Buckinghamshire Healthcare NHS Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of two services at each of the acute hospitals provided by this trust. The inspection was in response to information we hold about the trust and as part of our risk based inspection schedule. We did not inspect any community services on this occasion, although the historic ratings from previous inspections counted towards the overall ratings.

We also inspected the well-led key question for the trust overall.

We inspected the surgical services and the medical services at both Stoke Mandeville Hospital and Wycombe hospital. We did not inspect community health inpatient services.

We rated effective, responsive and well led as good, caring as outstanding and safe as requires improvement.

In rating the trust, we considered the current ratings of the 15 services that we did not inspect this time.

Our rating of services remained the same. We rated them as good because:

- Staffing levels were carefully monitored, and steps taken to maintain safe staffing levels. Although at times staff felt stretched. Staff understood how to protect patients from abuse. Medicines were managed well, in general. The trust managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Key services were available seven days a week
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Our findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- In most areas' leaders were visible and approachable and staff were supported to develop their skills. Staff understood the trusts vision and values. In general staff felt respected, supported and valued. The trust promoted equality and diversity in daily work and provided opportunities for career development. The trust engaged well with patients and the community to plan and manage services and staff were committed to improving services continually. There were established governance systems with clear reporting lines from the ward and units to the trust board. The trust collected data and analysed it. Data was used to understand performance and make decisions.
- The trust had worked to maintain some of their elective services during the COVID 19 pandemic and recovery plans were being implemented to ensure that the backlog was addressed.

However,

- Staff adherence to infection control guidance was variable.
- Staff were not always supported to develop through yearly, constructive appraisals of their work.
- Engagement in and understanding of quality improvement was variable. • Training in working with people living with dementia and those with learning disabilities was not mandated.
- Substances that were subject to COSHH regulations were not always managed safely.

How we carried out the inspection

- We reviewed 68 patient records.
- We spoke with 129 members of staff,
- We spoke with 40 patients and three carers.
- We visited 25 wards and units including the operating departments.
- We attended one site meeting and one senior nurse's safety meeting.
- We observed interactions between staff and between staff and patients.
- We looked at information such as staffing number and rotas, staff training, and bed management. We looked at medicine's management, checked equipment, medical devices and consumables.
- We reviewed information provided by the service following the inspection.

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

What people who use the service say

Patients were complimentary about the care they received and felt they were treated with respect and kindness. There was a general recognition staff were busy and at times appeared to be short of staff, which meant sometimes patients waited a little longer than they would have liked but did get the help they needed.

The Inspection team

Our findings

The team responsible for inspecting and reporting comprised two inspection managers, CQC inspectors and specialist advisors. The inspection was overseen by Amanda Williams, Head of Hospital Inspection.

Outstanding practice

We found the following outstanding practice:

- The trust's learning disability liaison team supported patients through their pathway. They supported with consent and mental capacity assessment processes, and supported patients through any procedures or interventions. They also supported staff to make any reasonable adaptions to support the wellbeing of patients with a learning disability.
- In July 2020, the trust adopted a third party e-Stroke Suite imaging platform at Wycombe and Stoke Mandeville Hospitals. Created in Oxford, with expert clinical input from frontline NHS stroke physicians, the award-winning e-Stroke Suite leveraged cutting-edge Artificial Intelligence & Deep Learning methodology to help stroke physicians make life-saving decisions.
- The trust staff worked hard to support patients and carers throughout the pandemic by introducing several initiatives such as the purchase of iPads and tablets which enabled patients to keep in touch with their families via video calls and a 'Letter to a Loved One' service which allowed friends and family to email letters and photos which were colour printed and hand delivered to patients.
- The Patient Advice and Liaison Service was extended to the weekend and the Chaplaincy service offered a phone service to friends, family and carers.
- A Same Day Emergency Care Service was launched in November 2020. Following a GP referral or triage in the emergency department reception, patients could be admitted to the new unit to be rapidly assessed, diagnosed and treated by a team of doctors, nurses and therapists without the need for a hospital admission or waiting to be seen in the emergency department. Trust data showed that this initiative had improved flow through the department and helped ensure that patients were treated in a timely way.

Wycombe Hospital

- The development nurse in Ward 9 had developed a mouthcare awareness project to improve oral care and assess the impact on rates of hospital acquired pneumonia.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with four legal requirements. This action related to four services.

Trust wide

Our findings

- The trust must ensure that the process to assess, monitor and mitigate risks is effective and accurately reflects current risks across all services. (Regulation 17(1)).
- The trust must ensure that records are maintained securely and are accurate, complete and contemporaneous for each patient. (Regulation 17(1)).
- The trust must ensure patient risks are assessed, reviewed and plans implemented to manage the risk. (Regulations 12(1)).
- The trust must ensure that all substances subject to COSHH regulations are stored safely.
- The trust must ensure infection control risks are assessed and action taken in a timely way to manage the risk. (Regulation 12(1)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that staff compliance with mandatory training meets the trust target.
- The trust should consider making dementia and learning disability training mandatory for staff
- The trust should consider reviewing how the service can reduce the number of bed moves.

Stoke Mandeville Hospital

Medical Care (including older people's services)

- The trust should consider improving the environment to meet the needs of people living with dementia.
- The trust should ensure the environment enables staff to provide care and treatment that protects the privacy and dignity of patients.

Surgical care

- The trust should ensure that mental capacity and consent training is in place for all staff and that capacity assessments and consent decisions are clearly recorded in patient records. (Regulation 11).
- The trust should ensure that medical equipment is routinely monitored to ensure that they do not pass their expiry date.
- The trust should ensure that boxes containing sterile equipment are not kept on the floor.

Wycombe Hospital

Medical Care (including older people's services)

- The trust should consider reviewing signage across the service to improve patient experiences of being in the hospital

Is this organisation well-led?

Our rating of well-led went up. We rated it as good.

Our findings

Leadership

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

Leaders had the experience, capacity, capability and integrity to ensure that the strategy could be delivered and risks to performance addressed.

The board and senior leadership team had seen some changes in the last two years, including new appointees and promotions. The established chief executive (CEO) had continued in post, along with the chief finance officer, the chief people officer and the chief commercial officer.

Having been with the trust since 2015, the CEO brought both stability and organisational memory to the trust. With a master's degree in healthcare management, he had the necessary underpinning knowledge and experience from previous executive posts to ensure he had the skills and ability to lead the trust.

The other longer serving executives offered prior experience gained as senior leaders in other trusts and from the wider healthcare arena. They were well placed to support the CEO and chair in providing strategic leadership.

The chief nurse joined the trust in March 2020, which meant their first focus had to be on the trust pandemic response. They brought fresh eyes and a commitment to addressing inequalities demonstrated by their role as a trustee of the Mary Seacole Trust and as a member of the National Workforce Race Equality Standards Advisory Board.

The chief medical officer, who had worked at the trust since 2004, most recently as interim chief medical officer had recently been appointed to this role. The chief operating officer was an interim and the chief digital information officer role was vacant.

The trust chair joined the organisation in January 2022 and brought with them a wealth of experience and knowledge. The chair had previously been a finance director and CEO of an NHS trust, so was well placed to support and to challenge the CEO.

The non-executive directors brought individual skills and experience that enabled them to understand the workings of an NHS trust and to provide challenge to the executive. Their combined professional skills included financial skills, clinical expertise, senior and strategic leadership experience.

There was a diversity amongst the board members that provided a reasonably balanced perspective and gave a message about the importance of valuing all members of society equally. There were five women board members from the fifteen. Additionally, one of the two board affiliates was a woman meaning the representation of women at the board was 43%. There appeared to be a similar level of ethnic diversity at board level, although individuals were not specifically asked about their own heritage.

The senior leadership team were open and honest with the inspection team and there was a sense of shared responsibility. They had worked well together in response to the pandemic.

Our findings

Members of the senior leadership team and the board were visible and approachable. There was a planned schedule of walkarounds for the non-executive directors. They spoke positively about this opportunity and the experience and insight it gave them. The CEO blocked time in their diary to be available to staff and frequently visited different departments and areas of the trust. Staff spoke positively about how approachable they were. The chief nurse and their team all undertook clinical shifts on a regular basis, working side by side with the clinical staff.

We reviewed the personnel files for four members of the executive team. Appropriate checks had been carried out in accordance with 'Fit and Proper Person' requirements. The executive team had an appropriate range of skills, knowledge and experience.

Leadership was sustained through a leadership development programme. The trust ran a three-tiered development programme for leaders, a regional talent programme for ethnic minority and black staff and an executive development programme. Staff talked about rich and engaged leadership training. An enhanced agile learning package was available to all line managers. Staff were supported to continue their master's degrees during the pandemic and one senior nurse spoke positively about being supported to continue with their doctorate. Two senior nurses spoke positively about how they had been supported and enabled to progress including the positive use of coaching.

The trust had two board affiliates who were members of the trust's patient facing workforce. This offered learning through hands-on experience to develop the skills required for future leadership roles and enabled them to impact board decisions that influenced the growth and strategic direction of the organisation.

The trust ran a 'Trainee Leadership Board', engaging a multi-disciplinary group of individuals in a programme which included introduction to leadership and quality improvement training, executive and non-executive director mentoring, trust board observation and design and delivery of a project. The Trainee Leadership Board recommendations had subsequently been incorporated into the outpatient's transformation programme.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a new strategy to turn it into action, developed with some of the relevant stakeholders. The vision and strategy were focused on sustainability of services and to some degree were aligned to local plans within the wider health economy.

There was a clear statement of vision and values, driven by quality and sustainability. The trust's vision was 'outstanding care, healthy communities and a great place to work' and their mission was 'personal and compassionate care every time'.

The trust values of 'collaborate, aspire, respect and enable' were well embedded throughout the organisation and all staff groups spoke positively about these.

The vision, values and strategy had been developed through a structured process in collaboration with people who use the service, a limited number of staff and some external partners. We were informed only five percent of staff had been engaged in the development of the trust strategy, with wider engagement across the community through surveys, focus groups and interviews.

The trust had identified three strategic priorities, led by joint executive leaders and supported by a group of objectives. These were 'provide outstanding, best value care; take a leading role in our community and ensure our people are listened to, safe and supported.'

Our findings

The current strategy had recently been published, delayed from publication in March 2021 by the pandemic. The strategy was promoted throughout the trust; however, staff did not always understand how their role contributed to achieving the strategy. Senior leaders told us they still had work to do, to translate the strategy into what it meant to the individuals who make up the workforce.

Key to achieving their vision priorities and objectives was the clinical strategy along with the enabling strategies of people, IT and digital transformation, estates and finance. The clinical strategy was a key driver for the estate strategy with the success of one clearly interlinked with the other.

The trust had an ambitious vision for their estates which would require significant investment. This had now been acknowledged as a risk and alternative plans developed. The plans were comprehensive and would, in the longer term improve the patient experience and reduce costs.

Throughout the pandemic, the trust worked closely with their health and social care partners within Buckinghamshire as well as managing the demand for services with partners in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS), with whom they have mutual aid agreement in place to share resources, as and when required.

A key part of the incident response structure was the establishment of a Buckinghamshire Recovery & Renewal Board with representatives from the trust, Incident response structure, Clinical Commissioning Group, primary and social care as well as Healthwatch.

The Buckinghamshire Recovery & Renewal Board has four delivery groups: Elective Care, Urgent and Emergency, Community Care and Infrastructure. These groups continued to be, responsible for coordinating the safe restart and redesign of our services post pandemic and each has a patient representative

Culture

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

Leaders modelled and encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. There were processes to support staff and promote their positive wellbeing.

The national NHS staff survey results published in March 2022 showed that 56% of colleagues had responded to the survey which was an increase from the previous year and 10% higher than the national average response rate. In 8 of the 9 themes the trust was at or above the national average. There had been a focus during the preceding year on teams and managers and the survey reflected an increase in colleagues feeling safe to speak up regarding unsafe clinical practice. A key priority for the coming year was learning from best practice with the rollout of a performance management system.

There was an established well-functioning junior doctor's forum which was focused on targeted intervention and the wellbeing of junior doctors. During the pandemic they organised 'medical support families' to support new junior doctors; this initiative received positive feedback. To help with communication each division had a junior doctor representative who attended bronze level meetings.

Our findings

Junior doctors spoke positively about the support they received from the guardian of safe working hours (GoSWH) for doctors in training. The GoSWH provided assurance to the board via the strategic workforce committee on a quarterly basis, that doctors in training were safely rostered and working hours were compliant with terms and conditions of service. Most reported issues related to hours and rotas. Junior doctors talked about how they had been supported to work together to try and solve rota issues and how the trust had introduced rota coordinators. In one area where immediate safety concerns had been identified the GoSWH had engaged with the chief medical officer and the director of medical education. This had resulted in direct work with the department concerned to develop a plan of action to address concerns.

Equality, diversity and inclusiveness were promoted, and attempts were made to identify any workforce inequality so that action could be taken to address these. The trust monitored their workforce data in relation to the protected characteristics as defined by the Equalities Act 2010 and the public sector equality duty and set objectives where improvement was required.

The Workplace race Equality Standards data for the five years to 2021 showed that the trust scored consistently lower than the benchmark for the question about whether staff had experienced discrimination from their manager or other colleagues. This was true for both white staff and those from other ethnic groups, although the level reported by non-white staff remained slightly higher than for white staff.

To ensure all members of the work force felt they had a voice and felt engaged with, there were eight staff networks. A priority for the trust had been to try and remove bias from the recruitment process. The ideas and new ways of recruiting had recently been used during executive level recruitment and was to be included in all future recruitment.

The trust had achieved and exceeded their own objective for the diversity of their board. The trust acknowledged there was more work required to achieve equal progression pathways to senior leadership roles but while a programme of work had started, it was paused due to the impact of the pandemic. All managers were required to undertake a learning programme on inclusive management, culture, decision-making and relationships.

Most staff spoke positively about feeling able to speak up when there were concerns. The trust leadership actively promoted staff empowerment to drive improvement, and raising concerns was encouraged and valued. Staff actively raised concerns and those who did were supported. The freedom to speak up guardian team had expanded and there were now five guardians with separate leads for the community and the acute hospitals. There were plans in place to grow a ‘champions network’ for staff to have more local contacts. Most staff spoke positively about the freedom to speak up guardians, describing them as accessible and approachable.

One small group of staff informed us even though they had raised their concerns, which related to perceived bullying, they did not feel they had been heard and told us they were unhappy with the way things had been addressed. However, in response to concerns of bullying, two task groups had been set up, one focussed on colleague to colleague bullying and harassment, and one on service user to staff bullying and harassment. A publicity campaign including a poster competition, and a group of champions had been used to raise awareness. Information provided by the trust indicated there was ongoing work to identify the drivers that caused bullying and harassment and to enable appropriate initiatives to be developed.

Governance

Our findings

Governance processes were effective, both throughout the trust and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the trust.

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

The trust had an agreed meeting structure with defined reporting lines. Each of the trust executives had a portfolio and lead responsibilities which included the divisional committees and groups. Divisional accountability to the executive team was through several executive committees such as health and safety committee, clinical effectiveness committee and infection prevention and control committee. These committees reported to the executive management committee where executive review took place and the executive team were accountable to the CEO. Seven board committees were in place to provide assurance to the board.

A review of board meeting minutes confirmed reports from these committees were presented and discussed. The board was sighted on key risks, achievements and performance. An example of this was seen in the May 2022 board papers which showed that the board had been updated on progress with implementation of the Ockenden 7 immediate and essential actions outlined in the Ockenden report, the plan to ensure full compliance and gave an update on staffing which was a key component of maternity care.

The Board were told that the trust was not currently compliant with the action to have twice daily consultant led labour ward rounds. In response to this the trust had committed to recruiting two consultants and there was a plan to uplift existing consultants to provide ward rounds over the weekends in the interim. The records showed that the trust had maintained optimal safe staffing throughout the pandemic. The board papers also showed that there was challenge and questioning by non-executive directors around the delay in recruiting and received a response that there was a delay in receiving Ockenden funding; an interim measure was being put in place. This demonstrated the board received enough detail to gain assurance and to enable challenge, as part of their governance responsibilities.

A review was being undertaken of the divisional governance meetings to standardise and strengthen the discussion in these meetings. The plan was for governance meeting agendas to incorporate the moderation of the divisional risk register.

Two external consultants had been engaged to prepare a ‘bottom-up’ budget for all divisions. The intention was for this to help with engagement and ownership and ultimately accountability at divisional level. Once implemented this would change the current governance arrangements for finance with more accountability and responsibility on the divisional directors. This would create a closer link between financial and clinical governance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance and risk. Whilst known risks were identified and high-level risks escalated with identified actions to reduce their impact, there was variability in the way risks were identified and recorded at a very local level.

The corporate risk register was clearly aligned to the strategic priorities and the trusts objectives. The corporate risk register included the top risks identified by the leadership team such as estates risk, staffing risk, risks relating to two Never Events with piped air and the trust electricity supply.

Our findings

There were established processes for the review of the risk register through committees of the board and through the full board. There was one risk relating to a ward which had been on the risk register for 10 years without a permanent solution, although we were told by senior leaders a solution had now been identified and would be enacted in the next financial year.

There was a process of escalation of risks from the service delivery units through to the board. We were told there was a plan to refresh the approach to risk identification and understanding across the trust, with an aim to gain more consistency and enable effective escalation upwards. As part of this process the hospitals electronic reporting and risk management system was being updated, policies were under review and training was planned.

Risk management was part of the chief nurse's portfolio and was allocated to the associate chief nurse portfolio. The trust board business manager held responsibility for the board assurance framework (BAF). The BAF brings together the information on the risks to the trust's strategic objectives. The BAF, had recently been moved to a digital platform, so there was an audit trail.

The BAF was linked to the trust risks. The BAF was being used effectively as a tool to track key strategic risks. Senior leaders told us there were plans to review and restructure the BAF and board minutes showed that the BAF was used as a tool to consider and respond to risk at a strategic level. The divided ownership of these two documents had the potential to cause misalignment. Risk oversight was held at board committee level, but the information escalated to the board was sufficiently detailed to allow full board accountability and challenge.

Information provided by the trust demonstrated the corporate risk register and the BAF were discussed at committees of the board and the board. The trust had a robust governance around

- the management of the estates
- compliance with legislation
- safe staffing
- the trust charity
- finances
- clinical performance and recovery against key targets.
- cultural performance indicators

The trust acknowledged that there was some duplication of information and work was being undertaken to reduce this. The board committee chair's reports had been reviewed and amended with the chair log going to the board. With the aim of giving assurance about what had been discussed at other committees, the front of papers now included a summary of those discussions.

The Buckinghamshire Healthcare NHS Trust Integrated Performance and Quality Report was aimed at providing a monthly update on the performance of the trust based on the latest performance information available and reporting on actions taken to address any performance issues and progress to date. The contents of the report were defined by the NHS System Oversight Framework for 2021/22, the trust's three strategic priorities and the trust improvement programme. Work was ongoing to improve the integrated performance report, with a move away from spreadsheets to the use of statistical process control (SPC) charts, with targets and latest month's performance highlighted. Benchmarking information, where available was also now included. Leaders spoke positively about the integration of performance and quality.

Our findings

The trust had two Private Finance Initiative contracts which contributed to higher than average operating costs when benchmarked against similar sized trusts.

The 2021/22 month 9 year to date (YTD) overarching position was a £1.5m deficit. This was £1.5 million less than the planned YTD position of £3 million deficit, which showed financial improvement better than anticipated and agreed.

The month 9 full year forecast of £5.6 million deficit was reported to the board as in line with plan. However, the YTD position and monthly run rate expenditure in recent months indicated a break-even or surplus was achievable.

The last two-years the trust was operating under an emergency financial regime put in place during the pandemic. The trust's financial position was stable with a projected breakeven position in this financial year, albeit with an underlying deficit of around £55m.

