

# Buckinghamshire Healthcare NHS Trust

# Stoke Mandeville Hospital

## Quality Report

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Date of publication: 06/10/2014

Date of inspection visit: 18-21 March 2014

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

### Ratings

#### Overall rating for this hospital

Requires improvement



Accident and emergency

**Requires improvement**



Medical care

**Requires improvement**



Surgery

**Requires improvement**



Intensive/critical care

**Good**



Maternity and family planning

**Good**



Children's care

**Good**



End of life care

**Requires improvement**



Outpatients

**Requires improvement**



National Spinal Injuries Centre (NSIC)

**Good**



# Summary of findings

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# Summary of findings

## Overall summary

### Letter from the Chief Inspector of Hospitals

Stoke Mandeville Hospital is one of seven hospitals that formed part of Buckinghamshire Healthcare NHS Trust. This hospital was an acute hospital and provided accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people' services, end of life care and outpatient services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. The hospital also had the National Spinal Injuries Centre (NSIC), one of 11 centres of expertise in the UK, and we inspected this service too.

Stoke Mandeville Hospital had 479 beds and provided a wide range of inpatient medical, surgical and specialist services as well as 24-hour A&E, maternity and outpatient services. The hospital had the regional centre for burn care, plastic surgery and dermatology, as well as the NSIC. The hospital had recently become a national bowel cancer screening programme site. It saw 48,000 inpatients and 219,000 outpatients a year.

We carried out this comprehensive inspection because the Buckinghamshire Healthcare NHS Trust had been flagged as a potential risk on CQC's intelligent monitoring system. The inspection took place between 19 and 21 March 2014 and an unannounced inspection visit took place between 6pm and 10pm on Saturday 29 March.

Overall, this hospital requires improvement. We rated it good for caring for patients but it requires improvement in providing safe care, effective care, being responsive to patients' needs and being well-led.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- The hospital was clean and well maintained. Infection control rates in the hospital were similar to those of other trusts.
- The trust had worked to improve emergency care and had improved its mortality rates. Patients whose condition might deteriorate were identified and escalated appropriately and mortality rates were now within the expected range.
- Patient's experiences of care was good and the NHS Friends and Family test was higher than national average for most inpatient wards but was lower than the national average for A&E.
- Patients were not always supported to eat and drink, where appropriate. However, standards to ensure that patients were properly hydrated had improved.
- The trust opened a new acute medical admissions unit, surgical assessment unit and clinical decision unit for short stay patients in November 2013 to improve the flow of emergency patients through the hospital and speed their assessment, treatment and discharge. During our inspection visit however, we found the hospital to be busy and under pressure. Capacity in A&E, on these wards and in the hospital was severely reduced. There had been a reduction in the number of hospital beds due to Norovirus. The trust described this as an exceptional circumstance as there were restrictions on one quarter of medical beds over a 10 day period in March 2014. Patients in A&E were waiting a long time to be assessed and treated by inpatient teams, and admitted to a hospital bed.
- The A&E doctors often identified patients informally for admission the decision to admit patients to the hospital was done by the inpatient speciality teams. There were delays with this approach. Patients were waiting on A&E trolleys for several hours. We witnessed several patients waiting over six hours before a decision to admit was taken and some patients had waited over 12 hours for a bed to become available on the ward. One 91-year-old patient waited over 13 hours on a trolley in A&E for a bed in the hospital.
- There were concerns about nurse staffing levels. Wards and patient areas were staffed appropriately but there was a heavy reliance on nurse bank and agency staff and in some instances this affected the delivery and continuity of patient care. The trust was investing to improve nurse staffing levels.
- Medical staffing in A&E had improved and senior staff were available out of hours and at the weekend. There were still concerns, however, about the presence of senior medical staff out of hours and at weekends, and the number of medical patients that a junior doctor had to cover out of hours. There was a system for consultants to see new patient admissions over the

# Summary of findings

weekend but some medical inpatient outliers were not seen over the weekend by a medical doctor unless their condition deteriorated. They were not assessed, or considered for discharge. The trust was working to improve this situation.

- The multidisciplinary approach to patient discharge was improving, although there were still discharge delays for some patients with complex needs.
- The support for patients living with dementia or who may have a learning disability was inconsistent.
- Some patients could wait a long time for surgery. Surgery was effective but some safety procedures for surgery were inadequate and patients could be unnecessarily fasted for long periods before surgery.
- Critical care services provided safe and effective multi-disciplinary care. The caring and emotional support provided to patients was outstanding.
- Maternity services provided safe and effective care but some women had their planned induction, or planned caesarean section delayed because of pressure on the availability beds on the postnatal wards.
- Children received safe and effective multidisciplinary care but were not always seen by qualified paediatric staff in A&E out of hours or at weekends.
- Patients receiving end of life care had good support from a specialist palliative care team but this level of support was not always available in the ward areas. There were examples of patients who did not have aspects of their care managed appropriately, this included pain relief, prevention of pressure sores, breaking bad news and managing distress.
- Outpatient services were safe and changes were being made to speed up treatment for patients, and bring care closer to people's homes. Clinic appointments, however, were often cancelled at short notice and patients could wait a long in busy clinics for their consultations.

We saw several areas of outstanding practice including:

- The care and emotional support for patients in the critical care unit and NSIC was outstanding.
- The 'Evian Project', was a multi-professional group led by the consultant nurse in critical care. This has improved the hydration of patients in the trust.

