provider. Staff told us that they could access equipment promptly. For example, they were able to access same day/urgent delivery of equipment for patients returning home to receive end of life care.
- Emergency mobile resuscitation trollies were available on all the wards. Equipment was secured with tamper-evident tags. We saw staff had documented daily checks and tests which ensured equipment was safe for use.
- The trust scored 89.95% for patient-led assessments of the care environment(PLACE) for condition, appearance and maintenance for the hospital 2016. This was below the national average of 93.37%. We saw clinical governance minutes which evidenced maintenance improvement programmes for the hospital.

Medicines

End of life care

- All medicines were supplied by the hospital pharmacy. There were 13 whole time equivalent vacancies for the pharmacy service across the trust. This was having a significant impact on the service that pharmacy staff provided to the ward and for patients.
- Clinical staff told us end of life care patients sometimes experienced a delay in supply because the central stores were held in the trust's other hospital site.
- Medicines were stored safely and medicine records were accurately completed. The trust guidance on the administration and destroying of unused controlled drugs was followed.
- Emergency medicines were available for use and were checked regularly. We looked at three ward clinic room where medicines were stored and found that the medicines fridge temperature was being recorded daily. Any changes in temperature were responded to appropriately.
- We observed medicine rounds on two wards. Staff carried out appropriate checks to ensure medicines were given to the correct patients. Staff wore bright red disposable tabards to indicate they should not be disturbed when administering medicines.
- The trust had procedures in place to prescribe anticipatory medicines. These are medicines prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness). We reviewed nine medical and nursing case notes of patients identified as being in the last days of life and saw anticipatory medicines were prescribed appropriately.
- The trust had consolidated to one model of syringe pump device, used to administer continuous medicines. There was a policy and protocol for the use of the device in order to reduce the risk of medicines administration error. Staff told us there were sufficient devices for patient usage in the hospital. We saw lists of clinical staff names in the wards who had attended training and competency assessment to ensure that they were competent to use these devices. Clinical staff told us they were not allowed to use the device unless signed off as competent.
- The pharmacy department did not provide any compliance aids for assisting patients taking medicines for example timed daily medicine boxes. . If a patient required a timed daily medicine boxes box, the pharmacy department liaised with the GP and community pharmacy. However, staff told us that this sometimes delayed discharge.
- The consultant led a multidisciplinary meeting one morning a week across the hospital and hospice. We observed plans of care discussed for both patients and carers and medicine changes were completed at the same time, so patients received timely changes to medicines for symptom relief.

  The pharmacy department were linked to the Trust governance structure. Representation on drug and therapeutics committee and reducing harm from medicine incidents governance meeting.

Records

- Medical and nursing notes were stored unlocked near the nurse's station which was situated in the middle of the ward. However, clinical staff continually accessed the notes, the trolley lid was shut and the trolley was not in public view.
- We reviewed 14 nursing and medical sets of notes for patients who were receiving end of life care onthe wards and saw they were up to date, legible, dated, timed and signed.
- The palliative care team in the hospital wrote in the patients' record. Decision about care and treatment and discussions with relatives were clearly documented.
- There was a clear recording process in place for the movement of deceased patients through the mortuary from point of arrival until the funeral director collected the deceased's body.

Safeguarding

- Staff told us that the trust had a dedicated child safeguarding team and a level 3 trained adult safeguarding nurses who provided training, advice and support to all areas across the trust.
- The trust policy described the processes to safeguard vulnerable adults, children and young people.
- Nursing staff we spoke with had a clear understanding of how to identify, report and protect patients from potential harm or abuse.

End of life care

- Safeguarding training was mandatory. All l staff from the palliative care end of life, had undertaken safeguarding adults and safeguarding children at level 2 training.

Mandatory training

- The hospital delivered statutory and mandatory training via online training or classroom based sessions. Topics covered included infection prevention and control, fire safety, information governance, summoning emergency help, health and safety, manual handling, conflict resolution and equality and diversity.
- Each member of staff was assigned a role-specific mandatory and statutory training plan via the online e-learning system used by the trust. This sent reminder emails to staff and their manager when they needed to renew a training module. Statutory training is training which staff are legally required to complete, such as fire safety. Mandatory training is training which staff must complete but is specific to the role they are completing, such as basic life support or advanced life support
- The data provided by the trust showed that compliance with mandatory training did not consistently meet the trust target of 90%. For example, attendance at the yearly medicines management awareness was 68.18%. The yearly practical resuscitation training staff attendance was 44.44% and attendance at the yearly fire safety training was 65.00%.Attendance at deprivation of liberty safeguards, duty of candour, emergency planning and dementia awareness exceeded the trust target.
- The clinical governance meeting minutes highlighted the low attendance on mandatory training but did not detail a robust plan of action to improve attendance.The low mandatory training compliance in some areas meant that staff may have lacked essential knowledge and skills to deliver safe care and treatment.
- Senior managers told us they were aware of this concern and had actioned a plan of improvement in attendance. The action included supporting managers to ensure staff completed mandatory training modules. Staff were sent an email reminder when their training was due and ward managers were also sent information about their staff compliance with mandatory training.

Assessing and responding to patient risk

- The trust use treatment escalation plans for inpatients. Senior staff told us they were aiming to build consultant confidence in using the 'surprise' question. For example, "Would you be surprised if this patient died within the next 12 months?" when reviewing patients with end stage long term conditions in clinics as a way of bringing forward end of life care conversations.
- The National Early Warning Score (NEWS) had been established for use with all patients to identify those who were clinically deteriorating and required increased intervention. Nursing staff used an early warning system, based on the National Early Warning Score, to record routine observations. The treatment escalation plan outlined the level of intervention required, treatment options, and best interest decisions discussed with the patient and family by the multidisciplinary team in the patients notes.
- There were daily morning handover meetings within the specialist palliative care team where they discussed all new patients and any escalation in risk for existing patients, such as potential breathing difficulties. Staff prioritised according to patient need and patient visits were planned at these morning meetings to ensure that increased risks were addressed.
- Staff measured physiological observations were measured for patients who were at the end of life to allow a focus on comfort.
- The specialist palliative care team was available 24/7 to give advice and support to ward staff if they were concerned about a patient condition. Staff on the wards was clear that the specialist palliative care team responded quickly to requests for advice and support and we were told that the team visit the same day of request.