For the financial year 2020-21 the external auditor had given an unqualified opinion on the annual accounts for this period. An unqualified opinion is an independent auditor's judgment that a financial statements is fairly and appropriately presented, without any identified exceptions, and in compliance with generally accepted accounting principles.

The trust finance committee provided sufficient information to the board through a detailed finance report for the board to gain assurance. The unqualified audit opinion showed that the information was accurate and an accurate representation of trust financial position. This allowed the board to set the strategic financial direction and to challenge use of trust resources.

Information Management

The trust collected data and analysed it. Data was used to understand performance and make decisions. However, data was not always in easily accessible formats, the information systems were not all integrated and secure.

The trust described themselves as being digitally immature. Information and communications technology (ICT) infrastructure did not meet the highest standards for data protection and cyber security. Digital immaturity was rated very high on the BAF. Financial investment to enable the trust to migrate away from unsupported systems had been agreed.

While the trust used data to monitor performance, they had not considered the wider picture across the integrated care system or the region. This meant the trust was not aware when they were not performing well compared to others until informed by a regulator. Following a review of how information was presented in the board's integrated performance review (IPR) benchmarking information was now included for some areas and needed to become embedded as standard, where relevant for all reporting.

The trust had a heavy reliance on paper. The trust had yet to introduce an electronic patient record (EPR). There was a reliance on scanning records to digitise and store them. Full records were available when necessary but there remained some risk around accessing a patient's history; some staff said it was difficult to get a holistic review of the patient.

The Data Security and Protection (DSP) Toolkit is an online tool that enables relevant organisations to measure their performance against the data security and information governance requirements mandated by the Department of

Our findings

Health and Social Care (DHSC). The trust had an action plan in place to work towards declaring compliance to all standards. However, not all actions from 2020/2021 were completed by their target of end of December. As of December 2021, the trust was 90% compliant with information governance training below the 95% required by the data security and protection toolkit.

Reviews were completed for any information governance breaches. Any serious breaches were reported as a serious incident and reviews included consideration of any emerging patterns and what mitigation action was required. We were told a combination of training, spot checks and deep dives in individual departments, ensured patients confidential information was safe and secure. An incident was shared with us where paper records were left out and some targeted work was undertaken with the senior team about the risk.

Engagement

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

The trust had five patient groups. There was a patient forum referred to as SPIN for spinal injury patient and their relatives. The spinal injuries unit also had a service users committee which met with representatives from the divisional board, clinical governance group, research board and patient experience group. They met quarterly to discuss issues and redevelopment plans.

The community hubs stakeholder groups in Thame and Marlow had been a key driver and influencer in the development of the community hubs at these locations. The patient communication advisory panel, introduced to support improvements in patient and carer communication, ensured all communication was clear, written in plain English and was easy to understand and navigate. The panel had recently worked with the communication team on the redesign of the trust's website which is said to meet accessibility standards.

The trust actively invited patients to make nominations for the annual One Team, One Goal award and monthly staff awards. These were awarded in recognition of individuals and teams who went to extraordinary lengths to deliver the trust’s values, ensuring that patients received safe and compassionate care, every time.

The trust was engaging with community partners. They were working with a local organisation to fund small groups with an aim to improve uptake of screening, access to two week waits and reduce late stage cancer presentation in the emergency department. This was to be achieved by working with key groups connected with the local community. Chiltern prostate cancer group was engaging with the trust patients going through the experience by visiting them. They had also carried out testing in a local football club to reach more men in the community through their local connections.

The trust’s dietetic team, in partnership with an autism and learning disability support charity, ran a community weight loss programme, called Energise, for people with learning disabilities and their carers.

In 2019, the trust began working with patients who were referred to as, ‘Research Ambassadors for Patient involvement in Research and Development’. Patient research ambassadors had attended committee and research group meetings to review research projects and were lay advisors on grant applications for planned studies, including how information was written in leaflets, consent forms and posters. The trust planned to continue the involvement of ambassadors as lay advisors on all grant applications and planned studies and to recruit more patient research ambassadors.

Our findings

Staff representatives spoke positively about the open engagement they were able to have with the executive team. There were pockets of concerns relating to bullying and in some cases, this was said to be by the line managers. There was positive feedback relating to staff redeployment during the pandemic and some of the programmes of support available for staff. The trust had several staff groups representing the diverse work force. The people strategy was about having people in the right place who were listened to, supported and healthy (physically and mentally).

Following feedback from staff, the trust worked with local community groups and volunteers to create and improve outside spaces on trust sites. When it was identified that additional wellbeing support was required, particularly during the pandemic, the trust launched 'Thrive@BHT.' Included in this programme was REACT (mental health listening skills training) and TRIM (trauma risk management). Additional counselling support was provided, mindfulness and understanding stress sessions extended, the wellbeing champions network expanded, specialist external partners were engaged to provide wellbeing sessions and the Thrive@BHT care pack was sent to every employee. On the last annual staff survey the trust score for 'does your organisation take positive action on Health and Wellbeing' had improved.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a mixed picture of investment in driving improvement. Junior doctors were clearly invested in quality improvement (QI) and knew how to express an interest in undertaking a project and how to gain support. There was a central QI team who guided the projects. Not all staff were clear which model they used and appeared to be reliant on the QI team to make these decisions and inform them how to proceed. A review of meeting minutes demonstrated with support from the QI team QI huddles had been introduced in the integrated medicine division.

The trust had an established mortality review process. Initial reviews were completed by a medical examiner who, following a criterion identified those that required a more in-depth structured judgement review (SJR). Activity was monitored through the mortality reduction group. Concerns were followed up with direct communication with those involved, an action plan and where required a follow up audit.

The trust initiated the founding of the Buckinghamshire Health and Social Care Academy which launched in July 2020. This was a virtual entity to bring together partner organisations to attract skills and build the supply of future workforce through the provision of healthcare education with a system-wide focus. The academy provided multi-agency continuing professional development, such as joint safeguarding training with the council and expansion of nurse training placements into primary care.

The trust's research and innovation department had a wide reaching portfolio across all specialties such as cancer care, cardiology, plastics and burns, respiratory medicine and ophthalmology and registered its 1000th research study in 2021.

Research nurses and practitioners worked alongside clinical teams and supported services to deliver industry-led studies. The trust was said to work with a range of companies to bring ideas to market. The intensive care unit team was involved with the success of the national recovery trial's discovery of a drug proven to be of positive benefit to COVID19 patients.

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ Jul 2022	Good → ← Jul 2022	Outstanding → ← Jul 2022	Good → ← Jul 2022	Good ↑ Jul 2022	Good → ← Jul 2022

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Good	Outstanding	Good	Good	Good
Community	Good	Good	Good	Good	Good	Good
Overall trust	Requires Improvement ↓ Jul 2022	Good →← Jul 2022	Outstanding →← Jul 2022	Good →← Jul 2022	Good ↑ Jul 2022	Good →← Jul 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Stoke Mandeville Hospital	Good →← Jul 2022	Good →← Jul 2022	Outstanding ↑ Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022
Wycombe Hospital	Requires Improvement ↓ Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022
Overall trust	Requires Improvement ↓ Jul 2022	Good →← Jul 2022	Outstanding →← Jul 2022	Good →← Jul 2022	Good ↑ Jul 2022	Good →← Jul 2022

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

Rating for Stoke Mandeville Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good → ← Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022	Requires Improvement ↓ Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022
Services for children & young people	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Critical care	Good Oct 2014	Good Oct 2014	Outstanding Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
End of life care	Good Jun 2019	Good Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019
Maternity and gynaecology	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Spinal injuries	Good Jun 2014	Outstanding Jun 2014	Outstanding Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014
Surgery	Requires Improvement → ← Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022
Urgent and emergency services	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Hospice services for adults	Good Jun 2019	Good Jun 2019	Outstanding Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Outpatients	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Overall	Good → ← Jul 2022	Good → ← Jul 2022	Outstanding ↑ Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022	Good → ← Jul 2022

Rating for Wycombe Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022
Services for children & young people	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Critical care	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
End of life care	Good Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019	Outstanding Jun 2019
Maternity and gynaecology	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Surgery	Requires Improvement →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Requires Improvement ↓ Jul 2022
Outpatients	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Overall	Requires Improvement ↓ Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Community health services for children and young people	Good Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019
Community health inpatient services	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019
Community end of life care	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Overall	Good	Good	Good	Good	Good	Good

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

Stoke Mandeville Hospital

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Description of this hospital

Stoke Mandeville Hospital is located on the edge of the market town of Aylesbury. Stoke Mandeville hospital has an outpatient service, planned day surgery and inpatient care, a consultant-led women and children's centre, neonatal intensive care, rehabilitation, chemotherapy, accident & emergency, critical care, emergency and trauma surgery, acute medical care, acute obstetrics and gynaecology. There is a National Spinal Injuries Centre, burns and plastic surgery unit, ophthalmology, radiology department, pharmacy and pathology services.

At Stoke Mandeville hospital we inspected medical care (including older people's care) and surgery.

Summary of our findings

- The service had enough staff to care for patients. Staff understood how to protect patients from abuse, and managed safety well. They managed medicines well. The services managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Most staff treated patients with compassion and kindness and helped them understand their conditions. They provided emotional support to patients, families and carers.
- People could access the service when they needed it and did not have to wait too long for treatment.
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care or plan their discharge. Staff had discussions about their patient's holistic needs.

However

- Not all staff completed all the trust mandated training in key skills. Not all staff received appraisal of their work.
- Ward staff used boxes holding sterile equipment to prop open fire and secure doors. This meant easy access for unauthorised people to potentially unsafe equipment, for example scalpels and detergents.
- Ward staff did not always follow infection control principles in the use of personal protective equipment (PPE).
- Staff did not consistently complete ward-based risk assessments. For example, falls risk or nutritional assessments.

Our findings

- The environment and training of staff did not fully meet the needs of people living with dementia.
- Capacity assessments were not conducted as required. Staff did not know who could carry out these assessments. Medical staff did not record capacity assessments in the patient record.

Medical care (including older people's care)

Good

Is the service safe?

Good

Our rating of safe remained the same. We rated it as good.

Mandatory Training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

Staff were offered a range of mandatory training, but due to the impact of the pandemic not all staff were able to remain current. Staff said they could access mandatory training and that time was allowed to complete the training. However, data demonstrated that completion of mandatory training at 31 January 2022 was below the trust target of 90%. Completion rates ranged from 50% to 83% for nursing and medical staff groups across the different medical services.

Mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. They used electronic systems to monitor completion of mandatory training and allocated study days for staff to complete the mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff demonstrated a good understanding about safeguarding patients. Staff completed training about de-escalation of challenging behaviour. In the event of a person's behaviours posing potential harm to themselves or others, clinical staff sought the support of the hospital security staff. Hospital security staff completed restraint training that was authorised by the restraint reduction network standards.

Staff could give some examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff described caring for patients with protected characteristics and knew how to keep them safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could describe what a safeguarding concern was and how to make a referral. Each area had visual prompts for the process and the safeguarding adult and children's policies were available for reference on the trust intranet.

Cleanliness, infection control and hygiene

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

Medical care (including older people's care)

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

The service performed well around objective indicators for cleanliness. Data for cleanliness was displayed in each ward. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Audits demonstrated that the cleaning of all medical wards met the standard set by the trust for each area. Cleaning staff were trained how to clean to minimise the spread of infection

Staff followed infection control principles and trust policies, including the use of personal protective equipment. All ward areas had dispensers of clean gloves, aprons and masks and staff used these appropriately. Antibacterial hand gel dispensers were available, and posters promoted staff and visitors to clean their hands regularly.

Staff were all bare below the elbow and during the inspection staff were observed to clean their hands regularly. Each bay and side room on the wards had clinical handwashing sinks and a poster reminding staff of the five moments of hand hygiene.

Laminated signs identified patients who were inside rooms who required barrier nursing to prevent the spread of infection.

Processes were followed to reduce the risk of transmission of COVID19, this included procedures for visitors.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Most equipment had stickers identifying when they were last cleaned. We observed that staff cleaned equipment after use.

Environment and equipment
The design and maintenance of facilities, premises and equipment supported safety of patients. Staff were trained to use equipment. Staff managed clinical waste well.

Daily safety checks were carried out on all specialist equipment including the resuscitation equipment and records of this were fully completed.

Electrical equipment in each area had been safety checked and maintained so was safe to use. Each piece of equipment had an asset number which allowed the trust to monitor when it was due for routine maintenance.

The service had enough suitable equipment to help them to safely care for patients. Staff could access all the equipment they needed to provide care. Staff completed training in the use of equipment.

Staff disposed of clinical waste safely. Waste was separated and stored securely before being disposed of safely. Sharps boxes were assembled, used and disposed of correctly.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. Staff completed scores correctly. When a concerning score was calculated the patient was escalated for medical review.

Staff completed risk assessments for each patient on admission using nationally recognised tools. This included a range of risk assessments- for example, falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). When actions or plans were required to reduce the level of risk, patient records showed these had been completed.

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff. Staff completed transfer forms when patients were transferred to other wards within the hospital.

Nurse staffing

Staffing was monitored centrally, and staff were reallocated when necessary to ensure safe staffing across all services.

The service, like most others nationally, experienced challenges in ensuring there were enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Planned optimum staffing numbers were not always met. However, bank and agency staff were used, and these staff had received a full induction.

The service experienced challenges in ensuring there were enough nursing and support staff to keep patients safe. Despite many areas being recruited to their planned establishment, the impact of the pandemic meant that there was higher than usual staff absences and an increased need to open and staff escalation areas. To manage the risk, leaders reviewed the position regularly during each day to ensure that no ward area was left unsafe due to low staffing. Because of this dynamic risk management, staff on wards described that senior leaders regularly moved staff to different wards. The trust moved to a Safest Staffing Model as a standard operating procedure, in line with work done by NHS England.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, the number of nurses and healthcare assistants frequently did not match the planned numbers. For example, on 9 February ward 10 was short of a nursing assistant for two shifts and a registered nurse for two shifts. On the frailty unit on 9 February 2022 there was one less nursing assistant than the planned number for both the morning and afternoon shifts. Data submitted by the trust demonstrated that between 1 January 2021 and 13 February 2022 wards 5, 7 and 8 did not always have the planned numbers of staff on duty, although it is acknowledged that the dynamic management of staffing based on frequently reviewed risk meant people were protected from unsafe staffing levels.

Ward managers had some ability to adjust staffing levels daily according to the needs of patients. Ward managers calculated and recorded patient acuity daily. Patient acuity and staffing across the hospital was reviewed daily by senior leaders and staff were moved to work on different wards to support the safety of patients across all areas.

The service used bank and agency staff to fill gaps in staffing. Data submitted by the trust demonstrated a significant dependency on bank and agency staff across the trust. Data showed that 64% of shifts across the trust were carried out by substantive staff. Longstanding lines of work or long-term bank and agency workers covered 28% of shifts. Only 8% of shifts were carried out by bank and agency staff that worked two or fewer shifts within the month and 2% of shifts were carried out by a bank or agency worker new to the trust.

Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

Medical care (including older people's care)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Like many other trusts, the service experienced challenges in ensuring there were enough medical staff to keep patients safe. Processes were followed to mitigate any risks associated with medical staffing numbers. This included consultants and specialist registrars covering work that was usually carried out by more junior doctors. Following a gap analysis against Royal College of Physicians guidance completed in 2021, an additional 23 whole time equivalent clinical roles were funded and were being recruited into.

Medical staffing was reviewed daily. Medical services always had a consultant on call during evenings and weekends.

Managers could access locums when they needed additional medical staff. Data provided by the trust demonstrated that across the trust there was a significant dependency on agency or locum staff to ensure safe medical staffing. Data showed 58% of shifts were carried out by substantive medical staff. Longstanding lines of work or long-term locum and agency workers covered 34% of shifts, 8% of shifts were carried out by locum and agency staff that worked two or fewer shifts within the month and 4% of shifts were carried out by a locum or agency worker new to the trust.

Managers made sure locum staff had a full induction and understood the service. The trust had a standard induction plan for locum staff, which included orientation to their specific area of work.

Records

Staff did not always keep full records of patients' care and treatment. Not all wards stored records securely and they were not always easily available to all staff providing care

Patient records were not always comprehensive. Staff did not always fully complete care planning documents. This increased the risk of patients not receiving care that met their individual needs and preferences. The trust used a standardised care planning document for most wards except ward 7, the acute medical unit and ward 10. Where the care planning document was used, there was only brief information to support safe delivery of patient centred care and treatment. For example, for a patient where their risk assessment detailed, they needed support with mobilising their care plan stated, "needs assistance with their mobility as they are not steady with his feet," but did not expand on what the required support was. The day to day records of treatment provided to patients were clear and up to date.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff completed patient transfer forms for all patients that included information about their condition, treatment plan, escalation plans and any ceiling of treatment plans and do not attempt cardiopulmonary resuscitation decisions. For patients transferred within the trust, their hospital notes were transferred with them.

On seven wards or units that we inspected; patient records were stored securely. Notes trolleys all had lids that were closed and most of them were locked with key code locks when not in use. However, on AMU patient notes were not in the records trolleys and were 'scattered' throughout the department. There were several requests from staff asking where patients notes were as they were not where they should be. Staff said patients' notes were regularly not put back

into the patient records trolleys. In the escalation bays in the same day emergency care unit patient notes were on a table and not stored in the available notes trolley. There was one set of patient notes in the escalation bay where the medicine record had been rewritten as this initial version had been lost. There was an increased risk of patients' records being accessed by an unauthorised person.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. They followed current national practice to check patients had the correct medicines. Medicines records were complete and contained details on dose, when patients received them, and controlled drugs were double checked.

Staff reviewed each patient's medicines regularly. Patients medicine charts showed that when patients were admitted pharmacists completed a check to ensure patients remained on medicines they were taking before admission to hospital.

Staff completed medicines records accurately and kept them up-to-date. Records detailed doses prescribed and administered

Staff stored and managed all medicines safely. All medicines were stored safely in locked cupboards.

Incidents

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

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses

Managers shared learning about never events with their staff and across the trust. Staff knew about never events that had occurred in the trust and knew what they needed to do to reduce risk of the events occurring again. Staff understood the duty of candour. They said they gave patients and families a full explanation when things went wrong.

Staff told us they received feedback from their managers about the incidents they reported.

Managers investigated incidents. Leaders reviewed reported incidents daily to monitor trends and identify incidents that required urgent investigations. Leaders felt confident incidents were reported and acted on appropriately.

Safety Information

Medical care (including older people's care)

Staff collected safety information and shared it with staff, patients and visitors. The service continually monitored safety performance and data was displayed on wards for staff and patients to see. Every ward had a notice board with the safety data displayed. This data included number of falls, pressure ulcers and urinary tract infections.

Is the service effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff used a patient clinical pathway record to plan, give and evaluate care and treatment. The document referenced the National Institute for Health and Care Excellence (NICE) guidance for each plan of care. NICE and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow.

Clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

Clinical audit was being undertaken and there was good participation in national and local audits. The trust performed in line with national clinical audits.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were regularly offered hot drinks and snacks. Fresh water was freely available and kept topped up by staff. Patients were offered cereal or toast at breakfast, hot lunch and soup and sandwiches in the evening. Where clinically required, different meals or snacks could be requested. There were two planned rounds in addition to offering snacks such as biscuits. Patients were supported to eat and drink if needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed and where required patient records clearly detailed how much nutrition and fluids patients had.

Pain relief

Medical care (including older people's care)

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

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

Staff monitored pain level of patients and recorded the information. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patients who could not communicate verbally. Most patients said staff gave them pain relief when they needed it and their pain was well managed.

Pain nurse specialists routinely review patients during the week. They gave advice on how to manage pain and dealt with problems regarding medications, epidural analgesia, patient-controlled analgesia and local anaesthetic blocks.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service was working towards accreditation, under relevant clinical accreditation schemes.

Managers and staff carried out a programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas.