- The trust had a 'Reflections at Birth' initiative for women. Women were asked to complete a 'birth reflections' questionnaire one month after the birth of their child and their answers were used to inform management and improve the quality of the service.
- Where appropriate, some children had pre-operative assessments done by phone to reduce the need for additional visits to the hospital.
- The children's outreach nurses supported early discharge for children. This included developing links with community nursing services, GPs, health visitors, education, occupational therapy and physiotherapy services.
- The NSIC was a centre of expertise and was internationally accredited. Patients were involved in setting their own treatment goals and outcomes. The centre carried out extensive research.

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

We have said the trust MUST take the following actions:

- Patients in A&E must be assessed by an appropriate specialist inpatient team in a timely way so that their treatment is not delayed. There should be clear standards to escalate patients who have long waiting times in A&E.
- The decision to admit patients must be made earlier by the A&E team. Patients waiting over 12 hours in A&E need to be accurately and appropriately identified, and the number significantly reduced.
- The accident and emergency (A&E) department must ensure that appropriate equipment is available and checked regularly to care for patients in the resuscitation bays, 'majors' area, initial assessment and treatment (IAT) and triage area.
- The procedures and facilities in the treatment room on Ward 16B need to change to ensure that medicines can be prepared safely.
- Medicines must be appropriately stored in locked cupboards and fridge temperatures need to be regularly checked, recorded, retained and acted upon.
- The appropriate medicines for end of life care must be available to avoid treatment delays.
- Care plans need to be developed for all patients.
- Patients at the end of life must have person-centred, holistic plans of care to enable staff to assess and treat patients effectively.

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- 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms must be accurately completed and records of end of life discussions with patients must be documented.
- Patients at the end of life should be treated according to the National Institute for Health and Care Excellence (NICE) 'End of life care for adults quality standards' (NICE, 2009).

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

12 June 2014

# Summary of findings

## What we found about each of the main services in the hospital

### Accident and emergency

The A&E department was full and was struggling with capacity issues while patients waited for an available bed. Patients were waiting on A&E trolleys for several hours, and some patients had waited over 12 hours for a bed to become available on the ward. This was often due to a lack of available beds in the acute medical unit and the surgical assessment unit.

Some agency staff did not have the skills to care for A&E patients, and this put extra pressure on permanent staff. Because of nursing shortages, senior nurse managers were often involved in clinical work and told us they did not get management time to focus on their team responsibilities. Although patients told us that they felt staff were caring, pressures caused by reduced staffing affected the ability of staff to consistently offer emotional support to patients.

There was not enough equipment to monitor patients, and the equipment that was available was not regularly checked. Defibrillators were only available in two of the four bays of the resuscitation room.

Requires improvement



### Medical care (including older people's care)

Patients received compassionate care and we saw that patients were treated with dignity and respect. There was regular monitoring of key safety measures, and ward areas were clean. There was no procedure for sharing learning about incidents among the medical staff. Patients were treated according to national guidelines but local guidelines were out of date. There was a lack of patient care plans, and there was a risk that patients could have inconsistent care due to staff, especially temporary staff, not being aware of the individual plans for their care. There were still concerns, however, about the presence of senior medical staff out of hours and at weekends, and the number of medical patients that a junior doctor had to cover out of hours. Some medical outlier patients were not seen at the weekend.

The trust had a dementia strategy and a dementia specialist nurse had been appointed to provide leadership and expert advice across the trust's hospitals. However, patients living with dementia had inconsistent support. Discharge was delayed for patients with complex needs.

Requires improvement



### Surgery

The use of the Five Steps to Safer Surgery checklist was being monitored and was improving and action was being taken to improve compliance which was currently 88%. Medical handovers were not consistently formal and structured. Staff told us that they were worried about understaffing. The wards did not have care plans to identify what care should be given to patients. This meant that agency nurses who were new on the wards did not have access to information on how to care for a patient.

National guidelines were used to treat patients and care pathways to support and speed patient recovery were followed. Patients, however, were not

Requires improvement



# Summary of findings

meant to be in the surgical assessment unit for longer than 23 hours, but we found instances where patients were there for more than four days waiting for their surgery. The trust was not meeting national waiting times of less than 18 weeks for patients having operations or procedures.

## Intensive/critical care

Patients we spoke with gave us examples of the outstanding care they had received in the unit. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. There was strong local leadership of the units. Openness and honesty was encouraged at all levels.

The unit had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality improvement projects and audit. There was good multidisciplinary team working. Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes.

Good



## Maternity and family planning

The ward areas were modern and clean. Women and their partners said that the staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. The average ratio of births to midwives was higher than the national average, but this had improved recently. There were, however, some comments from women on the postnatal ward about insufficient staff and staff being under pressure.

There was good multidisciplinary team working and learning throughout the service. Staff development and continuing professional development in general was a priority within the service. The leadership of the service was described as strong and effective. The head of midwifery and her team were well focused and fully engaged. Reporting arrangements to the board and within the division required improvement and the service did not have a strategy to develop its services. There was a risk management strategy to manage operational and performance risks. Risks were appropriately managed although the the lack of available postnatal care beds was not identified as a risk. Staff were good at implementing innovations in care.

Good



## Children's care

Services for children and young people were good throughout. Most parents told us the staff were caring, and we saw that children and their parents and carers were treated with dignity, respect and compassion. Ward areas and equipment were clean. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs.