Nursing staffing

- The specialist palliative care nurses included three full time and three part time palliative care clinical nurse specialists working across both hospital sites. The hospital had access to a palliative care nurse specialist 24 hours daily. The wards felt that they provided a good support service.
- The team had appointed an end of life care facilitator in August 2015. Staff told us they had already made a

substantial impact on the ward in terms of advice on caring for end of life patients and helping with discharging patients who expressed a wish to die at home.

- Staffing was planned using a recognised Department of Health patient acuity and dependency tool which had clear guidance on levels of care and inclusion criteria for clinical staff to follow. The tool had been in place for 8 months and was linked to cost and quality indicators.
- Senior managers told us they could see areas of risk and mobilise additional staff appropriately to reduce risk areas. Clinical staff told us the tool alerted senior staff to higher risk areas which they responded to by moving nurses from ward to ward as needed.
- Nurse and health care assistant staffing levels were displayed on the hospital wards. These were displayed in three categories; planned, actual and safe. During the course of our inspection, actual and safe staffing met the planned levels of staffing to deliver safe care with the exception of one morning shift which was one healthcare assistant below planned.
- Staffing was sufficient to allow for staff to handover thoroughly between shifts. We observed a multidisciplinary team handover of patient care. Each member of staff used a typed handover sheet which was updated daily during handover. Time was taken to discuss each patient and their families thoroughly.

Medical staffing

- The trust employed 1.8 full time equivalent trust wide specialist palliative care consultants. One full time and two part time associate specialist and general practitioners with a specialist interest in palliative care covered evening and weekend cover with direct access to an on call associate specialist or consultant. The Trust has a total of 572 beds including inpatient beds across hospital sites, community hospitals, intensive care units, and children's services. The trust did not meet nationally recognised commissioning guidance of one whole time consultant for every 250 hospital beds. Service leads told us that a business case for an additional full time consultant was being considered by the trust at the time of our inspection
- The consultants for specialist palliative care divided their working week between the two hospital sites and hospice. The consultant's covered 24/7 medical support to the hospital team and for health care professionals across all settings. This enabled a link between the two services and provided "joined up care" between the hospice and hospital. End of life care patients with complex symptoms were generally offered to be transferred from the hospital with the patient and families permission to the hospice.

Major incident awareness and training

- The trust had an 'emergency preparedness, resilience and response' business continuity plan. The porter discussed attending a "mock" emergency scenario training exercise of a wing of the hospital building on fire. Mortuary staff and the specialist palliative care team were aware of the plan and actions to take in event of a major incident.
- There were 24 spaces in the mortuary; a contingency plan was in place with a local hospital in the event that the mortuary became full.
- The chaplaincy service told us that they were on call for any major incidents.

Are end of life care services effective?

Requires improvement

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

We rated effective as "requires improvement' because:

- Care did not consistently take account of evidence based practice and guidance. End of life care plans were not routinely completed for patients nearing the end of their life.
- Staff had an awareness of the responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLs). However, we saw that patient's capacity was not always formally assessed when decisions were being made on behalf of patients who were deemed to lack capacity.

End of life care

- The trusts new getting it right for me end of life care plan contained information about the assessment of pain and gave examples of the scoring system which could be used. We saw pain scores were not consistently used on the wards.
- End of life care was not included in the hospital's core training package for all staff which was not in line with national guidance. The trust did not provide standardised or formal training in end of life care or infection prevention and control for porter or mortuary staff.
- The trust did not have a protocol for withdrawal of treatment, which was not in line with national guidance.
- Staff did not use a standardised pain assessment tool to ensure staff delivered a consistent approach to pain measurement or management.
- Some DNACPR forms we inspected were not completed according to national guidelines. The trust audits had identified this as an area for further improvement, to ensure that forms showed discussions with patients and families and that mental capacity Act decisions were documented.

However,

- Patients identified as having end of life care needs were assessed, reviewed and their symptoms managed effectively. We saw positive multidisciplinary working relationships between specialist palliative team members and ward teams.
- Medicines were prescribed for end of life patients in anticipation of symptoms to ensure patient comfort. Patient's nutrition and hydration needs were effectively managed.
- Specialist palliative and end of life care staff were skilled and competent to perform their roles effectively.

Evidence-based care and treatment

- Advance care planning is a process of discussing and/or formally documenting wishes for future care. It enables health and care professionals to understand how patients want to be cared for if they become too ill to make decisions or speak for them. We found good quality information and guidance available for staff in the advance care plan; 'getting it right for me, patient held record', designed by the palliative care team with patient and family involvement and completed in January 2016.
- This document had been in use since January 2016. However, we saw that not all clinical staff used the document so staff and families would not be aware of patient's care preference for before and after death. We saw eight patient care records of patients recognised to be in the last days of life. The patient's preferred place of care/death had been recorded in five records, however, two records were using the personalised care plan and the other three were found in the patients care notes.
- We found that care did not consistently take account of legislation, evidence based guidelines and best practice. Following the national withdrawal of the Liverpool Care Pathway in July 2013 the trust had implemented a two stage care pathway for palliative and end of life patients. Stage one was an assessment and treatment care pathway of individual care needs and stage two was implemented when the patient was in their last days of life. We reviewed 14 care records for patients considered to be in the last year or days of life. Five care records contained partly completed care plans. Nine care records did not contain care plans at all to support staff to deliver end of life care. Senior nurses acknowledged that the care plans were not being consistently used.
- The trust had employed a full time practice educator to implement the document across the trust and improve documentation of palliative care patients and family's needs. The practice educator told us they conducted regular training events and visited ward staff to highlight the need to ensure the care plans were completed effectively.
- Senior managers acknowledged that end of life conversations needed to happen sooner and there was a challenge to support staff to identify end of life care started in the last year of life. The action plan to improve documentation included additional staff training. We saw that 300 clinical staff had received foundation end of life care training as of October 2015.
- The consultant led a multidisciplinary meeting one morning a week across the hospital and hospice. We

observed plans of care discussed for both patients and carers and medicine changes were completed at the same time, so patients received timely changes to medicine for symptom relief.