The service participated in relevant national clinical audits. The trust performed in line with the England national average in most key performance indicators. The trust performed about the same for the national lung cancer audit and the national bowel cancer audit.

The trust performed better than the England national average for emergency readmissions for chronic obstructive pulmonary disease and bronchiectasis and pneumonia.

The endoscopy service was working towards full accreditation by the Joint Advisory Group on GI endoscopy.

Competent staff

The service made sure staff were competent for their roles. Managers held meetings with staff to provide support and development. However, managers did not always appraise staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff said the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff development and training was supported by clinical educators and practice development nurses.

Medical care (including older people's care)

Managers made sure most staff received any specialist training for their role. Staff completed competencies for the specialist area they worked in. For example, staff working on the respiratory wards completed competencies in the care and management of patients with respiratory illness and conditions.

Where formal training was not possible, bite size training was provided to equip staff with relevant skills. For example, staff working on the frailty unit had not received any formal training about the care and management of elderly frail people. Bite size training about aspects of frailty had been provided from the therapy teams and plans were being put in place to provide additional formal training to staff.

Dementia training was mandatory for all staff both clinical and non-clinical, with 83% compliance in January 2022. Mental health needs, learning disabilities and autism were optional training programmes. In addition, the frailty team offered bespoke session on dementia, delirium and management of challenging behaviours, focusing on non-pharmacological interventions.

The increased demands placed on the service during the pandemic meant that staff were redeployed to other areas. Some staff said they did not always feel they had the skills or knowledge to provide care to patients when they had to work on other wards.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The trust had set a target of 80% to receive a yearly appraisal. Appraisal rate for medical division was 57% on 31 January 2022. The current appraisal monitoring system did not enable the trust to provide appraisal rates for individual departments. The trust had identified this as an area for improvement and planned to introduce a new appraisal system in April 2022 that would allow this data to be collected.

Multidisciplinary working

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

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were daily multidisciplinary board rounds where doctors, nurses and allied health professionals discussed patient care.

Staff worked across health care disciplines and with other agencies when required to care for patients. If oncology and haematology patients required radiotherapy, this was provided by a neighbouring NHS trust. There were clear pathways for these patients and the plan of treatment was made during multidisciplinary meetings that included staff from both trusts.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff had access to a mental health liaison team that was provided by another organisation.

The divisions worked across the trust's acute and community services. They worked collaboratively to improve outcomes for patients and avoid admissions to hospital.

Seven-day services

Medical care (including older people's care)

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

There were medical consultants working seven days a week. At weekends consultants were on site between 8am and 8pm. At other times, a consultant was available for advice or to attend the hospital in an emergency.

Out of hours interventional radiology was available for patients who presented with an emergency. The trust provided diagnostic radiology such as scans or x-rays seven days a week.

The endoscopy service was currently a five day service but was in the process of recruiting staff so the service could be extended to a seven day service.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle. For example, we saw a poster about living well with cancer.

Cancer patients were offered a recovery programme after treatment which included exercise, diet and access to a clinical psychologist. The aim was to support patients to return to a normal life after their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limited patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering the patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were mostly completed correctly. Records of Do not Attempt Cardiopulmonary Resuscitation decisions showed mostly were completed correctly. One record of the five looked at did not have detail about who the decision had been discussed with.

Staff understood the use of Deprivation of Liberty Safeguards. Records showed staff completed applications for Deprivation of Liberty Safeguards correctly. Staff understood that unless they were advised differently, applications for Deprivation of Liberty Safeguards had been approved.

Medical care (including older people's care)

Is the service caring?

Good ➔➔

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. In most wards, call bells were answered promptly by staff. Curtains were pulled around the bed area to provide privacy when needed. However, staff experienced challenges in promoting patient's privacy and dignity when they were being cared for in corridor areas.

Most patients said staff treated them well and with kindness. However, a few patients mentioned some staff were brusque in their approach which patients attributed to staff being short staffed and pressured.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke with clearly understood patient needs. There was an awareness of loneliness, particularly in respect of restrictions on patients receiving visitors due to the current pandemic.

The trust's palliative care team provided support to patients and their families who were in the final stages of their illnesses. The trust provided a bereavement service for families who had a relative die when in the hospital. This service provided emotional and practical support for families who had been bereaved.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us staff had clearly explained their care and treatment and we saw clear communication between staff and patients. Patients commented that the clinical nurse specialists working in cancer care always gave them information in a manner they understood and in a timely way.

Medical care (including older people's care)

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. All areas invited patients to provide feedback using the national Friends and Family Test (FFT). This was paused during the pandemic and had recommenced in April 2021. Data from the December 2021 Friends and Family Test showed most medical wards and units had positive feedback.

However, ward 18 had a 38% negative response for patients reporting they had a poor or very poor experience. The trust monitored patient experience closely and had linked patient experience to both mortality and financial management. The Quality and Clinical Governance committee received a monthly report that considered patient experience by both protected characteristic and by geography. Where patient experience data suggested negative data, this was reviewed and support provided to improve.

Staff supported patients to make advanced decisions about their care. The trust's palliative care team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed patients about their care. Staff had access to specialist teams who supported patients.

Is the service responsive?

Requires Improvement 

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

Service planning and delivery to meet the needs of the local people

The service planned and provided some services in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, facilities and premises did not always support the delivery of a service to meet patient needs

Not all facilities and premises were appropriate for the services being delivered. They did not always support the delivery of a service to meet patient needs. The Short Stay frailty unit was in an area of the hospital that had not originally been designed for the care of older frail people. There was no facility for social interaction and stimulation for patients and the environment was not adapted to meet the needs of patients living with dementia.

The practice of accommodating patients in non-designated areas, such as corridors and in the middle of patient bays did not enable staff to protect the privacy and dignity of patients. We observed one event when a patient's privacy was compromised when using toileting facilities and staff spoke about challenges in promoting patient's privacy and dignity when they were being cared for in corridor areas. It is acknowledged that the impact of the pandemic had resulted in significantly increased demand and that there was a need to use escalation areas more frequently.

The trust sometimes had to move patients into designated escalation areas. These included corridors and inpatient bays (whilst awaiting other patients to be discharged). Data provided by the trust showed that between September 2021 and February 2022 there were a total of 85 patients accommodated and cared for in non-designated areas in AMU with a total of 43 patients in ward 10 and a total of 24 patients in ward 6. Patients accommodated and cared for in non-

designated areas are at increased risk of poor care and avoidable harm as it is difficult to monitor patients and to carry out clinical practices and interventions. At the time of the inspection, the hospital was at maximum capacity and the hospital was trying to reduce the risks of infection transmission. All patients were cared for in line with the trust pre-emptive transfer policy.

Throughout the hospital signs to wards were not always clear. For example, one sign to the medical short stay unit (ward 10) said ward 10 (AMU). This could confuse people looking for the medical short stay unit.

However, managers planned and organised some services to meet the changing needs of the local population. For example, the oncology and cancer service worked in partnership with the local cancer alliance group to develop services to meet the needs of the local population. This included supporting communities who were identified as less likely to take part in cancer screening programmes.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no reported mixed sex breaches in the past 12 months.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments for some patients to help them access services.

The needs of patients living with dementia were not always fully met. The trust had "This is me" documents but acknowledged that there was more work to be done to ensure consistent use. For patients with dementia, confusion or distressed behaviours, care plans did not provide guidance about how to best manage their behaviours and confusion.

Staff made sure patients living with mental health problems and learning disabilities received the necessary care to meet all their needs. Staff were aware of the external mental health liaison team and knew how to contact them for advice and guidance about how to support patients with mental health problems. The gastroenterology ward employed registered mental health nurses through temporary staffing to support patients admitted to the ward with anorexia.

The trust had a learning disability liaison team who provide guidance and advice to staff and were an advocate for patients with a learning disability. They supported the patient through their pathway, ensuring consent and mental capacity assessment processes were carried out properly. They also supported the patient through any procedures or interventions. They helped staff to make any reasonable adaptions to improve the wellbeing of patients with a learning disability.

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

Access and flow

People could access the service when they needed it, but it was not always possible to provide the care and treatment in the most appropriate ward setting for their condition.

Managers monitored patient moves between wards. Staff reported patients had frequent bed moves between wards, and some of these were overnight. Staff said bed moves over night were sometimes in response to reallocating patients to reduce risk of transmission of Covid19 or to reduce the risk of patients waiting over 4 hours for admission from the emergency department. In the six months preceding the inspection the average number of bed moves per patient was 1.

For the same period the number of patient bed moves between 10pm and 6am was 3699. One older patient was moved between two medical wards overnight. Another patient who had been admitted to ward 10, was moved to the acute medical unit during the night, followed by being moved to ward 6 two days later. A third patient said that during their admission to the hospital they had moved wards several times and had been on five different wards. On one night seven patients were moved from the medical short stay ward (ward 10) overnight. However, senior leaders said they tried to move patients only when there was a clear medical reason or in their best interest.

Senior leaders said they involved nursing staff in decisions about patient flow. Ward leaders were given the accountability to select the patients who were most appropriate for their wards and pull them through from AMU, so the patient was on the most appropriate ward which resulted in optimal care and fewer moves. However, findings from the inspection showed this was not always possible with high demand and admission levels.

Patient flow through the hospital was monitored and managed through site meetings held three times a day. This was attended by discharge coordinators and senior representatives from the divisions across the trust. This meeting identified where there were medical outliers, (medical patients accommodated on non-medical wards), and patient discharge delays that were affecting patient flow throughout the hospital. There was evidence that increased demand during the pandemic had resulted in additional patient bed moves between wards, with some patients having multiple moves. In January 2022 there were a total of 110 medical patients accommodated on non-medical wards.

The trust had taken some action to support admission avoidance. This included the rapid early assessment care team (REACT) working with the frailty team, a physician of the day and an elderly care physician of the day.

Managers and staff worked to make sure that they started discharge planning as early as possible. Plans for patient discharge were documented in patient records and discussed at multidisciplinary board rounds. Patient documentation promoted staff to start planning for patient discharge soon after admission.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas. Details about how to raise a concern or make a complaint were displayed on the trust website and displayed in ward areas. The service displayed quality boards in the ward areas. Staff updated these boards monthly and recorded the number of complaints received for each area for patients and visitors to see.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. The ward and unit managers were responsible for investigating complaints in their areas

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Complaints were reviewed at divisional and service delivery unit governance meetings.

Medical care (including older people's care)

Is the service well-led?

Good 

Our rating of well-led remained the same. We rated it as good.

Leadership

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

Medical care, as reported on in this inspection, was in three divisions, namely integrated elderly and community care, specialist services and integrated medicine. Leaders of each division worked in a multi professional triumvirate which included an operational manager, medical consultant and divisional head of nursing. Each division was further divided into service delivery units also led by senior nurses, clinicians and operational managers

Ward staff said they were well supported by their immediate managers who understood and managed issues the wards faced within their ability. We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues

Matrons met with ward leaders on a one-to-one basis and discussed issues such as workforce and current trends and themes around risk and issues. However, a few staff said they did not feel supported by senior leaders. They felt senior leaders did not always understand the challenges, issues and risks of their services.

Staff were encouraged and supported to develop their skills and take on more senior roles. The trust had multidisciplinary leadership programmes for leaders already in post and was introducing development programmes for staff aspiring to be leaders.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Staff at all levels could describe a vision and strategy for their individual wards. The trust wide vision was displayed in all ward areas. Divisional leaders said divisional strategies were developed based on the needs of the local population and were aligned to the trust vision and strategy.

The trust vision “Outstanding care, healthy communities and a great place to work” was included in all trust documents and in records of leadership and governance meetings.

Culture

Medical care (including older people's care)

Staff were focused on the needs of patients receiving care. The service provided opportunities for career development. Staff did not always feel respected, supported or valued

Staff felt valued and supported by their immediate managers and spoke highly of their jobs. At a ward and unit level, staff said there was good teamwork and peer support.

Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients. However, some staff felt unsupported by some of the senior leaders, matrons and heads of nursing. Staff spoke positively about wellbeing resources provided by the trust.

In the 2021 National NHS staff survey, the trust scored above the benchmark of similar trusts for 9/10 questions. It scored 7.4 out of a maximum 10 for compassion and inclusiveness and 7.1 out of 10 for compassionate leadership.

Staff felt they could raise concerns and those concerns would be acted on. Staff said immediate managers listened to their concerns and acted on them. This included raising concerns about any poor behaviours and practices of staff. Staff knew how to access the Freedom to Speak Up Guardian if they needed to raise concerns about staff behaviours and practices in a safe and confidential manner.

Some staff were unhappy that they had needed to work in areas and on wards they were unfamiliar with because of the need to maintain safe staffing during the pandemic. Some staff said they did not always feel they had the skills or knowledge to provide care to patients when they had to work on other wards as part of the Safe Staffing Model. They felt senior leaders did not understand or acknowledge these concerns.

The workforce across the medical services was multicultural. Staff felt their identity and culture was respected.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance structures within the trust with good representation from all disciplines. Divisional governance group meetings fed into the quality or governance meetings which reported to the executive management committee and to the sub committees of the board.

There was a clear governance structure within the divisions. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and were clearly recorded. Actions could be tracked, and minutes showed they had been completed.

The trust board received routine reports on cancer waiting time performance. The report showed the trust's performance against each of the cancer operational standards and the actions taken to improve and sustain cancer performance.

Management of risk, issues and performance

Medical care (including older people's care)

Leaders and teams used systems to manage performance effectively. Leaders and teams identified local risks and escalated those which scored more highly. However, they did not always identify local actions to reduce the impact of the risks.

Risks were recorded at ward, division and trust level, in accordance with the governance framework. It was clear from the corporate and divisional risk registers that high scoring risks were escalated and considered at a more senior level and for the most significant risks at board level.

Staff identified their top risk as the negative impact of the number of patient moves, patient flow and staff having to work in specialties where they had limited knowledge about the patients' conditions. They were concerned this would affect patient safety. This risk was not reflected across all the divisional risk registers.

Records of governance meetings showed that risks were considered at most meetings. Most risk registers, such as the one for integrated elderly and community care clearly set out who was responsible for the risk and the dates the risk had been reviewed which included actions taken to reduce the risk. However, not all risk registers demonstrated risks were reviewed. For example, the integrated medicine risk register had entries dated 5 February 2021 that had a projected date of completion of 28 February 2021. There was no detail about who was responsible for the management of that risk and there was no detail to show those risks had been reviewed since entry onto the register.

Wards and units had business continuity plans, which included action cards for staff to follow in the event of situations such as loss of power, lack of staff or failure of equipment. Following identification of a risk to the interruption of power supply to services, a new power supply line was installed. The old line was repaired which resulted in a backup power line in the event of the main line failing.

A programme of audits measured the performance of the service, including staff adherence to trust policies and guidance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The trust collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The trust's website provided annual quality performance reports and board reports which included data about performance. This gave patients and members of the public a range of information about the safety and governance of the hospital. Senior leaders had confidence that data was accurate and reliable. The service had employed a data analyst who supported clinical staff with identification and interpretation of data needed to accurately monitor the service.

Each area we visited had several computer terminals to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use

Engagement

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

Medical care (including older people's care)

Leaders encouraged staff to share ideas for improvement. Quality improvement boards and 'you said, we did' boards were displayed in wards and unit areas.

Services had collaborated with partner organisations during the pandemic to help improve services during the pandemic for patients with cancer and to encourage specific communities to access cancer screening programmes.

Staff advised us there were regular staff meetings and that managers arranged these for different times and days to ensure all staff were able to attend regularly.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Medical services demonstrated several actions they had taken to develop the services they provided. All wards and departments were being supported to identify areas for improvement and use quality improvement methodology to bring about the changes. For example, ward 10 had a quality improvement board that identified projects and monitored progress. All staff could contribute to identifying areas for improvement.

To support a better flow of patients through the hospital one ward was trailing a live bed board on one ward so that staff could immediately see what the occupancy of the hospital was like. A nationally recognised patient flow programme was being introduced to offer a better patient experience by reducing length of stay whilst improving patient flow, safety and multidisciplinary working.

The respiratory service, in response to national guidance, had set up a non-invasive response and retrieval service. This meant all patients requiring non-invasive ventilation were treated and cared for on the respiratory ward where staff had the required specialist skills.

Surgery

Good  

Is the service safe?

Requires Improvement  

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

Mandatory training

The service provided mandatory training in key skills to all staff. Managers did not always make sure everyone completed it.

Managers did not always have oversight of mandatory training and did not always alert staff when their training was nearing expiry.

Nursing staff received mandatory training but did not always keep up to date with it. The average compliance with mandatory training was 85%.

Medical staff received mandatory training but did not always keep up to date with this. The average compliance with mandatory training was 72%. Neither the nursing staff nor medical staff groups met the overall target of mandatory training of 90%.

Mandatory training was comprehensive and met the needs of patients and staff. Staff accessed training either online or face to face with experienced staff working at the trust. Mandatory training included topics such as sepsis, infection prevention and control, manual handling and safeguarding.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse in adults and children and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. This included training in both adult and children safeguarding. Staff could access the trust's safeguarding team and ask for more training if needed.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had information boards displaying contact details for internal and external safeguarding support.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Surgery

The service had posters to explain how and when to don and doff personal protective equipment (PPE) such as gloves and aprons. Ward staff did not always follow infection control principles in the use of PPE. They did not always remove PPE correctly and did not follow the guidance. Staff did not always make sure visitors used PPE correctly. For example, we saw visitors of an end of life patient entering and leaving the bay without following the guidance of donning and doffing personal protective equipment.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. However, staff did not always complete cleaning records and did not always label equipment with 'I am clean' stickers. They could not have assurance of how often staff cleaned ward areas and if it met local standards.

We saw in some areas that staff used boxes holding sterile medical equipment to prop open fire doors to storerooms. This meant that sterile equipment was potentially compromised.

The service had large notice boards on the wards with infection prevention and control information and advice. Staff reported they felt supported by the infection prevention and control team.

Staff used infection control measures in aerosol-generating procedures in theatres (these are procedures that stimulate coughing and promote the generation of aerosols which can spread infection). For example, they wore fit tested masks, visors and protective goggles. However, theatre staff did not always wash their hands after taking off their gloves.

Staff in the main and day theatres did not have a checklist for cleaning or checking equipment. Staff told us they cleaned and checked equipment. However, the service could not be assured this was done.

To mitigate COVID19 transmission risks each patient could have one visitor within a 5-hour timetable. Staff ensured visitors had done a lateral flow test on the day of the visit. Staff completed a COVID19 checklist for every visitor.

Staff did not always make sure that sharps bins were dated, and we saw several sharps bins left open. This was not safe as it could increase the risk of needlestick injuries to healthcare staff.

Environment and equipment

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

Patients could reach call bells, but we saw that sometimes staff could not always respond quickly. The trust usually did call bell audits, but these were less frequent during peak demand. The most recent audit showed that in the first quarter of 2022, that call bells were answered within 3 minutes 96.4% of the time, across the trust.

We spoke to one patient who reported she timed her toilet breaks in advance to ensure a staff member took her to the bathroom. The patient reported she called for staff on behalf of another patient who did not have the ability to do it themselves.

Doors which staff should have been kept closed, or closed and locked, were propped open leaving patients and staff at risk; for example, a storeroom of medical equipment, including scalpels. Staff had not secured the dirty utility room and left containers of detergent and cleaning materials accessible to unauthorised people.

Surgery

Some equipment in the storeroom on ward 16 had passed their expiry date. We informed the nurse in charge who arranged for staff to dispose of all expired items at once.

The service did not always dispose of clinical waste safely. In theatres the flow of clean and dirty instruments and waste was compromised although staff followed the correct practice for a department that does not have a dirty corridor in its design. Clean and dirty instruments were carefully managed to ensure cross contamination was avoided. Staff had to carry dirty items along the general corridor to the dirty utility room. Theatres shared the linen and waste bins with the Radiology Department. Staff left access doors to the dirty utility area unlocked.