Good



# Summary of findings

The services were responsive to the needs of children and young people and their families and carers. The ward sisters communicated well with staff, and staff were positive about the service and quality. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements.

## End of life care

The specialist palliative care team provided a safe, effective and responsive service. However, end of life care was consistent across the hospital ward areas and patients were not always appropriately referred to the specialist palliative care team. Some aspects of end of life care were not provided in line with national guidance, for example, access to medicines. We saw that there were delays in providing pain relief to patients. Ward staff were not appropriately trained in end of life care and essential nursing care was not delivered appropriately, for example, assessment and monitoring, pressure ulcer management, pain relief, comfort and managing distress.

Patients were not consistently involved in decisions about their care and some did not receive the compassionate care and emotional support they needed. The end of life care for patients was not monitored appropriately.

Requires improvement



## Outpatients

Patients received compassionate care and were treated with dignity and respect. Patients told us that staff were kind and supportive, and they felt fully involved in making decisions about their care. Medicines and prescription pads were securely stored. The outpatient areas we visited were clean and equipment was well maintained.

However, many clinic appointments were cancelled at short notice. Clinics were busy and patients had to wait a long time. Patients and staff told us one of the biggest challenges was clinics running late. Outpatient clinics were over-booked; there was not enough time to see patients, so clinics often over-ran. Although there had been recent improvements, many staff, particularly in the general outpatient area, said they had not been listened to on key service changes and that outpatients had not been a priority for the trust.

Requires improvement



## National Spinal Injuries Centre (NSIC)

The NSIC is a national centre for spinal injuries and develops guidelines for other units in the UK to follow. It has been internationally accredited. Staff built up trusting relationships with patients and their relatives through their interactions. Patients and relatives told us that they received considerable support. There was a sense of belonging for them. Care plans for patients with spinal injury identified goals set by the patients and these were monitored by them in partnership with the staff. There was support for current patients from former patients of the unit.

Good





# Summary of findings

Staff within the Centre spoke positively about the service they provided for patients. There was enthusiasm and energy for providing a high quality of care for patients with spinal injury. The drive to recruit more nurses and healthcare assistants was seen as an example of positively and making a difference to the culture within the service.

# Summary of findings

## What people who use the hospital say

- We held two community focus groups that were run by Regional Voices for Better Health. There were 15 participants in total representing individual views as well as community and voluntary organisations. The groups identified the concerns about staffing attitude, the pressure on beds which caused delays in admission, and the fact that staff shifts were organised around staff rather than the continuity of care for patients and discharge processed could be delayed and were sometimes inappropriate. Staff did not know how to care for vulnerable patients living with dementia or a learning disability. Positive experiences were shared about examples of good care in A&E, the breast screening unit service and that the appointment system in outpatients was problematic but was beginning to improve.
- We spoke to 12 people at our listening events. Some people told us about us that they had good care at Stoke Mandeville Hospital and were kept informed. However, people had concerns about the long waiting times in A&E at Stoke Mandeville Hospital for frail older people. People also told us about delays to surgery and delays in getting a hospice bed.
- Between September 2013 and January 2014 a questionnaire was sent to 850 recent inpatients at the trust as part of CQC Adult Inpatient Survey 2013. Overall trust was rated the same as other trusts. Comparison with the Adult Inpatient Survey in 2012 showed that the trust had improved its performance overall. The survey asked questions about waiting times for appointments, waiting for admission to a hospital bed, the hospital environment, having trusting relationships with doctors and nurses, care and treatment and operative procedures, being treated with dignity and respect, and leaving the hospital. However, patients rated the trust worse than other trusts for being given information about their condition in A&E, and for being given information on health and social care services on discharge and on the letters written by the trust to their GP that were understandable.
- The Cancer Patient Experience Survey (CPES), Department of Health, 2012/13, showed that the trust was better than other trusts in providing information to patients about their condition and treatment, but worse than other trusts in giving patients information about treatment side effects, ensuring privacy during treatment, being part of research, and having accessible notes and care plans.
- CQC's Survey of Women's Experiences of Birth 2013 showed that the trust was about the same as other trusts on all questions on care, treatment and information during labour and birth, and care after birth.
- In December 2013, the trust performed above the national average in the inpatient Family and Friends Test. It scored significantly lower than the national average on the test for accident and emergency (A&E). Most wards scored above the national average with the exception of ward 2 (orthopaedics), wards 8 and 9 (respiratory medicine), wards 16a and 16b (general surgery), and the neurology ward.
- Between January 2013 and February 2014, Stoke Mandeville Hospital had 153 reviews from patients on the NHS Choices website. It scored 4 out of 5 stars overall. The highest ratings were for cleanliness, excellent care, respectful and dedicated staff, and good aftercare. The lowest ratings were for overcrowding, discharge arrangements, waiting times, and feeling abandoned when the hospital was busy.
- Patient-Led Assessment of the Care Environment (PLACE) is self-assessments undertaken by teams focus NHS and independent healthcare staff and also the public and patients. In 2013, Stoke Mandeville Hospital scored below the national average for cleanliness (90.0% compared to the national average 95.7%), for privacy, dignity and well-being (77.5% compared to 88.9%) for facilities (75.4% compared to 88.8%). The hospital scored above the national average for food and hydration (89.3%; compared to 85.4%).
- During our inspection, patients told us staff were caring, helpful and supportive.