- The trust did not have a protocol for withdrawing treatment as recommended in the 2015 National Institute of Clinical Excellence guidelines. However, two members of the clinical staff and one senior manager said that they were prioritising this guidance for completion in 2017. We did not see in the clinical governance meeting minutes any discussion or dates set for the implementation of the protocol for staff.
- The DNACPR forms were kept at the front of a patient's notes, which allowed easy access in an emergency.
- We reviewed 8 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) or 'allow a natural death' forms. 5 of the DNACPR forms had been fully completed and discussions held were recorded in the nursing and medical notes. For the other three forms, the medical notes did not show, if a discussion had taken place with the patient or relatives or the patients' mental capacity assessed.
- The trust carried out an audit for Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in February 2016. The results of the audit reflected what we found on inspection, 24% of discussions with patients were not documented and only 12% of decisions had not been signed by a consultant within 48hrs. The results of the audit were discussed in clinical governance meetings. We saw an action plan for clinicians to improve and a repeat audit was planned for later in the year.

Pain relief

- Patients had appropriate access for pain and symptom relief. Anticipatory end of life care medicines were correctly prescribed for symptom and pain relief and patients were provided with pain management support.
- We reviewed eight patient notes in the hospital and saw that a recognised pain assessment tool was rarely used to assess patient's level of pain. All eight patients' records contained a detailed narrative of patients' pain and the outcome of pain relief.
- However, we did not see any evidence of which pain scoring system was used so there was no baseline for clinical staff to judge whether pain relief was effective for the patient. We saw staff had checked patient's pain levels every two hours and pain relief given. The trust's getting it right for me end of life care plan contained information about the assessment of pain and an example of the scoring system which could be used. However, we saw that the end of life care plan was not used for six patients considered at the end of their life.
- Patients we spoke with on the wards told us that the nurses both day and night ensured pain relief was given promptly. One patient said "even though the staff are busy they always get my pain meds when I ask"

Nutrition and hydration

- Patients were assessed using the Malnutrition Universal Screening Tool (MUST) which identified nutritional risks.
- We reviewed 14 nursing and medical sets of notes for patients who were receiving end of life care in the wards and saw that all of the patients had received an assessment of their nutrition and hydration requirements. Staff told us that there was good access to a specialist assessment from a speech and language therapist (for swallowing difficulties) and a dietitian both employed by the trust.
- Two patients we spoke with in the hospital told us the food was "good" one patient on the ward said "there is plenty of food and good choice"

Patient outcomes

- The service provided data to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, to provide an accurate picture of specialist palliative care service activity. This data highlighted the length of stay for some patients were longer than it needed to be.
- The trust had begun monitoring the preferred place of care figures in April/May 2015, which demonstrated staff needed to improve documented evidence of patient's wishes. Not all patients who wished to die at home could be discharged home from the trust in a timely due to a lack of care packages. The trust reported a 44.2% of delayed transfers of care due to awaiting residential home placement or availability. We saw two patients on

the wards waiting for care at home Senior staff told us action plans to improve this included regular meetings with colleagues from adult social care to discuss improvement and recruitment sharing strategies.

- Senior staff told us there had been a reduction in the length of stay in hospital for some palliative care patients. Patients had timely access to the specialist palliative care team (SPCT). The trust audited inpatient referral to contact waiting times for the palliative care team for 2016. The audit showed that no patient referred to SPCT as an emergency waited longer than seven hours to be seen. Similarly, patients urgently referred to SPCT were seen within 24 hours.Patient records we reviewed further evidenced data provided by the trust.
- The provision of emergency equipment had improved and mattresses to prevent pressure ulcers could generally be provided the same day.
- For the quarter 01/07/16 to 30/09/16 inclusive, 116 specialist palliative care patients expressed a preferred place of death of which 95 achieved their preference.
- There were trust wide targets such as zero percent of patients being moved to other wards for the 24 hours before their death. Staff said that this target was met in all the wards. The trust had set a target of 85% of end of life patients to be discharged to the preferred place of care within 48 hours of their request. Plans to audit this target in autumn 2016 were documented in the end of life care meeting minutes.
- The trust participated in the National End of Life Care Audit – Dying in Hospital, 2016, the trust was better than the England average for four out of the five indicators. The trust achieved 91% against KPI 3 which measured whether there was documented evidence that patients' concerns were listened to. This was higher than the national average score for other NHS trusts of 84 %.The trust scored 81% compared to the England average of 83% for KP1, evidence of last episode of care being recognised that the patient would die in the coming hours/days.
- The 2015 Royal College of Physicians National falls audit showed that this trust has lower numbers of inpatient falls resulting in serious harm or death. From 1 January to 31 December 2014 all participating trusts and health boards in England and Wales falls data was 2.76 per 1,000The trust fall data was 0.06. Staff we spoke with on the ward gave examples of preventing patient falls in end of life care.

Competent staff

- A practice educator had been employed full time to ensure staff was supported to deliver high quality care for patients. They worked with staff across the trust, community staff, GPs and GP trainees to ensure they were suitably trained to care for people at the end of their life.
- All staff we spoke with told us they had good access to further training and development and felt they had the right skills to deliver care to patients. End of life and palliative care training was delivered at both medical and nursing induction days, including input from the chaplaincy services. The inspection team noted the education, learning and development newsletter summer 2016 highlighted two full day training sessions in end of life care clinical skills for health care assistants. Six days palliative care update training sessions for qualified staff in both the community and hospital had been allocated.
- Staff were given opportunities to attend conferences and other courses and one staff member discussed attending the Royal college of physicians palliative care spotlight training day.
- The trust also delivered university accredited modules in cancer care level 6 and 7 and end of life care level 6 and 7. We saw that 300 clinical staff had received foundation end of life care training as of October 2015. Records showed 41 staff had completed the Level 7 EOLC Degree Module as of August 2016. We also noted that there were eight end of life care skills in-house training days available for staff from July 2016 to October 2016. The draft end of life care strategy also prioritised that all clinical staff to be trained in foundational skills in end of life care by the end of 2017
- Porters told us that they received training around sensitively handling the deceased, moving and handling and infection control practices. This training was delivered in-house by the senior porter. The senior mortuary staff member delivered in-house training to mortuary staff which included an orientation to the mortuary, health and safety training, manual handling

and training on the administration duties required when registering a body in the mortuary. The porter and mortuary staff told us that they had not received formal trust level end of life care training or infection control training from the infection control nurse.