The theatre environment was cramped with equipment but clean and tidy. Staff we spoke with reported the trust had no central storage facility. We did not see 'I am clean stickers' in use in the theatre environment. This meant that staff could not be assured that equipment had been cleaned. Staff did not consistently date or change sharps bins in theatres and anaesthetic areas.

Emergency/general theatre staff carried out daily safety checks of anaesthetic machines including the change of disposable tubing. Theatre staff checked, recorded, and sealed resus equipment regularly for expiry dates and stock.

The service secured fire extinguishers to the wall and tagged them with a recorded date. This was in line with the Regulatory Reform (Fire Safety) Order 2005.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. However, staff identified and quickly acted upon patients at risk of deterioration.

We looked at 15 sets of patient records across the surgical service. Staff did not always fully complete patient risk assessments on admission and did not always review these regularly. Examples of risk assessments include the pressure damage risk assessment, falls risk assessment and the Malnutrition Universal Screening Tool (MUST). The service used a combination of paper and electronic patient notes and it was not always clear what staff recorded on paper or electronically.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Theatre staff told us they had access to clinical teams 24 hours a day in case they needed support with a deteriorating patient.

Staff knew about and dealt with any specific risk issues. The service assessed patient's risk of sepsis, venous thromboembolism (VTE), falls and pressure ulcers. The service displayed monthly data of completion of these assessments on information boards in the ward areas. We saw staff notice boards displaying information on how to spot sepsis and how to prevent falls.

Staff checked emergency resuscitation trolleys regularly. We checked four trolleys, and all were clean, organised, and fully stocked with in-date equipment. Staff secured all trolleys with numbered tags and recorded checks appropriately.

Staff in an ophthalmic theatre did not use the correct procedure during step 1 of the World Health Organisation (WHO)5 steps to safer surgery checklist. The surgical checklist includes briefing, sign-in, timeout, sign-out and debriefing. WHO guidelines dictate that when a patient does not attend planned surgery, staff must print a new theatre list for the day on different coloured paper to ensure the correct procedures are carried out for the remaining patients. However, staff in main theatres used the WHO 5 steps to safer surgery checklist appropriately and well.

Surgery

Nurse staffing

The service had enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, in common with many trusts, the pandemic and subsequent challenges of higher demand and higher staff sickness rates meant optimum levels could not always be maintained. Managers regularly reviewed and adjusted staffing levels, and gave bank and agency staff a full induction.

The surgical division recognised the risk of staffing challenges and had taken steps to ensure that staffing levels remained safe, if not optimal. There was daily monitoring of nurse staffing levels by the lead nurses/matrons and Head of Nursing in addition to the daily safety huddles where staffing levels were reviewed.

The service used weekly safe staffing meetings to review and plan safe staffing levels and had several measures to ensure that patient care remained uncompromised. These included the use of temporary staff to ensure safe staffing levels and the use of Band 4 practitioners, where appropriate.

A safe staffing review was carried out in February 2022 by a third party contractor. They made recommendations to the trust, several of which were already completed, and others were in progress.

We saw a report produced by the trust comparing planned staffing hours to actual staffing hours for five of the wards. There was variation across all the wards, each having times when the planned nursing hours were not met. This was particularly so for the burn's unit and ward 2. For example, in January 2022 the burns unit only had three days when the planned hours were met.

Managers said they aimed to staff each shift with the right skill mix. This could not always happen as managers often needed to redeploy staff to help on other wards. Some staff told us redeployment occurred regularly. Some staff told us that they did not always feel they had the right experience for these different wards, and this added to their stress. Executive leaders told us that they understood this, but that patient safety had to remain the priority and that meant unavoidable movement of some staff from wards that they were more familiar with.

Ward staff told us that sometimes they had enough nursing staff on the wards but that they did not always have the necessary mix of skill and expertise. Some staff we spoke with reported they felt a low morale due to staffing issues.

Managers limited their use of bank and agency staff where possible. Managers made sure all bank and agency staff had a full induction and understood the service. Staff told us bank or agency staff did not always have the right experience for certain specialisms. For example, this happened on the burns unit where staff required specific skills to look after patients safely.

A consultant in theatres said that the service will not go ahead with an operating list unless safe staffing is in place.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, although there were vacancies that meant the optimum medical staffing levels were not always available. Managers gave locum staff an induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The surgical division also made use of medical support workers to enable medical staff to focus on clinical rather than administrative work.

Surgery

We spoke to one junior doctor who told us there was always a consultant available to speak with. The doctor felt well supported and supervised.

The medical staff across surgical services did not always match the planned number. For example, we saw the medical staff roster for January 2022. This showed a demand gap of 8.3% of medical staff across the month. This meant that whilst the services were safe the staffing was below optimal levels.

Managers made sure locums had an induction to the service before they started work.

Records

Staff did not always keep detailed records of patients' care and treatment. Ward staff did not store records securely. Records were clear and easily available to all staff providing care.

Stoke Mandeville surgical services used both paper-based and electronic patient records. Ward staff did not always store paper-based records securely and left patient files out of notes trolleys or cabinets around the nurses' station.

Patient notes were not always comprehensive. For example, staff did not complete care plans. The trust had developed a comprehensive Hearts and Mind Care Plan package; however, we did not see any care plans in the 15 patient records we reviewed. Therefore, it was unclear what care the patients required.

Staff from all disciplines recorded patient contact legibly and signed and dated their entries clearly. Staff recorded entries in chronological order.

Staff did not always complete legal documents fully. For example, in three out of 15 patients' Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms, it was not documented if the decision was discussed with the patient or a family member. This issue was reflected in a DNACPR forms audit carried out in March 2021. An action plan outlined how the project lead planned to use the audit results in reminding staff of the correct use of DNACPR.

Medicines

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

Staff mostly stored and managed medicines and prescribing documents safely. Staff carried out regular medicine stock checks and ensured they recorded this. Pharmacy teams checked and ordered medicines weekly, recorded this and ensured they rotated medicines so those with the closest expiry date were at the front of the cupboards. Staff locked medicine trolleys and secured the trolleys to the wall. Staff stored controlled drugs safely in locked cupboards.

Staff followed national practice to check patients had the correct medicines when admitted, or when moving between services. We checked six medicine records and found they were legible, complete and up to date following guidance.

On one ward we saw a plastic cup holding blister pack tablets in the medicine cupboard. Staff had not labelled this, and it was not clear whose tablets they were. Staff had cut the blister packs in a way that an expiry date could not be identified. We informed the nurse in charge of this who removed the medication from the cupboard for disposal.

Staff did not check the medicine fridges in theatres or the anaesthetic room every day. The last recorded check was on 1 February 2022, seven days before the inspection took place. Staff had checked the temperature three times in January 2022. An automated temperature monitoring system has been partly installed across the trust to ensure that medicines are stored at the correct temperature. There was further action planned for this.

Staff did not always carry out the required daily checks of the hypoglycaemia boxes on the ward (these are boxes with easy to use, accessible glucose products in case of patient developing low blood sugar levels). We saw that one hypoglycaemia box did not hold the correct glucose ampoule in accordance with trust guidance. It was an 18g ampoule instead of a 21g, which would not cause a significant risk to patients, but the dose calculation might be less familiar to ward staff.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service at meetings, such as the weekly Safety and Quality meeting. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them in line with trust policy. Staff said the trust encouraged the reporting of incidents. Staff reported incidents and near misses on an electronic reporting system. Staff had a choice as to whether they wanted feedback from the incidents they reported. However, they told us managers did not always give feedback when they had asked for it.

Managers on the wards shared learning from incidents via different routes. For example, managers wrote summaries in a newsletter, or printed out the learning from incidents and placed them in staff areas. Some areas had regular multidisciplinary meetings where managers presented and discussed incidents. For example, this happened on the Burns Unit.

Managers debriefed and supported staff after any serious incident. One manager gave us an example of an incident that upset ward staff. Following this incident, the manager arranged specific counselling for all staff involved.

Managers had a database to track action plan progress following incidents, but they did not always update this in a timely manner.

The service had 606 incidents in the six months prior to inspection. The majority of those (97%) led to no harm or low harm (low harm means that patients may require minor treatment following the incident). This level of low harm reporting indicates a very good reporting and safety culture.

Moderate harm incidents (moderate harm is where a patient has suffered short term harm because of the incident and required further treatment/procedure) occurred in 2.8% cases.

One incident led to severe harm (in severe harm a patient has suffered permanent or long-term harm). This is classed a serious incident. Serious incidents are events in healthcare where the potential for learning is so great, or the consequence to patients so significant, that they call for an in-depth investigation which was undertaken and learning shared. This incident was reported and investigated using the national framework.

Surgery

Theatre managers shared learning about never events with their staff. We saw slides from the December Quality and Safety meeting at which managers discussed the most recent never events. The learning points on the slides did not assure us lessons had been learnt and effective processes had been put in place to mitigate this happening again. We spoke with two managers who said virtual meetings made it difficult to assure themselves staff understood the learning.

Is the service effective?

Good 

Our rating of effective remained the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, several of the trust's guidance documents were past the intended review date.

Managers reviewed guidance from the National Institute for Health and Care Excellence (NICE) and cascaded any latest information to their teams via their matrons.

Staff followed clinical guidelines and policies to plan and deliver care according to best practice and national guidance.

However, managers did not review all the clinical guidelines and policies within the review date due to more urgent priorities. The December 2021 surgery and critical care divisional assurance report showed that 46 out of 115 guidelines and policies were out of date and there was potential that some key changes were not made known through the policies. It is acknowledged that policies and guidance were changing rapidly throughout the pandemic and ensuring all policies were current would have been very difficult to achieve.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for prolonged periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Three patients told us the service gave them food and drink choices throughout the day. On the Burns Unit we saw a variety of menus catering for patients with diverse needs and wishes. For example, we saw an African Caribbean menu, an allergen aware menu, and a finger food menu.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition, which was recorded electronically.

However, staff did not always fully and accurately complete patients' fluid and care round record sheets where needed.

Pain relief

Surgery

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

Services had access to a pain team, and we saw members from that team on the wards on both days we visited. Pain nurse specialists routinely review patients daily during the week. They give advice on how to manage pain and deal with problems regarding medications, epidural analgesia, patient-controlled analgesia and local anaesthetic blocks.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw evidence of staff recording this in the patient notes.

Patients received pain relief soon after requesting it. Two patients told us that staff were attentive and ensured patients did not suffer pain needlessly. One patient said, "my pain has been controlled, staff have been attentive in asking about pain and taking action to control it."

Patient outcomes

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

Performance against national audits and surveillance was better than other similar trusts. For example, the surgical site infection rates for hip and knee surgery were 0%.

The service took part in relevant national clinical audits. We saw there were 28 clinical audits on the surgery and critical care divisional programme. All audits were given a priority rating, ranging from low, medium, high, and very high. The service recorded start dates and planned completion dates. The service recorded the audit leads for each clinical audit. Managers checked clinical audit activity (reviews and action plans) and it was a standing agenda item on the monthly divisional assurance report. We saw the slides of the divisional assurance report from November 2021. This showed that, in six cases, staff had completed audits but that action plans relating to those audits had not been monitored since completion.

Managers cascaded outcomes and learning from clinical audits to the matrons. Matrons held a monthly quality meeting in which they cascaded the information to their teams.

Surgery matrons told us monthly quality meetings had been less interactive in recent months. Matrons said they did not feel assured the information shared in the quality meetings was always listened to.

Managers ensured serious incidents or never events led to clinical audits. For example, managers reinstated the World Health Organisation (WHO) surgical safer checklist audit programme following a never event in ophthalmic theatres.

Competent staff

The service ensured staff were competent for their roles, but the pandemic had reduced the delivery of face to face and specialist training available. Service demands meant that managers could not always support their staff's development. Appraisal completion rates were below target.

Staff told us they had the opportunity to discuss training needs with their line manager. However, throughout the pandemic managers had not always been able to ensure staff had the time and opportunity to develop their skills and knowledge.

Surgery

Managers made sure clinical ward staff received any specialist training for their role. The service had a rolling programme of clinical skills and simulation courses to ensure clinical staff attained and maintained the skills to deliver safe patient care. This programme included training for new staff, updates for existing staff and additional training opportunities. For example, the programme included courses on intravenous therapy, deteriorating patients, and anaesthetic trainee simulation.

Practice Development Nurses (PDNs) supported the learning and development needs of nursing staff on the wards. For example, they taught ward-based blood transfusion to new nurses. However, PDNs were not always able to perform their role as an educator due to managers redeploying them for clinical support on the wards.

New theatre staff completed an induction programme which included a competency document. New international staff had mentors who assessed them throughout their competency programme. Managers kept records of this in personnel files.

A few theatre staff felt that they did not have the time to complete training. Theatre staff said the education team in-house was large, but due to theatre work being very specialised, the education team did not conduct training for theatre staff.

Staff felt supported by their direct managers and were able to discuss situations as they occurred. Surgery matrons said they had launched a supervision programme 6 months prior to the inspection. However, ward staff we spoke with were not aware of this programme.

Managers said they supported nursing and healthcare staff, admin and clerical staff, and Allied Health Professionals to develop through yearly, constructive appraisals of their work. Staff we spoke to found this helpful. At the time of the inspection 72% of staff had received an appraisal in the previous 12 months, which equated to 582 staff members. Whilst this did not meet the trust target completion rate of 807 staff members, it was acknowledged that staffing priorities had to change during the pandemic.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to help patients. They supported each other to provide good care. Staff worked together to plan patient discharges.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care or plan their discharge. We joined two meetings and saw staff had holistic discussions about their patients.

Staff ensured that they referred patients with complex needs to the community care hub. This is a team of staff from healthcare and social care who work together to look after patients in the community. The service at Stoke Mandeville Hospital had ward-based discharge coordinators who liaised with relevant services to plan patients' discharge.

We saw different healthcare professionals visiting the wards, including occupational therapists, physiotherapists, community team members, and pain team members.

Patient-related meetings included all necessary key information to keep patients safe. We attended two multidisciplinary ward meetings. Nursing and therapy staff discussed patients' medical status, discharge plans, and social situation. Staff listened to each other and made decisions as a team.

Surgery

In theatres the team present for surgical procedures included the consultant surgeon, the consultant anaesthetist, the anaesthetic practitioner, the recovery nurse, and the circulating nurse.

Seven-day services

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

The surgical service at Stoke Mandeville Hospital was available 24 hours a day, seven days a week.

Consultants led daily ward rounds on all wards, including weekends. Consultants reviewed patients depending on the care pathway.

Staff could call for support from doctors and other disciplines, 24 hours a day, seven days a week.

Consent and Mental Capacity Act

Staff did consistently follow national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

All patients undergoing surgery signed a consent form after the benefits of the procedure and any associated risks had been explained. The consent was checked again before the patient was anaesthetised. Consent was obtained by staff who had the knowledge to explain the risks and benefits of the procedure to the patient.

There were no recorded incidents relating to lack of consent for patients undergoing surgery.

Consent audits had been suspended during the pandemic because of the need to maintain safe staffing on wards and patient facing areas. The most recent audit identified several improvement actions that were being followed up by the trust.

Ward nursing staff understood how and when a patient's capacity had to be assessed to make decisions about their care. Staff told us only members of the medical teams could carry out formal capacity assessments. We saw one example of a consent form 4 in a patient's notes (a consent form 4 is relevant for adults who are unable to consent to an investigation or treatment).

We did not always see evidence that medical staff made decisions in their patients' best interest when they were unable to give consent. Medical staff did not always clearly record consent in the patients' records or complete a consent form fully.

Surgical matrons said staff carried out the Abbreviated Mental Test Score (ATMS) where they had concerns about a patient's capacity. We looked at the patient record of a person with dementia who had scored 2/10 (a low score showing reduced cognitive ability).

Is the service caring?

Good 

Surgery

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Patients told us staff treated them kindly and attentively and always helped them when necessary. Staff took time to interact with patients and those close to them in a respectful and considerate way. It was clear through observation and conversations that staff considered patient care to be at the heart of what they did.

Staff followed policy to keep patient care and treatment confidential. Staff closed curtains and spoke discreetly to prevent people outside of the curtains overhearing.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw a nurse taking time to speak with a patient whose first language was not English.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

One patient said "staff have been lovely and attentive. They have given me lots of information". Another patient said, "staff always help me when I need them".

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. One patient we spoke with told us she understood all elements of her care and was able to ask questions whenever required.

During a discharge planning meeting we saw discussions included patients' wellbeing, family support and needs on discharge. This was a multidisciplinary meeting which allowed a comprehensive approach, looking at patients as individuals.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. On the Burns Unit staff gave patients the Friends and Family test on discharge.

Surgery

Patients gave positive feedback about the service. We saw thank you cards displayed on notice boards in the ward areas. On the Burns Unit staff regularly updated a notice board with patients' most recent feedback from the Friends and Family test and we saw this was all positive.

Is the service responsive?

Good

Our rating of responsive remained the same. We rated it as Good.

Service delivery to meet the needs of local people

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. In the surgical core service at Stoke Mandeville there were no mixed sex breaches during the period January 2021 to January 2022.

During the pandemic the trust had needed to made changes to some clinical areas. For example, in the Day Surgery unit, the recovery area turned into five Intensive Care Unit (ICU) beds and this was still the case when we visited. Staff told us the Day Surgery discharge lounge now had one bed rather than two. Staff said this made it challenging to allow for a fast patient flow. Patient flow was managed in accordance with the trust Full Capacity Policy and Pre-emptive Care Policy, which did result in moves that were essential to maintain safe care and treatment. At the time of the inspection, the trust was over full capacity.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access community services, for example Social Services, to plan proper patient discharges.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The hospital used a passport system, 'This is me', to inform staff about the needs and preferences of people with learning disabilities or dementia. Ward 2 had a notice board displaying information for staff about frailty and cognitive impairment. A patient we spoke to on ward 16 said they tended to press their call button for another patient who had dementia and was unable to do so themselves.

The hospital had a pastoral, spiritual and religious support service. They offered emotional and confidential support for patients and family members who wanted to make sense of their situation. They also offered spiritual and religious support including opportunity for prayer or reflection face-to-face or virtually.

The hospital supported loved ones to stay in touch, even when they were unable to visit. This included a letter to loved one scheme where friends and relatives could write a message in an email and include a photo which was then printed put in an envelope and delivered to the patient.

Managers made sure patients, and their carers could get help from interpreters when needed. Staff told us interpreting usually happened via telephone but face to face and signing could be arranged.

The trust had specialist nurses that provided support for adult patients with learning disabilities and autism. They helped with communication, care needs and supported families and carers.

The 'Snowdrop' side room included one ring-fenced bed on ward 16, for women having an early pregnancy loss. Staff told us, due to the nature of this care, ideally one staff member should be available to look after the patient on a one-to-one basis, although this was not always possible due to staffing needs across the service. The service was recruiting a part time bereavement officer in addition to support that was already available, if needed.

Access and flow

People could access the service when they needed it and received the right care.

The pandemic had an impact on patient flow. Services had to change the way they provided care and treatment. For example, the day surgery unit had to develop a new pathway to continue a safe patient flow.

The surgical service moved patients between wards at night. The figure for the 12 months before the inspection showed that staff had made 2710 bed moves between 10pm and 6am to ensure that people were protected from increased risk of infection transmission and to move people out of the emergency department.

As part of the trust Full Capacity Policy and Pre-emptive Care Policy, staff sometimes had to care for patients in corridors as there were not enough beds available. We saw these patients spent hours waiting for a bed to become available on wards. Patients received safe care and treatment, but were not receiving the best patient experience

Very occasionally patients were kept overnight in the recovery bay due to beds being unavailable on the wards. It was safer to keep people in the recovery area after surgery than move them to a less well-resourced escalation area.