# Summary of findings

## Areas for improvement

### Action the hospital **MUST** take to improve

- Patients in A&E must be assessed by an appropriate specialist inpatient team in a timely way so that their treatment is not delayed. There should be clear standards to escalate patients who have long waiting times in A&E.
  - The decision to admit patients must be made earlier by the A&E team. Patients waiting over 12 hours in A&E need to be accurately and appropriately identified, and the number significantly reduced.
  - The accident and emergency (A&E) department must ensure that appropriate equipment is available and checked regularly to care for patients in the resuscitation bays, 'majors' area, initial assessment and treatment (IAT) and triage area.
  - The procedures and facilities in the treatment room on Ward 16B need to change to ensure that medicines can be prepared safely.
  - Medicines must be appropriately stored in locked cupboards and fridge temperatures need to be regularly checked, recorded, retained and acted upon.
  - The appropriate medicines for end of life care must be available to avoid treatment delays.
  - Care plans need to be developed for all patients.
  - Patients at the end of life must have person-centred, holistic plans of care to enable staff to assess and treat patients effectively.
  - 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms must be accurately completed and records of end of life discussions with patients must be documented.
  - Patients at the end of life should be treated according to the National Institute for Health and Care Excellence (NICE) 'End of life care for adults quality standards' (NICE, 2009).
- The major incident policy needs to be updated to take account of the recent enlargement and changes to the A&E department.
  - Patients in A&E should be assessed by an appropriate specialist team in a timely way so that their treatment is not delayed. There should be clear standards to escalate patients who have long waiting times in A&E.
  - The decision to admit patients should be made earlier by the A&E team. Patients waiting over 12 hours in A&E need to be accurately and appropriately identified, and the number significantly reduced.
  - Work needs to be done to alleviate the pressure and stress on staff working in A&E, and to improve the culture of the department.
  - Work with partners on avoiding admission and planning discharge for patients with complex needs should continue, and there should be appropriate resources and care pathways across acute and community care.
  - The trust should ensure that there are suitably qualified, skilled and experienced staff to meet the needs of patients in A&E, medical care, surgery and the National Spinal Injuries Centre (NSIC).
  - There should be better arrangements for medical patients on non-medical wards (medical outliers) to be seen by specialist medical and nursing staff.
  - The use of the Five Steps to Safer Surgery checklist should continue to improve.
  - There should be arrangements in place to inform staff about learning from incidents, and incidents need to be investigated in a timely manner.
  - The trust should identify how staff can hold sensitive conversations in private in ward environments that do not have a relatives' room.
  - The trust needs to improve the process for the screening and assessing patients undergoing surgery to identify and subsequently manage those at increased risk of developing blood clots
  - The medical handover of patients in surgery should be formal, structured and documented.
  - The trust needs to improve the organisation of services in surgery, specifically on Ward 16B, so that patients are cared for by appropriate specialist staff.

### Action the hospital **SHOULD** take to improve

- More work needs to be done to address the capacity and flow of patients through A&E and the hospital as a whole, particularly on medical wards, in order to ensure that the services do not become unsafe.
- A&E staff should ensure cleaning policies and procedures are adhered to, so as to reduce the risk of cross infection and potential harm to patients.

# Summary of findings

- The capacity in maternity services needs to be addressed. Women should not experience delays in the induction of labour or elective caesarean because of pressure on the postnatal ward.
- Reporting arrangements in maternity should be addressed so that assurance is effectively gained by the trust board and division.
- Staff should have appropriate training for end of life care and this care needs to be regularly monitored.
- The trust should have an agreed plan to replace the Graseby syringe drivers that are only licensed for use to the end of 2015.
- More work needs to be done to avoid end of life care patients experiencing several ward moves during their inpatient stay.
- Patient feedback should be sought and used to improve the quality of the outpatient service.
- Clinic templates that are used to plan clinic appointments for consultants should be reviewed to ensure that clinics are not overbooked and patients do not wait for long periods in clinics.
- The outpatient department should have an appropriate process to identify, monitor and take action on risks.
- Outpatient clinics should be better planned and monitored. Medical staff should book annual leave according to trust policy to avoid the excessive cancellation of clinic appointments at short notice, and patients should not have repeated cancellation of appointments.
- A clear vision and strategy should be developed for all services.
- The trust needs to improve the quality of food served to patients in the NSIC.

## Good practice

### **Areas of outstanding practice seen at this inspection:**

- The care and emotional support for patients in the critical care unit and National Spinal Injury Centre (NSIC) was outstanding.
- The 'Evian Project', was a multi-professional group led by the consultant nurse in critical care. This has improved the hydration of patients in the trust.
- The trust had a 'Reflections at Birth' initiative for women. Women were asked to complete a 'birth reflections' questionnaire one month after the birth of their child and their answers were used to inform management and improve the quality of the service.
- Where appropriate, children had pre-operative assessments done over the phone to reduce the need for additional visits to the hospital.
- The children's outreach nurses supported early discharge for children. This involved developing links with community nursing services, GPs, health visitors, education, occupational therapy and physiotherapy services.
- The NSIC was a centre of expertise and was internationally accredited. Patients were involved in setting their own treatment goals and outcomes. The centre carried out extensive research.