- Staff told us they had regular annual appraisals. The trust target was 90% .As of August 2016, 100% of end of life care staff within the trust had completed an appraisal.
- The chaplain held listening skills and resilience training at the healthy living hub once a month attended by trust staff.
- The specialist palliative care team all received one to one clinical supervision each month with the palliative care consultant and told us they found these supervision sessions beneficial.
- The clinical leads informed us that there were champions for end of life care on all wards. The champions met formally every two months. We spoke with two end of life champions on the intensive care unit and they were extremely passionate about end of life provision. They had developed their own local initiatives to review patients to ensure that they are on the end of life care pathway and to teach other members of the clinical team.
- The hospital did not classify end of life care training as a mandatory subject as recommended by of the National Care of the Dying Audit 2013/14.

Multidisciplinary working

- Front-line staff worked well together, and there was obvious respect between, a range of specialities and disciplines.
- A multidisciplinary (MDT) team meeting was held daily for patients at the hospital. This included doctors, nurses, palliative care team, physiotherapists and occupational therapists. We saw evidence of members of MDT input into patients care documented in patient records. However, pharmacy staff told us they could not always attend the meeting.
- Trust data informed us there were a 6.39 whole time equivalent (WTE) clinical pharmacist vacancy and a 3.31 WTE pharmacy technician and 3.33 WTE support worker vacancy. Shortage in pharmacy staff numbers meant that the pharmacist could not routinely attend the multidisciplinary team meetings at ward level. Therefore, pharmaceutical advice regarding treatment options and possible side effects for the end of life care patients was not routinely discussed.
- We attended the weekly hospital palliative care multidisciplinary meeting. There was good representation of clinical staff in attendance at the MDT, including chaplaincy and psychology. The palliative care consultant led multidisciplinary and holistic discussions about the patients and their families, which determined the plan of care. Patients who were discharged or had died were also discussed, including ongoing support to their families. All staff in attendance were valued for their contribution.
- Medical consultants we spoke with said the palliative care team were good at networking throughout the hospital. They described them as always supportive and accessible for advice and requests for assessment on patient care and treatment.
- The chaplaincy services were represented on the trust end of life care committee and were a core member of the palliative care multi-disciplinary team.

Seven-day services

- The National Care of EOLC the Dying Audit report for Hospitals (NCDAH) 2013/14recommended hospitals should provide face-to-face specialist palliative care service from at least 9am to 5pm, 7 days per week, to support the care of dying patients and their families, carers or advocates. We saw that specialist palliative care services were available 24/7.
- The trust ran a pharmacist on-call rota so clinical pharmacy advice could be accessed day or night.
- The physiotherapy team told us they worked 7 days per week at the hospital.
- Mortuary services were available 8.30am to 9.30pm seven days a week with on-call cover out of hours. Out of hours involved the mortuary staff or the bereavement officer assisting the families with the viewing process.
- Chaplaincy services were available within normal working hours and on Sunday mornings. These hours were divided between two chaplains who also provided an on-call chaplaincy service for anyone who wished to

access them. The chaplain told us that the service was stretched due to a lack of staff in the bereavement office buta replacement chaplain position had recently been agreed by the trust.

Access to information

- Clinical staff such as the palliative care team could access patient records electronically from whatever care setting they worked within at the trust. This meant if a patient within the hospital required inpatient care at the hospice a referral could be made quickly and simply.
- All staff in the hospital had access to hospital policies and guidance specific to palliative and end of life care via the trust intranet. Staff found this resource valuable and easy to access.
- We saw that when a palliative care patient was discharged home from the hospital the GP, district nurse and care agency were informed via an electronic message.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust carried out an audit of consent forms in 2015 and found completed consent form for 98% of clinical procedures. 100% of consent forms audited were signed by a clinician. However in 11% of cases this information was either illegible or difficult to read. We saw an action plan for clinicians to improve and a repeat audit was planned end of November 2016.
- We reviewed 14 sets of nursing and medical records and we saw that consent to care and treatment was obtained in line with relevant legislation and guidance. Where applicable relatives were included in the discussions and these discussions were recorded. We observed staff in the wards, explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment.
- Staff had an awareness about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLs). Staff told us they would ask the consultant to complete mental capacity act assessments. Staff discussed being issued with NHS mental capacity act prompt cards. Staff had received Mental Capacity Act training and various resources were available on the trust intranet, if staff needed more support. However, out of 14 sets of nursing and medical records we found no evidence for seven patients that formal capacity assessments had been carried out despite documentation by clinical staff that stated the "patient lacked capacity" or that the patient was "confused"

Are end of life care services caring?

Good

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

We rated caring as 'good' because:

- Compassionate and person centred end of life care was provided to patients on the wards by medical and nursing staff and the specialist palliative care team. Medical and nursing staff showed sensitivity when communicating with patients and relatives
- The specialist palliative care team spoke with care and compassion at their handover meetings and considered the dignity of end of life patients. They were sensitive to people's needs in a holistic way.
- Feedback from patients and their relatives was consistently positive about the care they had received.
- All staff we spoke with valued and respected the needs of both, the patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered.
- The bereavement and mortuary staff were caring, understanding and responded sympathetically to patients and relative's needs.
- Friends and Family Test data showed 96% of respondents in June 2016 would be extremely likely or likely to recommend the service they were seen by to friends or family. Feedback comments were positive and highlighted the clinical excellence of staff.