Managers and staff did not always work together to make sure they planned patients' discharge from hospital. We spoke to staff who told us there were sometimes disagreements on scoring patients using an acuity tool (the acuity tool measures a patient's severity of illness or medical conditions in order to rate the dependency needs of the patient. The lower the score, the more independent patients are and the safer they are for discharge).

Staff reported that managers often reviewed scores to ensure they were safe and accurate but maintained patient flow. For example, staff told us about a patient who needed continuing support and treatment. When managers were on the ward, they saw this patient mobilising independently to the coffee machine. Managers felt this patient's score should be a zero and that they should be ready for discharge, which differed from the ward nurse's perception. This meant there was professional discussion about the needs of the patients.

Staff supported patients and their families/carers when they were referred or transferred between services. For example, they ensured that they did not discharge patients until a care package in the community was in place.

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service displayed quality boards in the ward areas. Staff updated these boards monthly and recorded the number of complaints received for each area for patients and visitors to see.

The head of nursing kept data on the number of complaints received across surgical services and shared this with staff in the monthly divisional assurance report. In the 12 months prior to inspection, the surgical service at Stoke Mandeville Hospital received a total of 132 formal complaints.

The head of nursing monitored response rates to complaints. In November 2021 four complaints (out of 14 complaints) breached the target of a response to the complainant within 25 days (=28.6%). The Head of Nursing tasked divisional managers with putting in place mitigation plans to improve response rates.

Managers investigated complaints and identified themes. Managers put in place action plans following complaints to improve patient care.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We spoke to staff on ward 2 and they were able to tell us about the most recent complaint.

Managers on the Burns Unit shared feedback from complaints with staff at monthly multidisciplinary meetings and the team used learning to improve the service. On ward 16 the nurse manager shared feedback from complaints in a document that they emailed to staff. This included an overview of complaints, things the team did well, things they got wrong, and an action plan. Staff also shared learning on a private ward social messaging platform, during handovers and during huddles.

Is the service well-led?

Good 

Leaders had the skills and abilities to run the service but had been working under sustained pressure due to the pandemic. This impacted on relationships with operational teams, as they had to make unpopular decisions sometimes. They understood the priorities and issues the service faced but a few staff said that they did not always communicate this well.

A senior lead told us they tried to visit each area across the two sites of Stoke Mandeville Hospital and Wycombe Hospital. However, this was not easy due to the considerable number of areas.

Staff on most wards told us they felt supported by their immediate managers. They felt their immediate managers were visible and always available to talk to.

Surgery

A few staff told us relationships with the management team had deteriorated since the pandemic begun and that everyone was working under pressure. They told us they often received operational information later than was ideal.

On the Day Surgery unit staff told us they did not feel they had enough support from leaders when they had to change the way they provided care during the pandemic. The team on the unit developed their own new pathways and some felt that this was done without senior management involvement.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision aligned to local plans within the wider health economy.

The trust's vision and strategy focused on outstanding care and 'a great place to work'. The trust strategy set out how the trust was planning to achieve their vision. The strategy aligned with local and regional plans, the health and social care of the local community, and with NHS long term plans. The trust had reviewed their strategy, considering the changes made during the pandemic. Divisional plans were in the early stages of development.

Culture

Staff focused on the needs of patients receiving care. The service had an open culture where patients and their families could raise concerns without fear, although a few staff told us they did not always feel comfortable speaking up.

We heard from a few people that staff's morale was affected by work pressures and demands due to the impact of Covid19. Nursing staff felt supported by their direct line managers and peers on the ward. They told us teamwork was excellent and that they helped each other to manage their shifts.

Medical staff told us they felt supported by their managers and that the senior leadership team were approachable.

The trust had a Freedom to Speak Up Guardian. However, a few staff said did not always feel they could speak to them. We spoke to staff in theatres who suggested that someone external to the trust may encourage staff to speak up more. Nursing staff did not always feel that they could speak up outside of their immediate team.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear management structure in place. The divisional director, divisional chairs and head of nursing met regularly to discuss any issues. There were monthly specialty level and care group level meetings to discuss governance and risk. Each surgical specialty had routine monthly governance meetings and governance and operational performance was reviewed.

Surgical service staff met regularly to provide divisional assurance. These meetings were minuted and relevant information cascaded to clinical teams.

Services displayed some monthly safety thermometer data on quality boards on the wards. This included the number of falls, the number of hospital-acquired infections, and the number of pressure ulcers.

The head of nursing produced a monthly divisional assurance report including data about, for example, trust risks, safeguarding and Deprivation of Liberty Safeguards, incidents, complaints, and safety thermometer information.

Management of risk, issues and performance

Leaders and teams used systems effectively to demonstrate that they had identified and managed risks within the service. They identified and escalated relevant risks and issues but at a local or ward level, risk registers did not always record the action taken to reduce the impact.

Risks were a standing agenda item at the divisional board meetings. We saw the board discussed new and emerging risks and minuted these.

The risk register for surgery, dated March 2022, showed key risks had been identified and that mitigation and monitoring arrangements were considered. For example, one of the most significant risks identified was a risk of potential clinical harm attributed to patients waiting for elective surgery as a result of the pandemic, where elective surgery was reduced. This has also affected the delivery and sustainability of the national standard for Referral to Treatment Time (RTT) There is an increased likelihood of 52-week breaches occurring in all surgical specialties and increasingly number of 104-week breaches. In order to monitor and manage the risk, RTT performance was monitored and improved though:

- weekly Patient Tracking List meetings.
- weekly Access Performance Management Group (APMG) meetings.
- weekly performance escalation meetings chaired by the Chief Operating Officer.
- daily 104 week breach meetings
- vetting of all referrals of all surgical specialties
- apriority post COVID19 elective recovery planning (commenced April 2020)
- maximising the use of the Independent Sector Outsource work via the ICS for orthopaedic surgery

There were long standing risks identified and they remained included because the risk persisted, despite trust actions. This included an entry where an increase in GP referrals created a risk that ophthalmology capacity would be unable to meet demand, resulting in appointment delays for first and follow-up appointments with the medical retinal specialty the most affected. As the population served by the trust had an ageing demographic, the demand and referral levels continued to rise and needed ongoing consideration. Therefore the risk remained on the register.

We saw minutes from the monthly divisional board meeting. Alongside risks, the board discussed the financial position of the trust, Human Resources, and the trust's performance. We saw clear actions and action leads identified.

The surgical service had ward-based risk registers. We reviewed the risk registers for general surgery, trauma & orthopaedics, and plastics and burns. It was not always clear what plans they had put in place to mitigate risks as actions were not always documented on the risk registers. There was an inconsistent approach to identification and documentation of risk. Staff took an inconsistent approach to reviewing risks with some not reviewed for several years.

Surgery

We saw minutes from the November 2021 meeting of the Risk and Compliance Monitoring Group. The group discussed the top three highest scoring risks of the surgery and critical care division. We did not see the consistent use of target dates for the completion of actions. Minutes did not reflect when risks had been added to the register.

Information Management

The service collected data. Staff could find the data they needed to understand performance and make decisions. The information systems were secure.

The surgical service at Stoke Mandeville used a combination of electronic and paper patient records. Staff recorded some data on an app on a work phone. For example, staff put the National Early Warning Score (NEWS) data and the Malnutrition Universal Screening Tool (MUST) information on the app. Staff recorded other information in the paper records. For example, fluid charts and risk assessments. This meant that staff had to check both the paper based and the electronic records to gain a picture of their patients' care and treatment.

Staff accessed most of their mandatory training online. Once they had completed the training managers received electronic confirmation of this.

Staff understood their responsibilities around the General Data Protection Regulation 2016. Computers were password protected and screen-locked during the inspection.

Engagement

Leaders and staff actively and openly engaged with staff and patients.

Nursing staff could access information through a variety of routes. Staff received newsletters relevant to their specific area and a daily communication bulletin relevant to the trust. Staff could also access social messaging platforms set up for each ward.

A senior leader told us that matrons carried out walk arounds. Matrons checked on patients as well as on their staff during these walk arounds. Matrons encouraged patients to give feedback to aspects of their care.

The leadership team told us they encouraged all staff to speak up. They told us that all staff had access to grievance policies and mediation if needed.

Learning, continuous improvement and innovation

The trust used several sources to improve services. For example, audits and clinical audits drove actions around patient care. The service used feedback from patients, both positive and negative, to learn about what they thought was good or could be improved. Managers sometimes used incidents to form the basis for clinical audits or projects.

The service displayed 'you said, we did' information boards on the wards. For example, during the pandemic patients asked for single use pens to be handed out on admission. The service sourced single use pens. A patient raised a concern that staff had poor knowledge of food intolerances and the service developed the resource folder for this topic.

Wycombe Hospital

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Description of this hospital

Wycombe Hospital is situated in the centre of the historic town of High Wycombe and 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.

At Wycombe Hospital, we inspected the medical care (including older people's care) and surgery.

Summary of our findings

- Medicines were stored correctly and disposed of safely. Staff kept accurate records of medicines.
- There were clear systems and processes to keep people safe and safeguarded from abuse.
- Most services had enough staff to care for patients and keep them safe.
- Staff had an induction that gave them the skills and confidence to carry out their role and responsibilities effectively.
- Staff gained consent and considered people's capacity to make decisions. Where patients did not have the capacity to make decisions, staff followed best interest practices.
- Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Staff supported patients and their families and personal, cultural, social and religious needs were understood.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- The needs and preferences of different patients were considered when delivering and coordinating services. Patients knew how to give feedback about their experiences, including how to raise any concerns or issues.
- Leaders were visible and approachable.

However:

- The service did not always control infection risk well and staff did not always follow infection prevention policies. Ward areas were not all clean and damage free. In some areas, the hospital did not keep the environment safe, secure and fit for purpose.
- Services did not always ensure products deemed as hazardous to health were stored securely.

Our findings

- Services did not always manage medicines well or ensure emergency medicines were available. Medicines were out of date such as insulin and others were missing from emergency medicine kits.
- Staff did not always maintain care records safely in accordance with trust policy. On one ward records were loose and not kept bound and secure.
- Staff were not always able to effectively contribute to improvements and guidelines were not kept current.

Medical care (including older people's care)

Good ➔➔

Is the service safe?

Requires Improvement ➔

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

Mandatory Training

The service provided mandatory training in key skills to all staff. Within the context of providing acute services during the pandemic, managers could not always ensure everyone completed it.

Staff received mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Training was a combination of online and face to face sessions, and included topics such as infection prevention and control, fire safety and safeguarding. Staff had allocated time to complete mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. They also identified areas of further training and supported staff to complete their training. Staff advised us they were allocated time to complete mandatory training. However, staff completion rates for mandatory training were below the trust target in all departments apart from endoscopy. Some mandatory training was paused so that frontline staff could deal with the pandemic as some face to face sessions were cancelled due to restrictions.

There were no trust requirements for staff to complete learning disability and dementia training, even for staff working with higher numbers of patients who were living with dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received safeguarding training for both adults and children. The level staff were trained to was in accordance with the intercollegiate document. Staff also received de-escalation training but were supported by hospital security if restraint was required.

Staff understood their role and responsibilities regarding making a safeguarding referral and where to find internal support and contact information for the local authority. Posters were displayed in managerial offices detailing safeguarding processes and guidelines and the trusts safeguarding policies were available on the intranet for staff to access.

Staff could describe how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff gave us examples of where they had supported patients with protected characteristics.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

The service controlled infection risk well. Managers oversaw control measures to protect patients, themselves and others from infection.

There was a comprehensive suite of guidance for staff on how to prevent and control the spread of infection. The infection prevention and control (IPC) team completed observations on wards of staff putting on and taking off their PPE, for example gloves and aprons. On inspection, we saw a few staff did not remove their PPE in line with national guidelines. Following our observations, the infection prevention and control nurse immediately spoke with staff.

Protocols had been introduced to reduce the risk of transmission of Covid19. Trust guidance was updated regularly, in line with the national guidance. Hand sanitiser and masks were readily available and visitors were encouraged to use these.

Infection prevention and control audits reviewed hand hygiene, screening and record keeping compliance. Audit results for the six months prior to inspection were in the high eighties.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed ten records and saw they were completed, up to date, and signed. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We checked ten items of equipment, all were visibly clean and had 'I am clean' stickers with that day's date recorded on them. Staff in the endoscopy unit cleaned scopes in accordance with British Society for Gastroenterology guidelines.

Trust data showed that there were low levels of hospital attributable MRSA and Clostridioides difficile (C.difficile). There had been one episode of MRSA the year 1 April 2021 to 1 April 2022.

The E Coli rate was 30 per 100, 000 for the same period, placing it in the middle range of all trusts; this was likely to be higher for community trusts such as Buckinghamshire Healthcare NHS Trust because there was less control over the environment of people cared for in their own homes and care homes.

The trust had fewer single rooms than many other trusts (14.2%) but maintained performance in IPC around the middle of the range, suggesting good infection and prevention control practice.

The trust scored 99.5% on the most recent patient led assessment of the environment.

Environment and equipment

The maintenance and use of facilities and premises did not always ensure the safety of people. Staff were trained to use equipment and managed clinical waste well.

The service did not have suitable facilities to meet the needs of patients. The flooring of the cardiology ward was not level and presented a trip hazard. We saw a member of staff trip because of the uneven floor during the inspection.

Environmental audits reviewed storage, stock and supplies. Cardiology audit results from the last six months showed compliance of between 81 and 94%, which meant that there were adequate supplies of equipment and that it was stored appropriately.

Staff did not ensure the fire exits were kept clear. During the inspection, we saw chairs obstructing a fire exit on the cardiology ward. We informed a manager and the chairs were immediately moved. Trust fire assessments described site systems and processes but did not include specific concerns regarding ward environments. The trust leaders told us that there was a PFI contract that limited the ability of the trust to make changes and repairs to some of the environment.

Staff carried out daily safety checks of specialist equipment. Staff ensured equipment was serviced and safe to use. The service had enough suitable equipment to help them to safely care for patients. Patients on the stroke wards could access rehabilitation support equipment for example, plate guards and easy grip cutlery.

Staff checked equipment on the resuscitation trolley daily. The trolley was clean, organised, easily accessible and ready for use if a patient deteriorated.

Staff disposed of clinical waste safely. The service had a contract with a third party who collected and destroyed the clinical waste.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on admission, using recognised tools, and reviewed these regularly. Staff completed risk assessments within 12 hours of the patient's admission onto the wards. Tools such as pressure area risk assessments and malnutrition universal screening tool were fully completed and reviewed weekly by competent staff.

Staff knew about and dealt with specific patient risks. Staff assessed patients against; sepsis, Venous thromboembolism (a blood clot in a deep vein), falls and pressure ulcers. Records showed staff completed these assessments in line with national standards.

Staff used nationally recognised tools and guidance to identify deteriorating patients and escalated them appropriately. Staff used nationally recognised risk scoring sheets to assess and monitor patients. Staff understood agreed escalation processes and what to do if a patient deteriorated.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Handover meetings and safety huddles were detailed and included all staff groups, ward rounds were well attended and included a holistic assessment of patient risk. Staff used a handover form to ensure staff starting their shift had all patient information that required follow up.

Nurse staffing

The service had enough nursing and support staff to keep patients safe from avoidable harm. Managers regularly reviewed staffing levels, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Staffing levels were reviewed at the safe staffing huddle meeting, which was held twice a day. Managers calculated and reviewed the number and grade of nurses,

nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers attended a daily meeting to review staffing levels for the following day. They booked agency staff and redeployed staff between wards. Staff advised us redeployment occurred regularly and they were usually not informed until they arrived for their shift. Information provided by the service indicated the number of required nursing hours was not always filled.

The service had high rates of bank and agency nurses used on the wards. Managers did not limit their use of bank and agency staff, however they requested staff familiar with the service. Staffing concerns across the service had increased the usage of bank and agency staff. Managers used block booking to ensure the same staff supported the teams. These bank and agency staff regularly worked on the wards, which meant they knew the service and the patients. Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff we spoke with knew who to speak with on the ward if they had any concerns or questions.

The service took action to improve staffing levels. Managers introduced a centralised rostering team in January 2022, who ensured safe staffing metrics were met. Managers allocated a matron of the day, who went to each ward to assess staffing levels.

Medical staffing

The service did not have enough out of hours medical staff with the right qualifications and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not have enough medical staff to provide optimum patients care. Managers understood staffing issues and 23 whole time equivalent clinical roles were being recruited into. However these positions were not filled at the time of the inspection. Managers were introducing flexible roles to encourage applicants, for example clinical fellows.

The service struggled to provide junior doctor cover out of hours. A resident medical officer from the surgical department supported the teams, however they were covering cardiology, stroke and surgery.

The Cardiac Stroke Receiving Unit received consultant support from the catheter laboratory three times a day. During the night, there was an on-call consultant and telemedicine support was provided 24 hours a day, seven days a week.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Care plans were detailed, up to date, reviewed weekly, clearly signed and dated and tailored to patient's needs. Records were stored centrally; all staff knew where to access them.

Records were stored securely. Paper records were locked in files and cabinets. Electronic records were stored on electronic tablets, which were password protected.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff completed patients transfer forms that included care plans and medical decisions including capacity assessments and do not attempt cardiopulmonary resuscitation forms.

Medical care (including older people's care)

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Wards 8 and 9 had a dedicated pharmacist who attended the ward to oversee prescribing. Other wards were served by the main hospital pharmacist who completed weekly audits of the prescription and administration processes. Staff learned from safety alerts and incidents to improve practice. Staff wore tabards whilst completing the medicine round to prevent them being interrupted. Audits showed the number of medicine errors had reduced since the tabards were introduced.

Staff completed medicines records accurately and kept them up-to-date. We checked 10 medicine records and found they were legible, complete and up to date in accordance with guidance. Records showed controlled drugs were double checked in accordance with guidance

Staff stored and managed all medicines safely and securely. We checked medicine cabinets and trolleys on all medical wards in the hospital and found they were locked. Stock was rotated to ensure older stock was used first. Staff monitored the temperature of storage areas including fridges and understood what actions to take if temperatures were outside of range.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers did not always ensure that actions from incidents were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported incidents on an electronic reporting system. Staff understood their responsibility to report all incidents including those with no harm and near misses in accordance with trust policy. Staff understood their responsibilities regarding duty of candour. Staff told us the service was honest and open when mistakes were made.

Managers provided feedback for staff involved in incidents and shared learning about incidents with staff across the trust. Incidents were discussed at team meetings and were reviewed weekly by the governance team.

The service had two similar never events in the 12 months prior to inspection related to using air rather than oxygen for nebulisers. Never events are adverse events that are serious, largely preventable and of concern to both the public and providers for the purpose of public accountability. There was a lot of input into providing additional learning to prevent recurrence.

Staff described learning from a COVID19 outbreak including; staff testing, patient swabbing and ensuring visitors provided evidence of testing.

Is the service effective?

Good ➔➔

Medical care (including older people's care)

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

Evidence-based care and treatment

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

Staff followed up-to-date guidance to plan and deliver high quality care according to best practices. Pathways referenced up to date guidance, such as National Institute for Health and Care Excellence (NICE) for example for recognising, diagnosing and early management of sepsis and national early warning scores (NEWS2) to monitor deteriorating patients. Consultants reviewed patients every 24 hours in line with NICE guidance.

Managers reviewed policies to ensure they were up to date and reflected best practice. Staff signed to confirm they had read and understood the content of policies. Managers reviewed staff knowledge and understanding at appraisals. Staff knew how to access policies and guidance and commented that pathways were clear and easy to follow.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. All patients had access to water jugs, there were tea and coffee rounds and three meals a day were provided by a contracted service. Staff thickened fluids in accordance with care plans for patients with swallowing difficulties and food options were available in a variety of textures.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We checked 10 patient records and found that all contained up to date malnutrition universal screening tools and completed food and fluid charts. Staff understood their responsibility to report concerns where a patient's input/output was low.