# Stoke Mandeville Hospital

## Detailed Findings

### Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients; National Spinal Injuries Centre (NSIC)

## Our inspection team

### Our inspection team was led by:

**Chair:** Heather Lawrence, Non-Executive Director, Monitor

**Team Leader:** Joyce Frederick, Head of Hospital Inspection, Care Quality Commission

The team of 36 included CQC inspectors, a pharmacist inspector and analysts, the medical director quality and service design, NHS England, a chief nurse and director of patient experience, consultant in emergency medicine, consultant in obstetrics and gynaecology, a professor and consultant in orthopaedic surgery, a consultant adult and paediatric cardiothoracic anaesthetist, senior clinical fellow in emergency medicine, a junior doctor, a midwife supervisor of midwives, a director of nursing, a theatre nurse, a nurse practitioner in cancer and haematology, a patient experience matron in A&E and ophthalmology, a nurse in paediatrics and child health, an associate director for the division of medicine and professional lead for therapies, student nurse, patient and the public representatives and experts by experience. The Patients Association was also part of our team to review how the trust handled complaints.

## Background to Stoke Mandeville Hospital

Stoke Mandeville Hospital is part of Buckinghamshire Healthcare NHS Trust. The trust is a major provider of community and hospital services in South Central England, providing care to a population of more than 500,000 people in Aylesbury Vale, Wycombe, Chiltern and South Buckinghamshire. The trust had approximately 6,000 staff and 822 beds in total. There were two acute hospital sites at Stoke Mandeville Hospital and Wycombe Hospital, and also community hospital sites at Buckingham Community Hospital, Chalfonts and Gerrards Cross Hospital, Marlow Community Hospital, Thame Community Hospital and Amersham Hospital.

Buckinghamshire Healthcare NHS Trust was formed in a merger of the acute and community hospitals in 2010. The trust had faced some financial challenges and had developed services across Buckinghamshire where most emergency and inpatient services were centralised at Stoke Mandeville Hospital. In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in July that year. After that review, the trust entered special measures because there were concerns about the care of emergency patients and those whose condition might deteriorate. There were also concerns

# Detailed Findings

about staffing levels (particularly of senior medical staff at night and weekends), patients' experiences of care and, more generally, that the trust board was too reliant on reassurance rather than explicit assurance about levels of care and safety.

At the time of the inspection, the executive team was going through a period of change. A new trust chair had been appointed to start in March 2014, and a new chief nurse in April 2014. The medical director, chief operating officer and director of human resources were all new appointments within the past 12 months.

Stoke Mandeville Hospital had 479 beds and provided a wide range of inpatient medical, surgical and specialist services as well as 24-hour A&E, maternity and outpatient services. The hospital had the regional centre for burn care, plastic surgery and dermatology, as well as the National Spinal Injuries Centre (NSIC). The hospital had recently become a national bowel cancer screening programme site. It saw 48,000 inpatients and 219,000 outpatients a year.

Stoke Mandeville Hospital had been inspected five times since its registration with the CQC in April 2010. It was inspected in July 2011, July 2012, February and March 2013. On several occasions, the hospital was not meeting essential standards for staffing and supporting workers. In March 2013, we issued warning notices for Regulation 22: Staffing, and Regulation 23 supporting workers and required the trust to improve staffing to safe levels for patient care at the hospital. We followed up the warning notices in July 2013 and identified that the trust had made some improvements. The trust had compliance actions to continue to improve.

We inspected this trust as part of our in-depth hospital inspection programme. We chose this trust because it represented a variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, the trust was considered to be a high-risk service.

The inspection team inspected the following eight core services at Stoke Mandeville Hospital:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery

- Critical care
- Maternity
- Children's care
- End of life care
- Outpatients.

In addition, we also inspected the National Spinal Injuries Centre (NSIC).

## Facts and data about this hospital Buckinghamshire Healthcare NHS Trust: Key facts and figures (Latest data from March 2014)

### 1. Context

- Around 731 beds (479 beds at Stoke Mandeville Hospital)
- Population around 346,000
- Staff: 5,750
- Deficit: £1.8m in 2012/13

### 2. Activity

- Inpatient admissions: 91,307pa
- Outpatient attendances: 473,949pa
- A+E attendances: 93,806pa
- Births: 5,684pa

### 3. Beds and Bed occupancy

- General and acute: 675 (B.O. 92.3%)
- Maternity: 56 (B.O. 60.9%)
- Adult critical care: 17 (B.O. 86.5%)
- PICU: n/a
- NICU: 3 (B.O. 100%)

### 4. Intelligent Monitoring – (March 2014)

- Safe: Items = 8, Risks = 1, Elevated = 0, Score = 1
- Effective: Items = 32, Risks = 0, Elevated = 0, Score = 0
- Caring: Items = 10, Risks = 0, Elevated = 0, Score = 0
- Responsive: Items = 11, Risks = 2, Elevated = 0, Score = 2
- Well led: Items = 25, Risks = 2, Elevated = 1, Score = 4
- **Total:** Items = 86, Risks = 5, Elevated = 1, Score = 6

### 5. Safety

- 3 never events (2 previous Never Events now reclassified under STEIS as serious incidents).
- STEIs 127 SUIs (Dec 2012-Jan 2014)
- NRLS - Deaths 10; Severe 31; Moderate 833
- Safety thermometer: Pressure ulcers = High but variable; VTE = High; Catheter UTIs = High; Falls = Low but variable

# Detailed Findings

- Infections - Cdiff = 34, MRSA = 0

## 6. Effective

All within expectations

## 7. Caring

- CQC inpatient survey: within expectations
- FFT Inpatient: Above England average overall
- A+E: Below England average
- Maternity survey 2013: within expectations
- Cancer patient experience survey: Performed better than average for 5 out of 69 questions and worse than average for 8 out of 69.