Compassionate care

End of life care

- All of the staff on the wards spoke passionately about providing high quality compassionate individualised care. Staff developed trusting relationships with patients and their relatives. Staff encouraged family members to visit, including children and family pets.
- Throughout our inspection we heard conversations between all members of staff that recognised the individual needs of patients and their families. Staff ensured confidentiality was maintained when attending to individual care needs by closing doors to side rooms or asking patients to move from ward area's to private rooms to talk
- We spoke with five patients on the wards. All of whom were overwhelmingly positive about their care. We observed patients had a high level of trust in the specialist palliative care nurses and were appreciative of the support and care provided One patient on the ward said "the staff are just lovely, they cannot do enough for you"
- The trust participated in the National Care of the Dying Audit in March 2016. The results identified the trust was in line with the national average in relation to the provision of care that promoted patient privacy, dignity and respect, up to and including after the death of the patient.
- We saw Friends and Family Test data for 1March 2016 to 1 June 2016 demonstrated overall patients would be extremely likely or likely to recommend the service to friends or family.

Understanding and involvement of patients and those close to them

- We reviewed 14 sets of nursing and medical records the hospital. All of the notes contained detailed documentation about caring discussions held with patients and those close to them.
- We observed nursing and medical staff having compassionate and inclusive conversations with relatives. Staff immediately responded to requests for discussions with relatives. We observed all members of staff knew patients relatives by name and greeted them warmly when they arrived in the ward. Relatives told us that staff communicated to them in sensitive and unhurried way.
- Patients and their relatives told us that they received a high standard of care and were involved in decisions as much as they wanted to be. None of the patients or relatives we spoke with had any concerns with regard to the way they had been spoken with, and all were complimentary about the way they were treated.
- The trust participated in the National Care of the Dying Audit in March 2016. The results identified the trust as in line with the national average in relation to health professional's discussions with both the patient and their loved ones regarding their recognition that the patient was dying. The survey also identified the trust as in line with the national average for communication regarding the patient's plan of care for the dying phase.
- Patients and family members told us staff discussed with them any issues they had identified as potential risks to their well-being or risks associated with their treatment. An example of this was a staff member discussed different food options family members could bring in as a treat that would prevent possible choking.
- The needs of family members caring for a dying person were always considered.This included assessment of carer stress and support for arranging respite care. Feedback from relatives highlighted how important this aspect of end of life care was to them.One relative in the hospital confirmed they had open access visiting and were pleased their relative had been moved into the side room. They said they had been at the hospital for three days and staff had been supportive and regular refreshments were offered during their visits.
- The bereavement officer or the chaplain met with relatives after a death and talked through aspects of next steps and provided information to relatives with a help for the bereaved booklet.

Emotional support

- Patients had access to counselling and psychotherapy services if required.
- The bereavement officer and chaplain saw offering emotional support to relatives as an integral part of their role. We were given examples where staff had met with bereaved relatives and assisted with the funeral arrangements.
- The chaplaincy service provided support for carers, family, friends and trust staff. Nursing staff on the wards

reported good access to the chaplaincy team.They knew the members of the chaplaincy team by name and said that the chaplains would frequently visit. During our inspection we observed the chaplain offering emotional and comforting support to a patient's relatives. However, at the time of our inspection the chaplain was working in the bereavement team to cover staff absence as well as visiting the wards to see patients. There was a business case for sessional chaplains

- We attended a weekly hospital palliative care multidisciplinary meeting. The emotional impact on family and staff caring for a dying patient was considered for all patients.
- All the specialist palliative care nurses were trained to Level 2 in psychological support for patients and carers.
- Trained volunteer bereavement listeners offer support to families and carers following the death of a loved one. Listeners provide time when it is mutually convenient with the bereaved client.

Are end of life care services responsive?

Good

By responsive, we mean that services were organised so that they met people's needs.

We rated responsive as "good " because:

- People's needs were met through the way end of life care was organised and delivered.
- The hospital delivered specialist palliative assessments and care in a timely way.
- Patients were reviewed by the specialist palliative care team within 48 hours of a consultant referral.
- There was open access for relatives visiting patients who were dying.
- There were adequate facilities to meet individual's spiritual and culturalneeds
- The trust operated a rapid discharge home to die pathway which served to discharge a dying patient who expressed wanting to die at home within 24 hours.
- Complaints were investigated thoroughly and we saw where positive changes were made following complaints.

However,

- There were insufficient facilities for relatives to stay overnight with patients at the end of their life at the hospital.
- Patients who expressed a wish to die at home did not always get to do so.

Service planning and delivery to meet the needs of local people

- Relatives told us they could visit the hospital wards at any time when their loved ones were approaching the end of life. Staff told us as much as possible they placed patients at end of life in a side room. We saw end of life patients on wards being cared for in side rooms. Relatives were supported with refreshments during the vigil.
- There was a chapel of rest mortuary viewing area, which was well maintained and dignified. The public entrance to the mortuary viewing area was through the bereavement room.
- The trust had conducted a balanced appraisal of the needs of the population with regards to cancer/non cancer end of life care and this had shaped the trust strategy for improving access for diverse communities such as travellers to end of life and palliative care services.
- Patients who required end of life care were nursed on general medical and surgical wards or were offered a hospice bed if appropriate and available. Nursing staff we spoke with on the wards told us they would give priority to the care of those patients in the last days of life and would try to offer a side room to allow privacy and dignity for the patient and family.
- The needs of family members caring for a dying person were always considered.This included assessment of carer stress and support for arranging respite care. Feedback from relatives highlighted how important this aspect of end of life care was to them.One relative in the hospital confirmed they had open access visiting and were pleased their relative had been moved into the side room. They said they had been at the hospital for

three days and staff had been supportive and regular refreshments were offered during their visits. The relative said there was a large chair to use, however, no bed was available for them to rest during the night.

- Staff told us that they were flexible with visiting hours if needed to meet the specific needs of individual patients.The hospital offered open visiting hours for relatives/loved ones visiting patients who were nearing the end of their life.