Specialist support from dietitians and speech and language therapists was available for patients who needed it. The service was available Monday to Friday 8.30 to 4.30 to assess patient requirements and support staff.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. We checked 10 patient records and found written notes were detailed, described what pain relief was administered, the time and reasoning. Staff documented that they had returned to the patient to ensure the pain relief had been effective and evidenced pain relief was regularly reviewed for efficacy.

Staff completed numerical pain scales at every medicine round. Staff could access a face pain scale if a patient had difficulty communicating. These scales are used as tools to assist in assessing pain in people who are not easily able to describe their pain.

Pain nurse specialists routinely reviewed patients daily during the week. They gave advice on how to manage pain and deal with problems regarding medications, epidural analgesia, patient-controlled analgesia and local anaesthetic blocks.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Managers reviewed audit results, documented key recommendations, monitored progress of action plans and assigned an accountable individual to each action.

The endoscopy service was accredited by Joint Advisory Group (JAG). JAG accreditation is a formal recognition that an endoscopy service has demonstrated it has the competence to deliver against the criteria set out in the JAG standards. Endoscopy had also achieved gold standard in accordance with National Centre for Biotechnology Information.

Outcomes for patients were positive, consistent and met expectations, such as national standards;

- antimicrobial audit results showed an improvement in urinary tract infections for catheterised patients since staff training focused on this subject.
- staff exceeded guidance thrombectomy times on the Cardiac and Stroke Receiving Unit (CSRU) for ischaemic stroke.
- audit data for 2021 showed the service performed better than the national average for; Emergency readmissions for Chronic obstructive pulmonary disease, bronchiectasis and Pneumonia.
- Staff on the stroke units were meeting national targets for door to needle times (the time from arrival to thrombolysis treatment). The stroke service achieved a grade A from the latest clinical audit from the Sentinel Stroke National Audit Programme. Grade A is the best grade for acute stroke services with between 15% and 20% achieving this standard.

Competent staff

The service made sure staff were competent for their roles. Managers provided support and development. Appraisal completion rates were below target.

Managers gave new staff a full induction tailored to their role before they started work. Staff received a one-day hospital induction before being allocated to their ward. On the ward, new staff had one month as supernumerary during which time they completed mandatory training. Staff then had to complete a preceptorship programme within one year.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection, 71% of staff had received an appraisal in the previous 12 months. This did not meet the trust target completion rate.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to

develop their skills and knowledge. Health care assistants were receiving training for administering oxygen and using suction machines. There was opportunity for progression. The ward managers for wards 8 and 9 had started at the hospital as health care assistants. Band 5 nursing staff were given the opportunity to complete a band 6 development programme. A leadership programme was available for all consultants.

Managers made sure staff received any specialist training for their role. Specialist nurses arranged weekly scenario training for all staff to attend, for example the stroke and dementia specialist nurses. These included Mental Capacity Act/Deprivation of Liberty Safeguards and safeguarding scenarios. The practice development nurse in ward 9 had developed a mouthcare awareness project to improve oral care and assess the impact on rates of hospital acquired pneumonia. The service was looking to introduce feeding and hygiene link nurses.

Multidisciplinary working

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

Staff held regular, effective multidisciplinary meetings across all areas of the service to discuss patients and improve their care. For example the daily board round was attended by doctors, nurses and therapists. Managers from the emergency department, cardiology and stroke units as well as a local NHS ambulance provider, met monthly to review cases, improve care pathways and build better relationships.

Patients had their care pathway reviewed by relevant consultants. Staff from all disciplines including; speech and language therapy, dieticians, physiotherapy, occupational therapy, nurses, consultants and health care assistants joined the multidisciplinary meeting and daily facilitating meeting. These meetings reviewed discharge planning, any patient concerns and progress review.

Seven-day services

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

The medical service at the hospital was available 24 hours a day, seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Therapy staff on rehabilitation Ward 8 were available seven days a week, whilst therapy staff on acute ward 9 were available Monday to Friday 8am to 4pm and on call at weekends.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Wards displayed leaflets on the importance of healthy eating and exercise. Ward menus indicated which meals were low calorie.

Medical care (including older people's care)

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Goal setting reviews included discussing the patient's lifestyle and how the team could support the patient to make healthier choices. For example, being supported to stop smoking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We checked 10 care plans and saw consent was recorded at the start of every therapy session and every treatment decision had a signed consent form from the patient to confirm the treatment had been discussed and agreed to. Staff knew their responsibilities in gaining consent and understood consent could be withdrawn at any point. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions as documented in the patients care plan.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Trained staff completed a capacity assessment on admission to the ward. Staff understood their role in reviewing capacity and making best interest decisions; they knew that capacity could fluctuate and completed care plans that detailed the best time of day to support a patient to make their own decisions.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The Deprivation of Liberty Safeguards nurse reviewed all applications, assessed competencies for those completing the assessments and audited applications to ensure the service was in line with legislative standards.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff supported patients during mealtimes, waited for patients to be ready before assisting with the next mouthful. Staff closed curtains and spoke discreetly to prevent people outside the bay overhearing.

Patients said staff treated them well and with kindness. Staff were aware of and focused on the six C's of caring; care, compassion, competence, communication, courage and commitment. Speech and language therapy staff on Ward 8 had regularly dropped off forgotten patient belongings at patient homes after discharge. During the pandemic, staff on ward

8 ensured patients who were at the end of their life had a staff member on a one-to-one basis with them at all times as visitors were limited, and staff did not want patients to pass away alone. Staff organised a wedding in the stroke garden for a patient who was receiving end of life treatment. Staff ensured patients were comfortable and could reach their call bell after providing care.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff now received training on different end of life religious practices to ensure all patients wishes were met in relation to their faith.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff spent significant periods of time with a patient in the stroke garden who liked to go there to remember their partner, who loved his garden at home.

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff on ward 8 recognised a patient's family member was not coping and took time to speak with them. After discussing their concerns, staff referred the family member to a support network.

Patients and their families could access mental health support seven days a week and emotional support from the on-site multi faith team.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff allocated each patient with a key contact; this was a member of staff who was the main liaison with family and ensured the next of kin was kept up to date with progress and answered any questions. On admission to Ward 8, all patients and their families attended a family meeting. This meeting was used to discuss the patient's lifestyle before their stroke, set goals, provide emotional support for patients and their family and discuss rehabilitation expectations.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Therapists explained exercises including reasoning in plain English to patients and family before the session started. Patients were given an opportunity to ask questions and during the sessions therapists repeatedly checked patients comfort levels. After the session, there was an opportunity for patients and family to give feedback and discuss the next appointment.

Staff supported patients to make informed decisions about their care. Therapy staff escorted patients into the community to support them to go shopping, use cash points, crossroads and use public transport to ensure they were ready before being discharged.

Medical care (including older people's care)

Patients gave positive feedback about the service. Patients returned to Ward 8 a few weeks after discharge to thank staff for their support. Patients advised us that staff on ward 8 and ward 9 took the time to wash and style their hair and do make up. One patient said they "Make me feel like I did before the stroke". We saw 52 thank you cards for Wards 8 and 9. A patient on the cardiology ward thanked staff after receiving personal care and said "That, feels beautiful, thank you". Other patients on the ward said staff were "Lovely" and "So kind, but very overworked", "The staff here are excellent and very approachable".

Is the service responsive?

Good 

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

Service planning and delivery to meet the needs of the local people

Some areas of the service planned and provided care in a way that met the needs of local people and the communities served.

The hospital had four car parks for patients and visitors, payment was required. However, visitors could purchase long term concessionary parking at a reduced rate. Parking for people with a blue badge and visiting patients receiving end of life care was free. All areas of the hospital were accessible to patients and visitors with wheelchairs.

Patients on the stroke wards had access to a day room, kitchen, gym and multisensory garden. Therapies took place in all four locations depending on patient preferences. The cardiology ward did not have a day room or space for patients outside of their bay. The unit could not install televisions due to structural concerns within the building. Patients described the impact boredom had on their mental health.

Signage across the service was difficult to understand. The hospital directory had not been updated when ward locations had moved and some signage, was not official and could be easily removed as they were paper posters. During the inspection, ward 8 received an updated door sign to show it was a rehabilitation ward. This was in response to patients stating they did not understand their journey through the service.

Meeting people's individual needs

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

The service was responsive to patients' individual needs. The service had information leaflets available in languages spoken by the patients and local community. All leaflets provided by the trust could be printed in different languages. Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. The service had a contract with a third-party interpretation service that could provide interpreters for over 200 languages. Staff supported patients to meet their cultural and religious preferences. Staff now received training on supporting various religious funeral arrangements. Patients were given a choice of food and drink to meet their religious and cultural needs. There was a wide choice of food options including vegetarian, vegan and halal.

Staff on ward 9 provided patients with numerous activities to support their rehabilitation and wellbeing. There was a unit choir, patient art sessions, music therapy, bingo, opera group and a therapy dog.

There was a pastoral care team who offered support and a listening ear to people of all faiths and none. The multi-faith room provided religious texts, symbols, prayer rugs and hats for the three major Abrahamic faiths, as well as a remembrance book for everyone to use.

Wards were designed to meet the needs of patients living with dementia and used dementia friendly signage to indicate the various bays and bathroom facilities. Staff received specific dementia training to support their understanding of how to provide better care. Staff supported patients by using 'This is me' documents. We checked 10 documents and saw they were detailed and completed in collaboration with the patient and their family. They included information on the patient's family history, hobbies, communication aids and any details regarding their appearance and how the team could support them. Patient care plans included sections on patient's spiritual needs.

Access and flow

People could access the service when they needed it and received the right care promptly.

Staff supported patients when they were referred to the service. The service provided a Transient Ischemic Attack (TIA) stroke clinic. A rapid access service for suspected 'mini strokes', was open seven days a week from 8am to 4pm. This was managed by the stroke specialist and two band three staff. The service ensured patients could be seen quickly and referred directly. The Medical Day Assessment Unit was a GP referral unit intended to reduce the number of people needing to be admitted as inpatients.

Staff ensured patients received the right care promptly. The Cardiac and Stroke Receiving Unit (CSRU) was devised to free space within the emergency department and provide a specialist space for cardiac and stroke patients to be treated. The unit had direct access to the ambulance docking bay. Staff on the unit had access to electronic systems that displayed all on call ambulances, patient observations and details of the patient's medical history. Staff then had time to prepare a bay in accordance with the receiving patient's requirements. The hospital had access to two cardiac catheterisation laboratories, which ensured wait times were below the national average.

The number of patient bed moves across the service was higher than the national average. This was disruptive to patients and impacted continuity of care. Managers attended two meetings a day to review and monitor discharges and reduce overnight moves and used a 'live' bed board to provide oversight of where there was space to admit patients. Staff advised us that bed moves had increased during the pandemic as patients who tested positive for Covid19, were moved to reduce the likeliness of transmitting the virus to other patients. Bed moves were made in line with the trust Full capacity and infection prevention and control policies.

Managers and staff reviewed outliers but did not use the information to improve care over time. In January 2022, there were 57 medical outliers at Wycombe Hospital. Staff monitored outcomes to ensure patients received appropriate care and treatment but struggled with the workload of supporting patients across wards.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff completed detailed discharge documents. These supported patients as they moved from inpatient to community support. The forms allocated space for all members of the multidisciplinary team to detail functionality for day to day tasks, risks and patient mood.

Medical care (including older people's care)

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with knew how to complain and felt their concerns would be taken seriously. The service clearly displayed information about how to raise a concern in patient areas and the trust's website clearly displayed how to complain, who to speak with and the process. Managers investigated complaints at service delivery and governance meetings. If themes were identified, they were escalated for further review.

Staff understood the policy on complaints and knew how to access the information. The complaints policy detailed leadership accountability, roles and responsibilities, timescales and the complaint review process. Staff knew their responsibilities, how to handle complaints and where to signpost patients and families wishing to complain.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers fed back the outcomes and learning from complaints at safety huddles, ward rounds and in team meetings. Staff could give examples of how they used patient feedback to improve daily practice, for example changes to compassionate visiting for certain patient groups during COVID 19 and providing quiet closing bins after complaints from patients about noise during the night.

Is the service well-led?

Good 

Our rating of well-led remained the same. We rated it as good.

Leadership

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

Medical care was organised into three divisions. The triumvirate team included an operational manager, a medical consultant and the head of nursing who oversaw the division. The triumvirate worked together, understood the performance and areas of risk faced by the service, and had plans for improvement.

Staff across the service praised the matron and head of nursing stating they were open, visible and easy to talk to. Staff stated the managers "empower us to learn". There were examples of staff progression across the service. Staff advised us that managers were supportive of this process. Managers could also access training in the form of a leadership programme.

Medical care (including older people's care)

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff attended a yearly vision and values day which promoted examples of staff "living the values". The trust values and vision were integrated into job application questions to promote staff buy-in. Managers assessed staff behaviours against the trust values and vision, the trust focused on a specific value each year and staff adherence to supporting this was reviewed at appraisal.

The current trust strategy outlined plans based on local population criteria, local priorities, the impact of the pandemic and included data from recent white papers and medical publications. The strategy included specific plans for the medical division. Staff knew the trusts strategy and how to find out further information.

Culture

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

Overall, staff reported the trust had a positive culture and that they felt respected and valued by their teams, matron and the head of nursing. Staff said "Staff are kind and caring and support each other" and "Really good team, we support each other, there is no 'them and us' here". Staff on ward 9 received a trust team award. Staff were focused on providing a good level of care, even when the physical environment did not support this.

Staff had good relationships with their ward wellbeing champions, however some staff felt the trust's freedom to speak up guardians were not always objective when providing support and advice. Staff in some areas of the service had personally experienced or seen inappropriate behaviours from other members of staff. These were managed within the teams, but staff advised high level managerial support did not assist the process.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was clearly defined accountability and governance structure to ensure oversight of the service and performance,

The head of nursing and matron met with the two-service delivery unit governance leads and service delivery unit governance facilitator weekly to review incidents, performance, complaints and provide a COVID 19 update. The findings from these meetings fed into the service delivery unit meetings.

The service had a service delivery unit governance lead for each area of medicine, one for cardiology and one for stroke. The governance leads reported to a service delivery unit governance facilitator. There were three facilitators across the trust, one for cardiovascular, one for medical specialties and one for emergency and acute medicine. Facilitators reported to the clinical governance lead who reported to the divisional chair.

The executive management committee had oversight of numerous sub-committees across the service. For example, risk and compliance monitoring, quality and patient safety group and clinical effectiveness. The bi-monthly audit committee was led by the non-executive directors and reviewed governance, risk management and had oversight of audit results and actions. The quality and clinical governance committee reviewed clinical outcomes, safety and patient experience. All committees reported to the board to ensure oversight.

Management of risk, issues and performance

Not all leaders and teams effectively identified and escalated relevant risks and issues and did not always identify actions to reduce their impact. Some leaders and teams did not use systems to effectively manage performance.

There were separate risk registers for each ward, division and an overall trust risk register. The service delivery risk register did not detail specific environmental concerns in the cardiology ward. The register described estates patchwork holes in the flooring as a short-term solution, this was not reflected in the environment we inspected. The completion date for moving the ward to another location had expired and there was no further projected date.

Managers were sometimes slow to implement change. The risk register for the stroke department included five risks, which had expired completion dates and one risk was logged on the register in 2015. The risk register for cardiology included 10 risks. Out of the 10 risks, one had not exceeded the planned completion date, one risk was logged on the register in 2012. Environmental concerns identified during incident investigations from six months ago were still present on the ward, these were not detailed on the risk register. There were no assurances a similar incident would not be repeated. Managers added concerns to the risk register after incidents, there were no assurances that potential risks were reviewed, identified and mitigated. This was in part because there was a PFI contract who had responsibility for some aspects of premises maintenance and which prevented the local managers acting to remove the risk.

Information Management

Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure.

The service used a combination of electronic and paper systems. Dashboard data was not provided electronically, therefore managers were required to review numerous reports to understand outcomes and performance.

The service had introduced an electronic clinical information toolkit. The toolkit was used to assess risks of deterioration, manage referrals and handovers. The system had not yet been audited to monitor improvements since being introduced.

The service was looking at introducing electronic prescribing, which electronically sends a new prescription or renewal directly to the pharmacy, it is quick and reduces medicine errors due to misinterpreting handwriting.

Staff were in the process of completing a key performance indicator project to improve methods of receiving patient feedback. At the time of inspection, the patient feedback team communicated updates from the public, however ward staff did not have direct access to this information.

Staff understood their responsibilities regarding the Data Protection Act 1998, what they were legally required to report and who within the trust to report breaches to. Computers were password protected and all screens were locked during the inspection.

Medical care (including older people's care)

Engagement

Leaders and staff actively and openly engaged with staff.

Staff could access a daily communication bulletin that provided updates from across the trust.

Managers held monthly team meetings, these were arranged on different days and times to ensure staff had an opportunity to attend. Managers set up an instant messaging group for ward staff to ensure they had access to information, for example upcoming team meetings and updates.

Senior managers created online forums for staff in bands 5, band 6 and band 7. These had no agenda and staff could present any issues or concerns.

Staff and patients could nominate people for the monthly staff awards. The nominations could be for a staff member who made a difference and who deserved recognition. The One Team, One Goal Awards were yearly trust awards. There were 11 categories staff could nominate from including; Rising Star, Lifetime Contribution and People's Award for Personal and Compassionate Care.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation.

The service introduced a quality improvement nurse to promote quality improvement and oversee projects. Quality improvement boards enabled staff to review ward issues, frustrations and provide ideas for improvement. The progress of the board was reviewed twice a week at the huddle meetings, where each post was updated and any successes whether personal to staff or ward based were celebrated. In ward 9, staff were looking to obtain two cordless phones, one for patients (as patients had to use the main reception phone) and one for staff.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

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

Mandatory training

The impact of the pandemic meant that service could not provide mandatory training in key skills to all staff nor made sure everyone completed it. Despite this, overall completion rates were just below the trust targets.

Mandatory training is training deemed essential by an organisation for the safe and efficient delivery of services. It included: blood transfusion processes, child safeguarding, clinical record keeping, complaints handling, consent, equality awareness and eliminating bullying and harassment, incident reporting, hand hygiene and medicines handling and management.

The trusts target for mandatory training was 90%. Most nursing staff had been able to keep up to date with their mandatory training. Nursing staff compliance with mandatory training was 87%. The trust stated gaps in training provision were due to an increase in patients with Covid19 and the suspension of protected educational time during peak times.

Not all medical staff were able to keep up to date with their mandatory training. Compliance with mandatory training for medical and dental staff was at 65%.

The mandatory training available was comprehensive and met the needs of patients and staff. The trust had nine mandatory training modules which included manual handling, health and safety and infection prevention and control. For example, basic life support training was mandatory, and all staff were required to undertake this on an annual basis. Staff told us they had completed this training which included use of emergency equipment. Training records confirmed this.

Statutory training is required by law or where a statutory body has instructed an organisation to provide training based on specific legislation (i.e. the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999). It ensures staff have the knowledge to maintain a healthy and safe working environment for themselves and their colleagues. Statutory training included: awareness of the control of substances hazardous to health (COSHH), when and how to report injuries, diseases and dangerous occurrences (RIDDOR), fire safety awareness training and manual handling training. Information on statutory training showed training was at 81% and 82% for November and December 2021 respectively. The trust target was 90%.

Managers monitored mandatory and statutory training and alerted staff when they needed to update their training. Managers reviewed and monitored mandatory training compliance and presented this as part of a report at the monthly divisional meeting. Managers were aware of the gaps in staff training and nurse mentors were working with their colleagues on the wards to assist with their training and development.

Surgery

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. They knew how to identify adults and young people at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, adult social care services or GP's.