## 8. Responsive

- A+E 4 hr standard – Overall below. Down to around 85.5% at some points but improving.
- A+E left without being seen: worse than average.
- Cancelled operations: average
- Delayed discharges: average

## 9. Well led

- Sickness rate 4.2% (England average = 4.2%)
- Agency 3.7% (average to area)
- FTE nurses/bed day 2.06 (above average)
- Staff survey 2013 – 28 questions: 1 much better than average, 4 tending towards better than average, 5 Neutral, 8 tending towards average, 10 worse than average
- GMC survey: 20 areas worse than expected and 5 better than expected.

The trust's performance was found to be worse than expected in two or more areas for the following specialties:

- Emergency Medicine
- General (internal) Medicine
- Geriatric Medicine
- Trauma and Orthopaedic Surgery

The trust's performance was found to be worse than expected in three or more specialties for the following areas:

- Overall satisfaction
- Clinical supervision
- Adequate experience

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the royal colleges and the local Healthwatch.

We held two community focus groups on 5 March 2014 with voluntary and community organisations were held specifically for Stoke Mandeville Hospital. The focus groups were organised by Community Impact Bucks in partnership with Raise, through the Regional Voices Programme. This aims to listen to the views of people about services that may not always be heard.

We held two listening events, in Aylesbury and Wycombe, on 18 March 2014, when people shared their views and experiences of Stoke Mandeville Hospital. Some people who were unable to attend the listening events shared their experiences via email or telephone.

We carried out an announced inspection visit on 19–21 March 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.





# Detailed Findings

We carried out unannounced inspections between 7pm and 11pm on Friday 28 March 2014 and between 6pm and 10pm on Saturday 29 March. We looked at how the hospital was run at night, the levels and type of staff available, and how they cared for patients.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Stoke Mandeville Hospital.



# Accident and emergency

Safe	Requires improvement 
Effective	Not sufficient evidence to rate
Caring	Requires improvement 
Responsive	Inadequate 
Well-led	Requires improvement 

## Information about the service

Accident and emergency (A&E) services provided care for both paediatric and adult patients and was the ‘front door’ for all patients referred by GPs and via 999 calls, as well as walk-in patients. The adult emergency department saw 73,757 new admissions for the year 2013/14, of which 18,541 were paediatric patients. 19,611 patients were admitted to inpatient wards.

The trust has recently enlarged and changed the department. The main department had five resuscitation beds, 10 major injuries (‘majors’) beds, three minor injuries (‘minors’) assessment rooms, five initial assessment and treatment (IAT) bays, 20 beds within the clinical decisions unit (CDU), three assessment rooms within the waiting area and an assessment room based in the triage area. The paediatric decisions unit (PDU) had five assessment rooms and four beds available for overnight short stay admissions. The emergency department is classed as a trauma unit and links with John Radcliffe Hospital, Oxford for major trauma services.

We visited A&E services and clinical decision unit. We talked with 16 patients, 8 relatives visiting the unit and 27 staff of different grades. These included nursing and medical staff, therapists, administrators, managers, support staff and members of ambulance crews. We observed care and treatment and looked at 14 care records. Before the inspection, we reviewed performance information from, and about, the hospital

## Summary of findings

The A&E department was full and was struggling with capacity issues while patients waited for an available bed. Patients were waiting on A&E trolleys for several hours, and some patients had waited over 12 hours for a bed to become available on the ward. This was often due to a lack of available beds in the acute medical unit and the surgical assessment unit.

Some agency staff did not have the skills to care for A&E patients, and this put extra pressure on permanent staff. Because of nursing shortages, senior nurse managers were often involved in clinical work and told us they did not get management time to focus on their team responsibilities. Although patients told us that they felt staff were caring, pressures caused by reduced staffing affected the ability of staff to consistently offer emotional support to patients.

There was not enough equipment to monitor patients, and the equipment that was available was not regularly checked. Defibrillators were only available in two of the four bays of the resuscitation room.

# Accident and emergency

## Are accident and emergency services safe?

Requires improvement 

Some agency staff did not have the skills to care for A&E patients, and this put extra pressure on permanent staff. The trust's policy on infection control and cleanliness was not always followed, and the department was below target for good hand hygiene. There was not enough equipment to monitor patients, and the equipment that was available was not regularly checked. Defibrillators were only available in two of the four bays of the resuscitation room. National guidelines on medicines management were not always followed. There was a consistent approach to investigating incidents. However, lessons about drug mistakes were not shared so that staff could learn from them. Risk assessments for patients were not performed routinely.

### Incidents, reporting and learning

- The department had no recent 'Never Events' (incidents that should never occur) during December 2012 to January 2014. Between June 2013 and July 2013 there had been 54 incidents in A&E reported to the National Reporting and Learning System (NRLS) and nine were serious incidents. More recent figures from January to February 2014 indicated that A&E had two reported incidents both were moderate harm for pressure sores.
- There had been 34 incidents reported to the National Reporting and Learning System (NRLS) between January 2014 and March 2014 and two of these incidents related to harm.
- There was a consistent approach to investigating incidents with root cause analysis performed for serious incidents and robust action plans to address concerns.
- Learning and changes to practice were communicated through a monthly newsletter.