Meeting people's individual needs

- The chaplaincy told us that when patients or relatives had requested faith leaders from other religious denominations, this would be arranged by the chaplaincy service.
- Patients' spiritual needs were not documented in a unified place within the care record.This meant that staff would not know how to quickly find the documented spiritual needs or corresponding plan of care presenting a risk that the individual's needs in that area were not met.
- Patients who did not speak English as their first language had access to translation services if required. Staff told us that sometimes these services where not appropriate when sensitive conversations were required. In order to meet this need, religious leaders were contacted for further advice and to support translation services.
- We saw information leaflets regarding the spiritual and pastoral care team and help for the bereaved leaflets on one ward. We also saw information leaflets on all departments regarding management of clinical conditions such as management of loss of appetite and preventing falls. Staff told us information leaflets about advance care planning, what happens when someone dies, and how to register a death had been devised by the trust with consultation from the people panel but had not yet been printed.Senior staff told us there was a plan to produce information leaflets in other languages but they weren't available at the time of our inspection.
- The needs and preferences of patients and their relatives were central to the planning and delivery of care at this hospital. We observed care was adapted to meet the needs of individuals. Staff sensitively discussed what care they would like and responded to any change in care requirements promptly. An example of this was a family of a patient at end of life told us they were offered a side room as this would be quieter for them.
- The recently refurbished multi-faith chapel, for patients, relatives and staff provided privacy and dignity for participants using this room as frosted glass obscured vision. There was a Muslim prayer room with culturally appropriate washing facilities available.
- The bereavement officer and mortuary staff demonstrated sensitivity and caring behaviour, family when returning precious possessions to the family. The chaplain or the bereavement officer attended the funerals of patients who did not have a next of kin. Chaplaincy services told us they had arranged weddings and blessings for patients who were receiving end of life care.
- The bereavement services, worked alongside mortuary services, chaplaincy, the coroner's office and the registrars to ensure arrangements were in place after death. They provided information to relatives and booklets around services available at the hospital, and for coordinating arrangements to view the deceased's body.
- The bereavement officer or chaplain would meet with bereaved families to arrange collection of the patient's death certificate in addition to arranging a viewing at the mortuary if required. Where post mortem arrangements were in place this would be explained to the family.
- Mandatory training for all staff included equality and diversity training. By June 206, 86% of staff had completed this training and staff we spoke with were able to demonstrate an understanding of equality and diversity.
- The hospital was accessible to patients using mobility aids by use of ramps and /or lifts. Disabled access parking was available.
- Hospital wards were decorated in a way that was suitable for patients living with dementia with large clocks and good signage for example signs to the toilets can be seen from all patient areas.Toilet facilities were fully accessible for patients with physical disabilities.

Access and flow

End of life care

- Staff in the bereavement office told us relatives did not consistently receive timely access to death certificates.They told us if a patient died at the weekend, the doctor who certified the death would not be on duty until Tuesday. During our inspection we observed staff attempting to contact doctors to arrange for the certificate to be signed. They told us it was often frustrating but some doctors did not recognise the importance of ensuring the certificates were signed promptly and the impact the extended wait may have on bereaved families.
- Bed occupancy for the trust is higher than the England average and is frequently close to 100% capacity. The trust has responded to this by employing three discharge planning nurses and one was based at the hospice, who may support with discharge planning from Wycombe hospital. Their role was to co-ordinate discharge home if requested by a patient. They worked closely with the occupational therapists, physiotherapists and community nurses to ensure all appropriate equipment and medicines were in place prior to a patient's discharge.They reported they were able to access all specialist equipment promptly.
- Senior staff told us there had been a reduction in the length of stay in hospital for some palliative care patients. Patients had timely access to the specialist palliative care team (SPCT). The trust audited inpatient referral to contact waiting times for the palliative care team for 2016. The audit showed that no patient referred to SPCT as an emergency waited longer than seven hours to be seen.Similarly, patients urgently referred to SPCT were seen within 24 hours.Patient records we reviewed further evidenced data provided by the trust.
- The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was published in 2007, and revised in 2012. This framework sets out that patients with a rapidly deteriorating condition should be 'fast tracked' to receive NHS funded care in a place of their choice at the end of their life. From January 2015, the trust began collecting data on the number of end of life patients who were discharged with fast track in place, as well as the numbers of patients who expressed a wish to die out of hospital for which this was not achieved. For the quarter 01/07/16 to 30/09/16 inclusive, 116 specialist palliative care patientsexpressed a preferred place of care of which 95% achieved their preference. Senior staff discussed they were working in partnership with adult care services to enable more patients to die in the place they requested.

Learning from complaints and concerns

- Staff in the hospital followed the trusts complaints policy. Staff in the hospital told us they try and resolve any concerns from patients or relatives in a timely way to quickly improve the outcome for the patient and avoid escalation to a formal complaint.
- From the 12 April to 12 September 2016 there were seven complaints relating to end of life care across the five divisions of the trust. All complaints were risk assessed using the national patient safety agency risk matrix. Six complaints were categorised as low risk and related to administrative matters and perceived attitude and treatment by staff. One of these low risk complaints was regarding communication in hospice care and the family was satisfied with the outcome and has accepted the apology. One complaint was rated as an amber risk and related to a complaint about temperatures in ward areas. Five of the seven complaints related to complaints made during July, August and September 2016 and are all still under active investigation. One complaint was not upheld and a full response was written explaining the trust's decision.
- 'You said, we did' boards were displayed to show how the trust had responded to complaints and feedback from patients and visitors. For example we saw one complaint from a relative about the cost of parking and staff not able to assist with change for the meter. In response this complaint had been raised with the trust board and staff had been reminded to inform families about the reduced parking scheme for visitors of end of life care patients. Staff had also introduced a float of one pound coins to ensure change was available for visitors to enable them to park.
- We saw Patient Advice and Liaison Service (PALS) leaflets available around the hospital.

End of life care

Are end of life care services well-led?

Good

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

We rated well led as "good " because:

- Leadership for palliative care was strong. Staff across the trust wanted to provide good care to patients and support relatives whose loved ones were at the end of life. Quality and patient experience were seen as a priority and everyone's responsibility.
- The end of life core services had a robust governance structure that went from team level to the trust board. The quality, risks and performance issues within end of life care were monitored through the executive governance framework
- Although the trust did not have a published end of life care strategy, the service leads had identified priorities around improving the end of life care services across the trust. Staff we spoke with was aware of these priorities and described high quality patient care as key components of the trust's vision.
- There was a designated executive lead for end of life care and an end of life care steering group.
- The trust values were well embedded in practice and staff had begun calling people to account if their behaviour was not representative of the values.
- The trust had set up a patient panel to ask for opinions and suggestions in what mattered to them regarding developing plans for end of life care.
- Senior leaderships had demonstrated their commitment to improving end of life care through the appointments of a dedicated senior end of life care nurse and an end of life care facilitator.