The service did not treat children but did treat young adults (16-18), most young adults were being seen by the oral surgery service. Staff gave examples of when they would make a safeguarding referral.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff protected patients through observation, listening to their patients and their friends and family and taking appropriate action, when necessary.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information about safeguarding was displayed on the wards which included contact numbers and how to raise concerns. Staff were positive about support received from the safeguarding team in the trust. For example: staff in the surgery directorate had sought safeguarding advice from the corporate safeguarding team on 46 occasions in the previous 18 months.

Staff followed safe procedures for children visiting the ward. The trust was restricting visiting due to the pandemic, staff told us what action they would take if they believed children visiting were at risk.

Cleanliness, infection control and hygiene

The service used systems to identify and prevent surgical site infections. However, the service did not always control infection risk well. Not all staff always used equipment and control measures in the correct way to protect patients, themselves and others from infection. They kept the premises visibly clean.

Ward and clinical areas were clean and had suitable furnishings which were clean and well-maintained. The department was bright and spaced chairs and beds to allow social distancing. The day care ward was bright, clean and beds were spaced to support effective infection control. The corridors were clear which allowed easy access for patients' transfers to the operating theatres.

The service generally performed well for cleanliness. Cleaning records were up to date and indicated that all areas were cleaned regularly. Cleanliness of the environment and equipment and hand hygiene compliance was monitored as part of routine monthly audits. The audits showed that areas were cleaned regularly although on three occasions it had been highlighted that hand hygiene could be improved. Staff could also seek advice and support from the trust wide infection prevention and control team.

Staff used audits and data to identify how well the service prevented infections. Staff followed the trust procedures, including routine testing of susceptible patients in line with best practice guidelines. Patients underwent infection screening (such as Covid19 and MRSA) prior to admission. Patient records confirmed this was undertaken. Patients who tested positive with an infection were isolated in single rooms. Appropriate signage was used to protect staff and patients.

Surgery

Surgical wards were categorised depending on their level of infection risk. Staff told us that the general surgery and urology ward was green (low risk of patients having Covid19). The wards categorised as green had ring-fenced beds for elective surgery to minimise the risk of elective patients getting an infection.

Most staff followed infection control principles including the use of personal protective equipment (PPE). The department had dispensers of clean gloves, aprons and masks. Antibacterial hand gel dispensers were available, and signs prompted staff and visitors to clean their hands regularly. In general staff followed infection control principles including the use of personal protective equipment (PPE).

Two staff were observed not following national guidance when donning PPE when it came to the order in which they put the items on. One staff member was observed taking a patient to another department without changing their PPE and a second member of staff was observed walking between patient bays without changing their gloves or wearing an apron, as per the trust policy

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff worked effectively to prevent, identify and treat surgical site infections. In theatres we observed theatre staff used aseptic techniques to minimise the risk of infection.

In the operating theatre we saw that staff adhered to the 'five moments of hand washing' in line with the World Health Organisation (WHO) protocols to prevent the spread of infection. The service carried out monthly hand washing audits and cleaning audits to monitor adherence to infection control practices.

In the operating department there were pathways staff followed to keep clean and dirty aspects of their work separate. This included limiting access to the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum. There was an effective facility for the sterilisation of surgical instruments.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff did not always manage clinical waste safely.

Patients could reach call bells and staff responded quickly when called. We saw staff responding to call bells in a timely manner. Patients said sometimes they had to wait when the ward was busy, such as handover or lunchtime.

The design of the environment followed national guidance. All the ward areas had enough shower and bathing facilities. The trust had reviewed the environment of all the surgery wards and identified infection prevention and control challenges. This had led to some changes and a 'green pathway' was developed for elective surgery. This included patients requiring a negative COVID19 test.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was visible and accessible. Resuscitation trolleys were kept on all surgical wards and in theatres and they had tamper evident tags. Staff told us they carried out daily safety checks of specialist equipment such as the resuscitation trolley. We saw check lists which confirmed this.

The service had enough suitable equipment to help them to safely care for patients. We reviewed three wards and three theatres and found no concerns regarding the amount of equipment available. Labels were used to indicate equipment was ready to use, and hand sinks were available for hand washing.

However, on the orthopaedic ward the resuscitation trolley and other equipment were covered in dust. We found the suction catheter had expired in May 2021. We brought this to the attention of the nurses on the first day of our inspection. The packaging had been torn and it was no longer suitable for use. We checked this on the second day and found that no action had been taken to address this.

Consumable items were checked however, on the general/urology ward several single use items were found to be past their 'best before date'. Checks were in place for nominated staff to complete. Staff had ticked to say stock matched what was needed and was in date. We asked senior staff who was responsible, for stock rotation. They told us it was 'stores' and the stoma care team. Monitoring had been affected by staff shortages due to the pandemic.

Staff disposed of clinical waste safely most of the time. Substances subject to the Control of Substances Hazardous to Health (COSHH) regulations (2002) were generally stored securely so cleaning products could not be accessed by unauthorised persons. However, on the orthopaedic ward the door to the dirty utility room was open and detergent could be accessed by anyone.

All the sharps bins inspected were properly assembled, labelled and signed and dated in line with best practice. However on the orthopaedic ward the sharps bins were overfilled on the medicine trolley. This posed a risk of injury to staff and others. We saw dirty linen trolleys were left in the corridors rather than being placed in a dirty utility room.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning System (NEWS) to identify deteriorating patients. Staff demonstrated how they escalated patients appropriately in line with the trust's policy. Staff responded promptly to any sudden deterioration in a patient's health. All staff at the hospital including outpatient staff received training to enable them to deal with life support scenarios. Senior staff nurses completed immediate life support training and basic life support training; all other staff completed basic life support training.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed risk assessments for each patient on admission using a recognised tool. Risk assessments including the Malnutrition Universal Screening Tool (MUST), falls, venous thromboembolism (VTE), pain, pressure ulcers, nutritional needs, risk of falls and infection control were completed. Patient records showed these were consistently completed. For example, patients who had a latex allergy would be put first on the theatre list and diabetics would also be prioritised to minimise the risks caused by latex contaminants or unduly long fasting.

Three out of five operating theatres were in use at the time of the inspection. We observed staff completed the World Health Organisations (WHO) '5 steps to safer surgery' checklist for patients going into surgery. This checklist is a nationally recognised system of checks designed to reduce avoidable harm and mistakes during surgical procedures. Audits showed over 90% compliance in the previous 12 months. We observed staff were engaged in the process and electronic records were maintained.

Staff knew about and dealt with any specific risk issues. Staff followed appropriate guidelines, pathways and screening tools, based on national guidelines (integrated sepsis recognition and response policy) for the management of patients with sepsis. Staff understood how to identify the signs of sepsis and how to manage sepsis in line with national guidelines.

Patients assessed as high risk were placed on care pathways, meaning they received the right level of care. Staff undertook 'intentional rounding' observations at least every four hours so any changes to the patient's condition could be promptly identified. Patient records on the general surgery and urology ward showed patients were reviewed regularly and escalated when required.

Staff shared key information to keep patients safe when handing over their care to others. Handover between surgical wards and theatre teams was comprehensive and identified patient risks.

Shift changes and handovers included all necessary key information to keep patients safe. Safety huddles were undertaken in theatres and on the wards. Patient safety issues were discussed, and action taken to mitigate the risks. For example, highlighting patients at risk of falls.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. Ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that additional care support staff could be allocated to patients with greater dependency or specific needs to allow one to one care across the surgical wards.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. In the operating theatres, there were adequately skilled staff to manage the elective surgery list and staff followed the Association for Perioperative Practice (AFPP) guidelines. The (AFPP) recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. We observed that theatre staffing consistently met these recommendations. Records showed that staffing numbers did not fall below national guidelines. Operating lists were cancelled if staffing was not in line with guidance. In these circumstances' clinicians prioritised the most urgent cases so these were not cancelled.

The ward manager could adjust staffing levels daily according to the needs of patients. The ward manager managed the rotas and planned the off duty in advance. Safety huddles took place in the morning and included discussions about patient needs and any staffing issues.

The number of nurses and healthcare assistants matched the planned numbers. The trust monitored nursing staff vacancies. Monitoring of nursing staff in September 2021**,** showed all staff turnover remained stable at 10% despite the vacancy rate increasing to 19%, a review of all vacancies was being carried out.

Temporary staffing had been increased to 16%. The vacancy rate had gone down slightly, however temporary staff figures had risen to 19% and was of concern to senior managers

Managers limited their use of bank and agency staff and requested staff familiar with the service. Records for shifts in January 2022 for nursing and midwifery staff showed 64% of shifts were worked by trust staff, 28% of shifts were worked by long term bank and agency workers, 8% of shifts were worked by bank and agency staff that worked two or fewer shifts within the month and 2% of shifts were filled by a bank or agency worker new to the trust.

Managers made sure all bank and agency staff had a full induction and understood the service. The local induction process was managed by each ward and department. If there were concerns about a bank or agency workers training or skills to work on a certain ward all managers and colleagues were able to raise these concerns online. Each concern was centrally logged and reviewed with senior clinical staff. Action taken in the past were requests for bank and agency member to undertake further training to help them achieve the standard required for where they were working.

Medical staffing

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

The service had enough medical staff to keep patients safe. Medical cover was available 24 hours a day seven days a week to support junior doctors. The consultant's provided on site and on call cover during weekdays to provide continuity of care. Junior doctors told us that there were no difficulties getting the support they needed. They also reported that senior colleagues were approachable.

The medical staff matched the planned number. Records for shifts in January 2022 for medical staff (doctors) showed 58% of shifts were worked by trust staff, 34% of shifts were worked by long term bank and agency workers, 8% of shift were worked by bank and agency staff that worked two or fewer shifts within the month, and 4% of shifts were filled by a bank or agency worker new to the trust.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Junior doctors were based on wards depending on their surgical specialty areas. The hospital operated some mixed-specialty wards. Patients were seen by their specialty consultants and doctors daily, including on weekends. Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

The service always had a consultant on call during evenings and weekends. Medical staff told us that support was available at weekends and evenings and senior medical staff were easy to contact.

Records

On one ward staff kept detailed records of patients' care and treatment. Records were clear, up to date, generally stored securely and easily available to all staff providing care. On two wards patient records were not always clear and up to date and staff did not always store them securely and they were not always easily available to all staff providing care.

Surgery

On two wards and in the theatres, patient notes were comprehensive, and all staff could access them easily. Patient records were mainly paper based. Staff recorded the necessary information. We reviewed 22 patient records, and all had dates, times or notes about patients' preferences or wishes. Staff could find the most up-to-date information about patients when they needed it. Patients told us that staff always knew their preferences or needs.

On the orthopaedic and day surgery wards we looked at nine sets of patient records and found they were not always easily accessible to staff. Records were not always bound together.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly. The records followed a clear pathway, and the most recent treatment information were at the front of the folder.

On two wards and in the theatres, records were stored securely in a trolley with restricted access in line with data protection processes. Staff told us on one ward, the junior sister had worked hard to ensure records were fit for purpose. They were very proud of their achievement.

Medicines

The service had systems and processes to safely prescribe, administer, record and store medicines. However, medicines were not always effectively managed, and some were missing or expired.

Staff followed systems and processes to prescribe and administer medicines safely. On two wards and in theatres, staff followed systems and processes to prescribe and administer medicines safely. However, on the orthopaedic ward we found medicines that had expired, and they were still available to be used. For example, Actrapid Insulin100u/ml was opened on 17 December 2021 and should have been discarded after 28 days as this can affect blood sugar level due to its product not having the desired or intended result.

Emergency cardiac arrest and anaphylaxis medicines were kept on the resuscitation trolley and were checked daily. Anaphylaxis is a life-threatening allergic reaction that requires immediate treatment.

The trolley checklists indicated there should be two pre-filled syringes of Magnesium Sulphate and Naloxone. The trolley contained ampoules instead, which would then have to be drawn into the syringe. We looked at the anaphylaxis emergency drug box on the day surgery ward. We found that whilst Adrenaline was available there was no Chlorphenamine, Hydrocortisone or water for injections as per the list in the box. We spoke to the sister in charge who was unaware of the recent changes to the national guidance. This posed a risk to patients experiencing an anaphylaxis emergency if the adrenaline was not successful in the treatment of the patient.

Controlled medicines stock levels were correct, and the controlled medicine registers were completed correctly.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.

Staff completed medicines records accurately and kept them up to date. Patients' prescriptions and medicines administration records were accurate, complete, legible, up to date and stored securely.

Surgery

Staff stored and managed all medicines and prescribing documents safely. Medicines management was recorded on the 'Perfect ward audit' and completed by pharmacy staff or nursing staff. The records were available to the senior management team to audit and oversee as they were recorded, and showed date, name and photo of the member of staff carrying out the check and any issues found.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Patient's medicines were checked on admission and when they were transferred between wards medical staff read the patients notes to ensure the correct medicines were available on the wards.

Staff learned from safety alerts and incidents to improve practice. Safety alerts and incidents were shared with staff at ward meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. There were risk assessments in place to assess patient's behaviours to clarify any underlying causes such as delirium following general anaesthetic.

Incidents

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

Staff knew what incidents to report and how to report them. The trust had internal processes to report and record incidents. Staff knew about incident reports and were able to use the electronic incident management system to make reports in line with trust policy. However, staff said they did not consistently report incidents such as staff shortages. Serious incidents were discussed at handovers.

The number of incidents reported showed that the majority resulted in no or low harm. This indicates a good reporting and safety culture where staff are committed to identifying risks, investigating and learning from incidents.

Managers shared learning about never events with their staff and across the trust. There had been one never event reported in surgical services during the six months prior to the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. The never event investigation had only just begun at the time of the inspection, in line with the national reporting framework.

Managers shared learning with their staff about never events that happened elsewhere. Managers investigated incidents thoroughly. Incidents were reviewed weekly and monthly at trust and divisional level to identify trends and to improve practice and patient safety.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient.

Surgery

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 and others of "certain notifiable safety incidents" and provide them with reasonable support. The trust monitored compliance with the duty of candour standards. Records showed 100% compliance had been reported.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There was evidence of this in a root cause analysis investigation reports that we reviewed.

Managers debriefed and supported staff after any serious incident. For example, staff were aware of an incident where a visitor trapped a member of staff behind a door. Staff were told what had happened and what action had been taken to help prevent the situation occurring again. We heard about a specific example where staff had been told about the incident and what had been done to reduce the risk of recurrence.

Is the service effective?

Good 

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed clinical guidelines and pathways that were based on national guidance, such as from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards. Clinical guidelines were easily accessible through the trust's intranet.

We reviewed care pathways for ten surgical procedures and found these were based on best practice guidance. The trust had an enhanced recovery programme for patients requiring a variety of specialty operations which included joint replacements or revision joint surgery with an established multi-disciplinary team. Staff spoke proudly and positively about this service. Enhanced recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery.

The service participated in both national and local clinical audits. Submission to some national audits had been paused during the Covid19 pandemic. Findings from clinical audits were reviewed during monthly surgical specialty group meetings and any changes to guidance and the impact that it would have on their practice was discussed

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff used specific care plans when providing care and treatment for patients with mental ill health, which included additional measures such as enhanced monitoring and supervision.

Surgery

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients with difficulties eating and drinking were placed on special diets. Patients told us they were offered a choice of food and drink including snacks and finger foods.

Patients who are unable to eat or drink orally may require a feeding tube (a tube through the nose into the stomach or straight into the stomach by surgical intervention. In cases where patients are unable to tolerate a feeding tube parenteral nutrition (PN) can be used. PN refers to the provision of nutrients intravenously and should only be used when all other routes of nutritional intake do not work.

Monitoring patients on parenteral nutrition (PN) requires a multidisciplinary approach with effective communication throughout the team. Staff told us this included doctors, nurses, dieticians and pharmacy staff who have experience in PN.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The Malnutrition Universal Screening Tool (MUST), is a five step that can be used by health care professionals in hospitals or the community to accurately identify those who are at risk of malnutrition. Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Records showed that there was dietitian involvement with patients that were identified as being at risk. Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff told us that if there was a delay in theatre this would be communicated to wards and departments to allow patients to drink fluids to avoid dehydration.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a numerical score to measure pain experienced by patients as part of the National Early Warning Score 2 (NEWS2) assessment record. Staff undertook 'intentional rounding' assessments, where staff assessed patients needs on a regular basis, including the assessment of pain.

There were pain assessment tools for use with patients who struggled to communicate and articulate their pain and staff gave us examples of when they have used them.

Patients told us that they received pain relief soon after requesting it. We saw referrals were made to anaesthetists or an acute pain clinical nurse specialist for specialist pain relieving procedures, when conventional pain relief was not enough.

Surgery

Pain nurse specialists routinely reviewed patients during the week. They gave advice on how to manage pain and deal with problems regarding medications, epidural analgesia, patient-controlled analgesia and local anaesthetic blocks.

Staff prescribed, administered and recorded pain relief accurately. Prescriptions were reviewed by pharmacy who ensured there were no issues with the medicines prescribed. Staff on the ward recorded when they had given pain relief and the records showed they had followed the prescription.

Patient outcomes

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

The service participated in relevant national clinical audits. The surgery division contributed towards Patient Reported Outcome Measures (PROMS) to assess the quality of care delivered to patients in hip and knee replacements. Managers told us they were aware of the delays and waiting lists due to the pandemic and staff shortages and were looking at how they could reduce this.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The numbers of surgery's that had taken place was less than they had planned due to the pandemic. The trust had a recovery programme to reduce the numbers of patients on the waiting list and the length of time they were waiting. Patients subject to delays were assessed to ensure it was safe for them to wait and patients at higher risk of worse outcomes were prioritised.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The trust shared that services had been asked to review their local Safety Standards for Invasive Procedures (LocSSIPs) to ensure they were current. The review highlighted there was no central record of LocSSIPs within the services and staff did not always know where they were stored. There had been no audits of LocSSIPs since they were introduced in 2016. Some LocSSIPs had been titled BuckSSIPs and others had been incorporated into clinical guidelines/flowcharts/ standard operating procedures. The review was continuing and being monitored by the Clinical Guidelines Review Group. The review will form the baseline for future audits.

Managers used information from the audits to improve care and treatment. Senior staff told us they were reviewing information from the last year and would be implementing an action plan to make improvements to the service.

Managers shared and made sure staff understood information from the audits. We saw meeting minutes which confirmed audit findings were discussed at ward and departmental meetings.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Specialist training was available to staff, when necessary. The clinical educators supported the learning and development needs of staff. We spoke with nurses who were also nurse trainers who worked alongside staff to enable them to develop their skills.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to a member of staff who was recently employed by the trust. They confirmed they had received a full induction including a period shadowing other staff.

Managers did not always support nursing staff to develop through regular, constructive clinical supervision of their work. Staff told us they had not received regular supervision and annual appraisals. The trust target was 80%. For nursing and midwifery staff for November and December 2021 the rates were 47% and 59% respectively. Managers told us this was due to changes in the wards and staffing made necessary due to Covid19.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Doctors in training told us that training sessions had carried on despite the Covid19 pandemic. Training records confirmed this. Consultant leads told us they had introduced formal clinical supervision for the doctors

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us it was not always easy to attend staff meetings due to staffing, however they said they could access meeting notes.

Managers identified any training needs their staff had and usually gave them the time and opportunity to develop their skills and knowledge. There were training sessions available, but staff were not always able to attend these. Senior staff told us this was due to the pandemic and staff absences, although every effort was made to support staff to attend developmental training.

Managers made sure staff received any specialist training for their role. The service had recently recruited several newly qualified and international staff on the surgical wards and theatres. The ward managers or other senior staff provided additional support for newly recruited staff and supported them to finish their education to obtain professional registration.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us they had good relationships with consultants and ward-based doctors. We saw there was effective team working and communication between all staff disciplines.

On the wards we observed ward rounds and safety huddles where there was involvement from nursing, medical and allied health professional staff. Staff identified patients nearing readiness for discharge from the hospital and supported that process.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was effective communication and handover of patients who were admitted to other healthcare providers from the trust.