### Safety Thermometer

- The department displayed its own patient NHS Safety Thermometer information in both the paediatric decision unit (PDU) and main areas of the department, and this included information on hand hygiene audits and complaints.
- The trust performed below the average for England for venous thromboembolism (VTE) in October 2013. We

found that risk assessments were completed on most patients who were admitted to the clinical decision unit (CDU). During our visit, a patient who had previously had deep vein thrombosis (DVT) had not had an assessment for three days. We reviewed four patient records and found these had completed assessments.

### Cleanliness, infection control and hygiene

- The general areas of the A&E department were clean and staff used hand hygiene gel and personal protective equipment, such as gloves and aprons.
- Scheduled cleaning records were kept in the resuscitation room. There was a laminated record for majors areas on the wall but this had not been signed for five days and we found two dirty commodes in the department.
- The department's hand hygiene audit indicated it was performing at 90% which was below the trust target of 95%.
- The trust policy on infection control procedures and cleanliness was not always adhered to. Green 'I am clean' tape and stickers were attached to equipment. However, we saw that some equipment was dirty despite tape and stickers being used, and we saw staff using equipment without prior cleaning.

### Environment and equipment

- The department did not have sufficient equipment to monitor patients and equipment that was available was not regularly checked. Cardiac monitors were available in all bays in the resuscitation room but not in other areas; defibrillators were only available in two of the four bays of the resuscitation room.
- Equipment in the resuscitation bays was not stored in standard places and not all staff were aware of the various locations which was a risk in an emergency.
- There were two blood pressure machines in the majors area and one in the IAT and triage area. Staff spent time looking for equipment and had to share between areas and this could mean delays in patient care and treatment. They told us they did not have a bladder scanner and had to borrow this from other areas.
- The department remained locked to visitors. Reception staff ensured no unauthorised visitors were allowed entry. A security team was on duty 24 hours a day. It was based at the door to the A&E waiting room.

# Accident and emergency

- Access to x-rays in A&E had been highlighted on the at-risk register as this was delayed, particularly during busy periods. Some patients were waiting over two hours for x-ray. The department now had a new CT scanner which was improving access.

## Medicines

- The department reported 49 drug-related incidents between April 2013 and December 2013. Staff who made drug errors met with the department manager and completed reflective documents that were placed in their personnel files. The lessons learnt were not shared across the department.
- Medicines were stored correctly in locked cupboards and fridges when necessary.
- The medicines' fridge temperatures were correct but accurate records of temperature checks were not available. This meant staff would not be aware if fridge temperatures were incorrect and this could affect the efficacy of medications.
- National guidance from National Institute for Health and Clinical Excellence (NICE) in 2007 on medication reconciliation was followed. This guidance identified that pharmacy staff should review patient medication within 24 hours of a patient admission as the potential risk of errors in prescribing could cause significant harm. The trust was achieving this for between 70% to 80% of patients.

## Records

- Assessment documents for the rapid assessment of patients on arrival were used for initial vital signs and analgesia requirements.
- Nursing notes however, were inconsistent and there were no guidelines to show the standards expected in nursing documentation. Body maps were available for patients with skin damage and pressure area assessments were done. Risk assessments were not performed routinely for example for patients at risk of falls and some of the notes we reviewed had large gaps of several hours when no nursing care had been documented. There was no evidence of patient review being given pain relief.
- Some patients did not have name bands, despite having been identified as confused.
- Documentation completed by doctors followed a consistent approach and used the medical model of assessment that included: presenting complaint, history of presenting complaint, past medical history,

medication and allergy history, social history, examination and initial diagnoses, and plan of care. Reviews were evident after investigations were completed and action plans clearly identified.

## Mental Capacity Act, consenting and Deprivation of Liberty Safeguarding

- Patients requiring procedures under anaesthetic had their consent obtained appropriately using trust consent forms.
- The trust had processes for patients who required assessment under the Mental Capacity Act 2005. The staff we spoke to had knowledge of the Act but were unable to show us relevant documents to demonstrate its use in the department.

## Safeguarding children

- Staff used the trust safeguarding policy, which ensured appropriate referrals were made to safeguarding teams. Some staff had differences in their understanding as to whom to refer safeguarding concerns within the paediatric decision unit.

## Assessing and responding to patient risks

- Patients who arrived by ambulance were assessed by the nurse in charge and streamed to appropriate areas of the department. Patients who arrived through reception were greeted by a receptionist and assessed by a triage nurse or a trained senior nurse who worked as the navigator to provide experienced assessment of patients.
- Paediatric patients were assessed by the paediatric nurses in the paediatric decisions unit and waited in a separate area designated for children.
- The department used the national early warning score for both paediatric and adult patients. Paediatric patients who were assessed with a high paediatric early warning score (PEWS) were escalated appropriately and staff said medical colleagues responded within designated timescales to high-scoring patients.
- Adult patients were escalated using early warning score tool and the trust escalation policy on the vital signs chart. Nurses told us specialty teams were sometimes delayed when concerns were escalated but, when this happened, the A&E doctors would review sick patients.