However,

- Risks related to end of life were escalatedand discussed at the clinical governance committee. However, there was no separate risk register for end of life care.
- The trust had not audited the views of the bereaved as recommended by the National care of the Dying audit hospitals) NCDAH) 2014/15.

Leadership of service

- Leadership within end of life care was strong with three senior leaders for end of life care. These include the lead nurse, lead consultant and chief nurse. Each lead had clearly defined responsibilities for all staff responsible for delivering care. The trust lead for end of life care was enthusiastic and proactive in driving forward the end of life agenda for the trust and reported good support from the medical director and the trust board members.
- The specialist palliative care team nurses on the wards contributed to the overall leadership of palliative and end of life care. All staff in the wards demonstrated a good awareness of developments within the service.
- The senior staff for end of life care attended the end of life steering group who then reported to the board. Clinical staff reported that this had improved clarity of who takes overall ownership of end of life care across the hospital.
- Clinical staff described the leadership of the service as "much better than before" and "they support and listen to me"
- The trust supported staff to develop their leadership and management skills. For example, staff at band 7 level and above were encouraged to enrol on the trust management course.
- Staff told us their concerns were taken seriously. For example, concerns raised by clinical staff, we saw staff attend a meeting to finalise actions before the launch of action cards for therapeutic one to one care of patients, detailing what is expected of the staff member, which included no use of mobile phones to ensure all concentration is on the patient requiring specialised care.

End of life care

- All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care. The culture was caring and supportive. Staff were actively engaged and there was culture of innovation and learning.

Vision and strategy for this service

- Senior management and clinical staff told us the trust's mission was to provide safe and compassionate care, every time with a focus on providing right care, right place, right time, and first time.
- The executive lead for end of life care was the chief nurse who passionately discussed the trusts commitment to ensuring quality end of life care. We saw minutes of end of life care steering group and forward planning meetings with action plans, named leads and timelines for completion.
- The trusts had worked collaboratively with stakeholders to produce a new end of life care strategy. Senior staff told us consultation on the new strategy would take place in September 2016 and be presented to the board in October 2016. The aims of the strategy were to ensure end of life care was everybody's business, to become more proactive in the identification of end of life patients and to improve communication to support end of life care.
- Staff were engaged with the goal of delivering end of life care. Staff were aware of the trusts developments in end of life care and had a good understanding of how to drive the service forward.
- The trust's strapline "we care" with the acronym as a team we collaborate, to be the best, aspire, respect everyone's value and individuality and enable people to take responsibility was visible on all paperwork. Ward managers displayed trust values on staff notice boards. Staff told us they were passionate about providing safe and compassionate care to patients. Senior staff told us that the values were well embedded in everyday practice and gave the example to encourage staff to take responsibility for safe medicines management..
- Senior leaders were committed to improving end of life care and delivering against the strategy once it had been signed off by the trust board. The trust had worked in partnership with Macmillan to employ a senior nurse for two years. The trust had also employed a dedicated end of life care facilitator.

Governance, risk management and quality measurement

- The end of life care services had a robust governance structure that went from team level to the trust board. The quality, risks and performance issues within end of life care were monitored through the executive governance framework
- The end of life steering group members had a quarterly meetings with the trust's quality assurance group where the outcomes of the quality dashboard and any issues related to end of life care were discussed. This was shared more locally at team meetings. Minutes of clinical governance meetings showed that patient experience data was reviewed and monitored.
- There were audit systems to monitor the quality of the service.. The National end of life care audit for March 2016 was completed by the trust and action plans to improve was highlighted in the trust end of life care strategy. The audit of end of life care plans was completed and presented to the board August 2016. Action plans to improve the service included auditing bereaved relatives experience of care and providing bereavement information.The National care of the Dying audit hospitals) NCDAH) 2014/15 recommended all hospitals should undertake local audit of care of the dying, including the assessment and views of bereaved relatives at least annually. However, the trust was aware that they had not audited the views of bereaved relatives
- The trust had a divisional risk register in place, with departmental risk registers completed to link into these. The top divisional risk, recruitment and retention of clinical staff, aligned with concerns raised by staff during the inspection. A lead was responsible for each risk and we saw they were effectively monitoring their risks on the register. Clinical leads informed us that any issues or risks related to end of life were escalated to the clinical governance committee and we saw minutes of end of life care meetings which highlighted risks were discussed and managed. There was no separate risk register for end of life care.

End of life care

- The palliative care team had regular team meetings at which performance issues, incidents, concerns and complaints were discussed. Where staff was unable to attend team meetings, steps were taken to communicate key messages to them using a communication folder, which staff signed to show they had read the contents.
- The palliative care team used a quality dashboard. It showed how the service performed against a range of quality and performance targets. Staff told us that these were discussed at team meetings.
- The trust held monthly mortality review meetings about the care of patients that had died in hospital. Senior nursing staff together with the palliative care consultant reviewed the care and treatment of all patients that died in the hospital. Analysis of patients who died in hospitals was presented to end of life care steering group to identify learning for improvement.
- The trust had a quality committee and a quality and patient safety group which met alternate months, with sub-groups meeting monthly reporting into it, such as the blood transfusion and medical devices committee, dementia, sepsis and falls groups**.**

Culture within the service

- Staff across the trust wanted to provide good care to patients and support relatives whose loved ones were at the end of life. Staff spoke positively and passionately about the care and the service they provided. They worked well individually and collectively across the trust to make the patient experience of care the best they could.
- Front-line staff worked well together, and there was obvious respect between, not only the specialities, but across disciplines. We were told by an occupational therapist how they felt welcomed in the team where they had started their new post three months ago. The occupational therapist said they felt very much part of the team and well supported by the team leader.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The handover meetings and supervision sessions were seen as a time for checking on team wellbeing. There were measures in place to ensure that staff affected by the experiences of caring for patients at end of life was supported.This included de-brief sessions and access to counselling

Public engagement

- The trust had formed a patient /public reference panel to develop the end of life care strategy, patient information leaflets and the end of life care plan. This arose from an invitation made to participant who attended our End of Life “Listening event” to which 60 people attended.Senior staff spoke passionately about the involvement of patients and families in the development of the future service.
- The trust did not audit views of bereaved relatives and could not therefore make care change improvements to the service based on their views.