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. For example, physiotherapists visited the wards when their support was needed.

Surgery

During the pandemic, when the service for orthopaedic surgery preparation was not able to offer physiotherapy classes face-to-face, they worked with other healthcare professionals to create online classes. Staff told us they offered one-to-one phone calls for any specific questions that arose during the class. These initiatives fed into the Wycombe Arthroplasty Rapid Recovery Pathway.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at the weekend.

Staff could call for support from doctors and other disciplines, including mental health and diagnostic services, 24 hours a day, seven days a week. Resident medical officers covered out of hours to support junior doctors. Staff told us that there was good support outside normal working hours and at weekends.

Radiology, imaging (such as x-rays or CT scans) and physiotherapy, were available on call outside of normal working hours and at weekends. Pharmacy services were available seven days a week. There was an on-call service for when the pharmacy closed.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. We saw information promoting a healthy lifestyle such as healthy food recipes and the importance of taking regular exercise. The service promoted health campaigns and encouraged patients to take ownership of their health. We saw a “love your breasts, be breast aware” campaign encouraging patients and visitors to check their breasts for any abnormalities. Staff assessed each patient’s health at pre assessment and provided support for any individual needs to live a healthier lifestyle. Patients identified with weight concerns were referred to dietitians for advice and support.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients on an enhanced recovery programme were offered additional support and guidance, with an aim of enhancing their recovery so that they had better outcomes and could go home as soon as possible. Guidance included aspects of care aimed at improving mobility, pain control and general health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit.

Surgery

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity, to consent to their care and treatment. Our review of ten medical records showed well documented consent forms. Staff could tell us how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. If a patient lacked capacity to make decisions about their care and treatment, staff sought consent from an appropriate person that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Staff made sure patients consented to treatment based on all the information available. Staff told us the risks and benefits of the specified surgical procedure were documented and explained to the patient. Consent forms were completed to a good standard with risks and benefits clearly documented. Most patients told us they had been given a copy of their consent form as recommended by the Royal College of Surgeons of England.

Staff clearly recorded consent in the patients' records. Patients were provided with written information such as patient information leaflets. Patients told us that they were given enough information and time to make a decision about their operation. Patient records confirmed this.

Staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Patient records included documentation of Mental Capacity Act assessments.

Staff could describe and knew how to access the policy and get accurate advice on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. There was a trust-wide safeguarding team who provided support and guidance for staff for mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications. Staff gave us examples of when they had accessed them and were positive about their support.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The trust monitored how well the service followed the Mental Capacity Act 2005 and made changes to practice when necessary. For example, staff completed monthly audits in relation to the completion of assessment records. These showed that staff followed the Act and completed necessary records.

Is the service caring?

Good 

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

Compassionate care

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

Surgery

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients were respected and valued as individuals and were empowered as partners in their care.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw patients were treated with dignity, compassion and empathy. In theatres we observed that staff took the time to interact with patients during their procedure by explaining the noises they would hear, providing reassurance and updating them on the progress of their procedure.

Patients said staff treated them well and with kindness. Comments from patients on thank you cards included; “Thank you for your care, kindness and compassion showed to me following my recent stay with you”.

Feedback from people who used the service and those who were close to them was continually positive about the way staff treated them. Patients thought that staff went the extra mile and the care they received exceeded their expectations. Patients commented positively about their experience of care and treatment they were receiving. They said sometimes they waited longer than they would like but understood that staff were busy.

Staff followed policy to keep patient care and treatment confidential. We observed staff lowered their voices when talking to patients about confidential matters.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff in the day surgery unit told us that the pre-assessment team informed them in advance if a patient with mental health needs was attending for an operation, and they would try to seat them in a quieter waiting area, with dimmed lighting away from the noise of the main area.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff gave an example of when a female patient wanted an all-female team caring for her throughout her operation for their religious needs. Staff were able to organise this and respected the patient’s religious needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Due to the Covid19 pandemic visiting was discouraged. However, where it was needed, staff offered the opportunity for a carer or family member to be with the patient when discussing treatment.

There was a visible person-centered culture. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Caring for someone has an impact on many aspects of a person’s life and when the cared for person is admitted into hospital it can cause stress, worry and upset. Staff tried where possible to keep family and carers updated.

Patient’s individual preferences, cultural, social and religious needs were met by all staff including the provision of dietary requirements. Records showed patients dietary preferences and religious needs.

Surgery

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us upsetting or unexpected news was delivered sensitively and in appropriate private surroundings.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients said they were given explanations about their treatment. They said staff explained procedures and obtained their consent before any treatment. Patients told us the consultants were thorough, they spent time explaining procedures to them and they felt comfortable and reassured. They felt they were given clear and adequate information. Written information was given which patients could share with those close to them

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. For example, an interpreter could assist if the patient agreed. There were translation and interpretation services available.

The trust had a learning disability liaison team who helped adult patients with learning disabilities and autism, and their carers, to access high quality care and have a positive experience in hospital. Learning disability nurses provided support with emergency admissions, outpatient appointments and inpatient stays. The trust patient letters and leaflets were available in an easy to read format and involved carers and families in the care planning process.

The hospital had open access WiFi across the site. This enabled patients to remain in contact with family members and reduced the effects of isolation.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff told us feedback they received was positive, but the level of response was low. Feedback from friends and family tended to be requested via text messaging after discharge. Staff thought it would be better to request feedback before a patient was discharged. The surgical wards received ‘excellent reports from the Patient Advice and Liaison Service (PALS).

Staff supported patients to make advanced decisions about their care. We looked at six do not attempt cardiopulmonary resuscitation (DNACPR) documents. We saw they were completed with enough information to provide assurances that decisions had been discussed with the patient or their family.

Is the service responsive?

Good ➔➔

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

Service delivery to meet the needs of local people

Surgery

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

Managers planned and organised services, so they met the needs of the local population. Senior staff told us that following the easing of Covid19 restrictions they were looking how to make access to their service easier for patients.

Conversations were taking place with other NHS services to see how they could work together. There were proposals to move services where possible into the community and close wards and move specialties around to provide a better service.

There were daily meetings with the site management team so patient flow could be monitored and maintained. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints. There was daily involvement by the matron and ward managers to address these risks.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Information from the trust said that there had been no breaches of this standard in the 12 months prior to the inspection.

Facilities and premises were appropriate for the services being delivered. The hospital provided a range of elective surgical services for the communities it served. This included orthopaedics, maxillofacial surgery, ear, nose and throat surgery, ophthalmology, urology and general surgery. The executive team managing the hospital were reviewing the facilities and all the premises belonging to the trust to ensure that they could offer the best service possible. These were long term plans.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had dedicated learning disability liaison nurses who provided support for people with learning disabilities.

Managers monitored and took action to minimise missed appointments. Cancellations were only made by the trust when they could not offer a safe service. These were being monitored and seemed to occur due to staffing.

Managers ensured that patients who did not attend appointments were contacted. Consultants supported staff in contacting patients when they had cancelled their treatment to assist the trust in managing waiting lists and ensuring those in greatest need were offered treatment.

The service relieved pressure on other departments when they could treat patients in a day. The day surgery ward attempted to relive pressure on other wards by carrying out surgery where there was minimal risk for the patient. These were usually less invasive, which meant patients could leave the hospital the same day.

Meeting people's individual needs

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

Wards were designed to meet the needs of patients living with dementia. Staff told us that they had clearly defined routines for the daytime and night-time to help all patients to orientate themselves to the time of day. However, we did not see information displayed, such as the day, date and weather outside to help orientate patients living with dementia.

Surgery

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff made sure patients living with learning disabilities and dementia, received the necessary care and information to meet all their needs There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust's learning disability liaison team helps adult patients with learning disabilities and autism, and their carers, to access high quality care and have a positive experience in hospital. Staff told us they do this by:

- making patient letters and leaflets easy to read and understand
- improving the use of patient health 'passports' – a document which helps patients communicate their likes and dislikes
- involving carers and families in the care planning process
- training and supporting hospital staff to help understand the individual's needs.

The service had information leaflets available in languages spoken by the patients and local community. The service had information leaflets available in languages spoken by the patients and within the local community. Information leaflets were also available in different size fonts and on coloured paper for patients with visual impairment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff confirmed it was easy to access interpreters when they needed to.

Patients were given a choice of food and drink to meet their cultural and religious preferences. For example, ensuring patients had seen and been able to choose from the menus. The menus were extensive with cultural and dietary choices such as, halal, kosher, asian, african and caribbean, vegetarian and vegan. The catering service could meet the assessed needs of people who required or preferred a soft or liquidised diet or who needed bite sized pieces.

Access and flow

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

There were daily meetings with the site management team so patient flow could be monitored and maintained. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints. There was daily involvement by the matron and ward managers to address these risks.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. In general surgery the trust managed to achieve an average of 50% of the national targets. Whereas specialty services such as gynaecology cancer surgery on average met 90% of the national target.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The biggest concern for the trust were the waiting lists. For

example, at the end of 2019 patients had to wait 40 week wait for knee replacement, the impact of the pandemic had increased this to 104 weeks. The management team were looking at how the list could be managed and were considering a risk assessment and a potential transition from the traditional number of theatres and lists to a demand led system. Emergency services were provided at Stoke Mandeville hospital.

Trust wide there was a recovery programme aimed at reducing the size of the waiting list and the length of time that people had to wait. This was planned and coordinated with other stakeholders within the integrated care system. A comparison with other CCG areas within the region showed that the waiting lists for this were around the middle of all CCG areas. For example, the gynaecology waiting list for this trust was 299 patients per 100, 000 which was worse than Surrey Heath CCG (167/100k) but better than Portsmouth CCG (495/100k) and West Sussex CCG (383/100k).

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. During the inspection there were no surgical patients on non-surgical wards.

Managers worked to keep the number of cancelled operations to a minimum. Senior staff told us they were looking at how theatre capacity could be increased to help minimise cancellations by the efficient use of available staff. During the 12 months prior to the inspection in February 2022, the hospital had to cancel 16500 operations and patients themselves cancelled over 11600. A total of 301 surgeries were cancelled for non-clinical reasons. Cancellations were mainly due to staffing or the pandemic.

Managers monitored that patient moves between wards were kept to a minimum. Staff expressed concern about the timings of patient moves with some taking place over the midday mealtime or medicine times, between 12pm and 3pm. Information from the trust for the previous 12 months indicated 2528 patient moves took place during this time.

Staff tried not to move patients between wards at night, but sometimes this was unavoidable. They tried to keep this to a minimum to decrease the negative impact for patients. Data indicated there were 172 patients moved between 10pm and 6am in the previous 12 months. These were made in line with the trust Full Capacity protocol and to reduce the risk of virus transmission.

Managers and staff started planning each patient's discharge as early as possible. The orthopaedic wards and general surgical wards planned discharges from the time of admissions. There was an enhanced care pathway which led to a quicker discharge particularly for orthopaedic patients.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they would speak to nursing staff if they had any concerns and knew how to make a complaint formally.

The service clearly displayed information about how to raise a concern in patient areas. The service clearly displayed information about how to raise a concern in patient areas. The wards and theatre areas had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS).

Surgery

Staff understood the policy on complaints and knew how to manage them and patients received feedback from managers after the investigation into their complaint. Staff said they tried to resolve complaints informally. However, if patients wanted to raise their concerns further, they escalated them to the manager. We saw evidence that learnings from complaints were used to improve the service.

Managers investigated complaints and identified themes. Senior staff monitored complaints, there had been 30 complaints in the 12 months prior to the inspection. Senior staff said complaint response time remained a challenge and the surgical services were trying to keep the number of overdue complaints down.

Is the service well-led?

Good 

Our rating of well-led remained the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most were visible and approachable in the service for patients and staff.

The surgical services were part of the division of surgery and critical care and were led by a division director, a divisional chair and a head of nursing. Wards were managed by a ward manager with support from senior nurses. There was a theatre matron who was responsible for overseeing theatres and day surgery supported by a senior nurse.

Staff told us they understood the departmental structure and knew who their line manager was. On two wards staff reported feeling able to discuss issues with their line manager and felt they could contribute to the running of the department.

- There had been a lot of staff movement in the previous six months, with ward closures and ward staff merging. Some staff spoke positively about the leadership and organisation structure particularly the medical staff, and described their line managers as approachable, visible and supportive. However, on one ward staff said they did not feel the leadership was positive, their line managers were not approachable and did not listen. Senior nursing staff such as the head of nursing, told us they were aware of some of the issues but had not yet arranged any meetings to speak with staff.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust published their current strategy in November 2021. Their vision was to deliver:

- outstanding care that was compassionate and inclusive and delivers the best possible outcomes in the most efficient way.

- healthy Communities where they play their role in communities, to support people to live independent healthy lives at home.
- a great place to work that is inclusive and compassionate.
- a workplace that learns and improves together and values the health and wellbeing of our colleagues because we know a happy, healthy workforce delivers the best care.

The vision and values had been cascaded to staff across the surgical services and staff had a good understanding of these. The trust had comprehensive plans on how they were going to restore elective and outpatient services following the Covid19 pandemic. Most staff told us they were aware of the plan and how they played a part in achieving the plan.

Culture

Staff generally felt respected, supported and valued, although there was recognition that the pandemic had placed a significantly increased burden on staff. The service had an open culture where patients and their families could raise concerns without fear of retribution. However, some staff did not feel they could raise concerns with senior staff following negative experiences. Staff were focused on the needs of patients receiving care.

The trust had a 'Trust CARE value awards' programme. Each month the executive management committee awarded four winners, one for each of four categories: Collaborate, Aspire, Respect, and Enable. Staff on two wards spoke positively about the trust values and considered there to be a zero tolerance of bullying. The trust performed well on the NHS staff survey. However, feedback from another member of staff indicated they did not feel the trust had an effective zero tolerance policy. We heard examples of staff being verbally abused, by other staff, patients or families. The member of staff said they felt there was no action taken by senior staff and they were expected to tolerate this abuse. They felt that this resulted in staff not always reporting violence or aggression as they did not believe action would be taken.

The trust had a freedom to speak up guardian (FTSU guardian), some staff spoke positively about the ability to speak to the FTSU guardian, whilst a few others reported felt the service was ineffective as they did not receive any feedback. The board minutes from January 2022 show that the number of FTSU guardians was being increased and there was consideration of how to ensure that the service of reached all staff. A member of staff told us of a misunderstanding in January 2022 when they had experienced shouting and aggressive behaviour from their colleague. Although this was reported to senior staff no feedback had been given and an uncomfortable atmosphere remained an issue.

During the Covid19 pandemic initiatives had been developed to boost morale. Staff were provided with emotional support. For example, staff had access to trained counsellors and wellbeing meetings were held. However, some staff said their confidentiality was breached with feedback from the meetings shared outside of that group of staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The surgical services had clear governance structures. There were monthly specialty level and care group level meetings to discuss governance and risk. Each surgical specialty had routine monthly governance meetings and governance and operational performance was reviewed.

Surgery

Managers were addressing governance ownership and oversight was aligned to the correct group of staff. For example, ward and department managers now had to present audit findings from their area at quality and risk safety meetings. The quality and risk safety meeting minutes showed key discussions around workforce, current risks, clinical effectiveness and performance issues.

Senior staff told us incident investigations and complaints were the responsibility of the medical and nursing speciality they belonged to. An incident action tracker had also been implemented for oversight of outstanding actions from incidents. Quality and risk safety meeting minutes showed that reviewing the tracker was a standard agenda item.

Mortality and morbidity meeting minutes showed that these now showed who had attended the meeting and any actions to take forward. This was in line with the Royal College of Surgeons guidelines.

There were monthly ward and unit meetings and minutes showed that incidents, complaints, staffing and risks were reviewed.

Senior staff told us they used a proprietary audit system which checked five domains for example, hand hygiene, medicines management, documentation). Senior staff allocated a month to different members of staff to complete the results of the audits to be shared within the division.

Management of risk, issues and performance

Leaders and teams had systems to manage performance. However, not all risks and issues they identified had been escalated or actions identified to reduce their impact. They had plans to cope with unexpected events. Not all staff felt they had been able to contribute to decision making regarding financial pressures and the quality of care.

The trust used an electronic risk register system to record and manage key risks. Each ward and department maintained a risk register, which fed into the planned care group and then into the corporate risk register.

Although the risk registers showed when risks were identified they did not all have control measures in place to mitigate risks. The risks did not have a review date or an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to care group and trust level.

Meeting minutes showed key risks were reviewed at the monthly quality and risk safety meetings. Mortality and morbidity meetings followed a set format, with attendance recorded and notes taken.

In each area, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.

Routine audit and monitoring of key processes took place to monitor performance against objectives. The service used a bespoke computer system to facilitate the collection and submission of data for audits and staff took it in turns to undertake the audits. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through team meetings, safety huddles and newsletters.

Surgery

Staff told us they regularly raised issues which affected patient care. For example since May 2019, staff raised the lack of availability of out of hours flexible cystoscopes (Cystoscopy is a procedure that allows the healthcare provider to view the urinary tract, particularly the bladder, and can help find problems with the urinary tract). The lack of availability was due to a lack of decontamination trained staff. The risk register did not show what action had been taken or when, only that the service was reviewing disposable scope options.

Information Management

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

The service used computer system to facilitate the collection and submission of data for audits. Staff took it in turns to undertake the audits and said it was easy to use.

We identified concerns in relation to the security of patient records on one ward. On the other wards paper-based patient records (such as patient bed side notes) were kept securely. Staff files and other records were a mixture of electronic and paper based.

Most patient records were still paper based, prescribing was undertaken electronically. Theatres used an electronic system to record the patient's pathway in theatre which allowed staff an overview of what was happening in real time. The system allowed for the recording of the World Health Organisation Safer Surgery checklist; the system did not allow staff to move on to the next step of the five-step checklist until they had confirmed the previous step had been completed.

Audit records and staff rotas were held electronically. The service used an electronic messaging system as a way of communicating key messages and rotas. For example, in theatres the staff allocation was sent out the day before via the electronic messaging system. If staff printed documents, it was dated and time stamped, including he name of the person who printed it.

Computers were available across the wards and theatre areas and staff access was password protected. Staff told us that there were several different IT systems that did not link with each other and all required different passwords, which could be a challenge. Some staff also told us that there could be connectivity issues and that the IT systems could be slow.

Policies, procedures and clinical guidelines were accessed through the trust intranet site. However, minutes from leadership meetings showed that at least 52 clinical guidelines were not up to date.

Engagement

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

Staff received good support and regular communication from their line managers. Records we saw showed staff regularly participated in team meetings. The trust engaged with staff through newsletters and staff briefings from the trust's executive team. Other general information and correspondence was displayed on notice boards.

Surgery

The service collaborated with partner organisations to help improve services for patients. For example, working with other trusts to ensure that patients received specialist treatment and with the integrated care system and clinical commissioning group to plan waiting list recovery.

Staff were provided with emotional support. For example, debrief support was put in place to support staff and staff had access to trained counsellors.

Staff noticeboards had information detailing the support available during the Covid19 pandemic. This included details of support available for staff in relation to emotional health and well-being.

To help improve internal communications, the new trust intranet, Connect and Keep Engaging (CAKE) was made available for all trust colleagues and was well received

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The Trust Improvement Plan had been implemented and the trust has been reducing the number of patients with extended wait times. The forecasting was that there would be zero patients waiting over 104 weeks for planned care. They were looking for zero increase from March 2022 in the number of patients waiting over 52 weeks compared with September 2021.

To help create capacity to safely meet demand, the trust has been following national guidance. Operation Reset was a multi-agency initiative covering acute, community and mental health beds aimed at reducing the length of stay and number of patients who no longer met the criteria for hospital, but who remained in beds.

In December 2021, communities and social care providers were urged to work with the trust to support patients to leave hospital in order to be home in time for Christmas. This was mainly for patients who were medically fit to be discharged but unable to return home due to social care requirements.