Staff engagement

- Trust leaders recognised the hard work and contribution of staff and publicly said thank you to individual staff through their quarterly newsletter. Nominations for these accolades were received either from staff working at the trust or, from the public.
- Trust managers noticed staff who had “gone out of their way” with an on the spot reward such as a cup of coffee or snack voucher. This scheme had been in place for over two years and was well received by staff.

Innovation, improvement and sustainability

- The trust was finalising action cards for therapeutic specialising of patients, detailing what is expected of the staff member, which included no use of mobile phones to ensure all concentration is on the patient requiring specialised care. Staff told us this would ensure staff members are concentrating on patient care needs and not looking at text messages on mobile phones.
- Staff told us that they felt valued by the trust and motivated to provide an excellent service to end of life patients.
- The trust had set up a patient panel and worked collaboratively with stakeholders to produce a new end of life care strategy, which was to be presented to the trust board in October 2016.

Outstanding practice and areas for improvement

Outstanding practice

- Excellence reporting had been introduced in the operating departments to encourage staff to report and learn from examples of good practice.

Areas for improvement

Action the hospital MUST take to improve

The hospital must ensure:

- Staff comply with all aspects of the trust's medicine management policy and associated standard operating procedures.
- Medicine stock is checked in line with policy and expired or unwanted medicines are disposed of in a timely manner.
- Staff working in theatres fully comply and are engaged with each of the stages of the five steps for safer surgery.
- All staff working in theatres comply with the trust's uniform policy, in particular changing their scrubs, if they leave and then return to theatre.
- Pharmacy staffing is as planned to provide clinical pharmacy support to departments.
- Anaesthetic machines and resuscitation equipment have appropriate checks and are safe to use
- Patients' medical records are stored securely and confidential information is not accessible to unauthorised staff.
- Patients' have care plans which accurately reflect their needs and risk assessments are completed in a timely manner.
- Patients who are thought to lack the capacity to make a decision about their care have a formal mental capacity assessment.
- All staff are up to date with their mandatory training.
- Action is taken to ensure compliance with informed consent.
- A standardised pain assessment tool across the hospital to ensure end of life patients have their pain accurately assessed and responded to.
- The end of life care strategy is completed and published and all clinical staff are aware.
- Prepare a protocol for withdrawing treatment as recommended in the 2015 National Institute of Clinical Excellence guidelines and train clinical staff in its use.
- The new end of life care plans "Getting it right for me" and the associated "Getting it right for me patient held record" are used by clinical staff for all end of life care patients in the trust.

Action the hospital SHOULD take to improve

The trust should ensure:

- The pharmacy service does not supply out of date British National Formularies.
- Audits completed by the pharmacy service are used to drive improvements and progress should be demonstrated over time.
- There is a clear process to demonstrate the mortuary trolley has been cleaned, with appropriate dates and times recorded.
- Suitable sealed storage is in place for deceased patients' belongings in the bereavement office and a documented cleaning schedule for the storage receptacle to be cleaned at least weekly.
- Nursing staffing levels are as planned and this takes account of staffing of the TIA clinic.
- The standard of record keeping is monitored through regular audits and action taken for areas of non-compliance.

Outstanding practice and areas for improvement

- Medical staff receive yearly appraisals.
- All staff understand the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and are confident to apply this in the clinical setting to safeguard patients.
- The learning from complaints and incidents is shared with all members of staff. The hospital should consider reviewing night time security arrangements to ensure staff are protected at work.
- The privacy and dignity of patients is maintained at all times in the operating departments.
- Meetings held within the division of surgery and critical care have documented actions to provide assurance that concerns are being addressed.
- Advance care plans are fully documented in order to comply with patient's wishes.
- Information leaflets on advance care planning, what happens when someone dies and how to register a death are available and up to date for patients and families
- Audit the views of bereaved relatives to make care change to improve to the service
- Porters, cleaners and mortuary staff receive standardised formal end of life care training.
- All staff are aware of how to contact different faith ministers to visit the hospital out of hours.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include- (b) doing all that is reasonably practicable to mitigate any such risks; (e) ensuring that the equipment used by the service provider for providing care and treatment to a service user is safe for such use and is used in a safe way. (g) the proper and safe management of medicines. (h) Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated **How the regulation was not being met:** • The new end of life care plans "Getting it right for me" and the associated "Getting it right for me patient held record" were not always being used for patients receiving end of life care. • Daily checks of the anaesthetic machines in the operating departments and resuscitation equipment on the wards were not always documented, to demonstrate the equipment had been checked, was safe for use and available. • Staff were not following the trust's medicines management policy to ensure safe management, storage and disposable of medicines. • Staff did not check medicine fridge temperatures daily or take action when the fridge temperature was out of range.

This section is primarily information for the provider

Requirement notices

- There was no agreed schedule or clear responsibility for the cleaning of the mortuary trolley.
- Belongings of the deceased were not being appropriately stored while awaiting collection.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. **How the regulation was not being met:** There were 13 whole time equivalent vacancies for the pharmacy service across the trust. There was a significant impact on the pharmacy service provided to the wards, operating departments and for patients

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (1) Care and treatment of service users must only be provided with the consent of the relevant person (3) If the service user is 16 and over and is unable to give such consent because they lack capacity to do so, the regulated person must act in accordance with the Mental Capacity Act 2005 **How the regulation was not being met:** • Out of 14 sets of nursing and medical records for patients receiving end of life care, we found no evidence for seven patients that formal capacity

This section is primarily information for the provider

Requirement notices

assessments had been carried out despite documentation by clinical staff that stated the "patient lacked capacity" or that the patient was "confused"