# Accident and emergency

## Nursing staffing

- There were 17 whole time equivalent (WTE) nurse vacancies and bank and agency staff were being used to fill vacancies. At the time of our inspection there was a ratio of one agency to one permanent nurse.
- Staff told us some agency staff had good knowledge of A&E practice. However, some did not have the skills to care for patients. Because of the need to ensure patients were seen by skilled staff, permanent staff said they felt 'pressured' and unable to take breaks if this meant leaving agency nurses alone. The supervision and workload of staff was not monitored effectively.
- A recruitment strategy in line with the Royal College of Nursing (RCN) guidance had been approved and recruitment had started to fill vacancies with permanent staff.

## Medical staffing

- There were five consultants who provided a service from 8am to 8pm during the week and from 9am to 11pm on Saturdays and Sundays. The consultants provided an on-call service outside these hours. There were three vacancies at consultant level that were covered by locum doctors. The trust was recruiting to four more A&E consultant posts.
- The middle grades and senior house officer provided cover 24 hours a day. There were 0.83 vacancies at middle-grade level and no vacancies at junior doctor level.

## Mandatory training

- The trust target for compliance with mandatory training was 100%. In December 2013, records within the division confirmed that 75% of staff were up to date with mandatory training.
- Adult and child safeguarding training was part of induction and all staff were up to date with either adult or paediatric safeguarding training, depending on whether they worked within the PDU or adult area of the department.

## Major incident awareness and training

- Staff we spoke with could locate the major incident policy and were aware of their roles.
- The major incident policy was dated May 2012. While it covered responses to a major incident, it did not take account of the recent enlargement and changes to the layout of the department.

## Are accident and emergency services effective?

(for example, treatment is effective)

### Not sufficient evidence to rate

We report on effectiveness for A&E below. However, we are not currently confident that overall CQC is able to collect enough evidence to give a rating for effectiveness in A&E departments.

## Evidence-based care and treatment

- The A&E department used a variety of guidelines including those from the National Institute for Health and Care Excellence (NICE), the British Thoracic Society (BTS) and the College of Emergency Medicine (CEM).
- The department was working to ensure the A&E was managed in accordance with the clinical standard for Emergency Departments (CEM)
- Care pathways were available for patients with specific conditions such as sepsis (a serious infection), fractured hip, community-acquired pneumonia and stroke. Both nurses and doctors contributed to the completion of the relevant documents, and they were monitored and audited regularly by inpatient teams.
- Local policies were written in line with these guidelines though some had not been updated. There were documents related to fractured neck of femur, sepsis, stroke and venous thromboembolism. There were no documents related to NICE guidance for patients presenting with head injury.
- There was a local audit programme for the A&E department but many audits had been cancelled or had not yet started.
- Monthly meetings were used to discuss outcomes of care and improvements were circulated via monthly newsletter.

## Patient outcomes

- The department contributed to CEM audits including consultant sign off, renal colic, vital signs in majors, fractured neck of femur and feverish children. The trust was similar to better than other trusts and had demonstrated improvement compared to audit results in previous years. The department needed to improve recording pain scores and measuring vital signs in feverish children.

# Accident and emergency

- The management of patients with sepsis (a serious infection) was monitored and 91% of patients received antibiotics within one hour which was lower than the trust target of 100%.
- Unplanned re-attendance rates that were below the national average of less than 5%.

## Pain relief

- The trust was similar to other trusts for timely pain relief and analgesia review for patients with fractured neck of femur but was worse than expected for recording pain scores for patients (CEM audit 2012/13).
- The trust was one of the best performing trusts for providing pain relief according to national guidelines for patients with renal colic (CEM audit 2012/13)
- We observed that some patients were delayed in receiving pain relief while they were waiting for assessment from specialist inpatient teams and some patients did not have a timely review after being given analgesia

## Competent staff

- Medical and nurse staff had appropriate qualifications to care of acutely ill children.
- Nursing staff told us they felt supported to develop and achieve training requirements.
- Junior doctors said that A&E training always happened. However, trust-level training was often cancelled.
- The National Training Scheme Survey, GMC, 2013 indicated that the training given to junior doctors was similar to other trusts but was worse than expected for overall satisfaction, adequate experience, workload, and clinical supervision.
- For the year to date, appraisals were completed for 78% of staff. This was higher than the trust target of 70%

## Multidisciplinary working

- Medical and nursing teams worked well with other specialties and therapy services to provide multidisciplinary care.
- There were significant delays for patients needing assessments by the medical and surgical inpatient teams.

## Seven-day services

- Consultants worked from 9am to 11pm on both Saturday and Sundays and were supported by four middle-grade doctors over a 24-hour period.

- Emergency nurse practitioners provided a service from 10am to 10pm on Tuesdays, Wednesdays and Thursdays, and 10am to midnight on other days of the week.
- The rapid early assessment care team (REACT) provided a reduced service at weekends. REACT provided nursing and therapy support to facilitate the discharge of frail and older patients. The REACT nurses told us their workload was 'too large' and they felt under pressure to discharge patients too early.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

## Are accident and emergency services caring?

Requires improvement 

Although patients told us that they felt staff were caring, and most patients told us they felt involved in their care, the trust scored significantly lower in the A&E Friend and Family Test than the national average for patients that were extremely likely to recommend the service to others. Pressures caused by reduced staffing during part of our visit affected the ability of staff to consistently offer emotional support to patients.

## Compassionate care

- The A&E Friends and Family (September 2013 to December 2013) demonstrated that the trust response rates were above the national average but scored significantly lower than the national average for patients that were extremely likely to recommend the service to friends or family
- The trust was worse than other trusts in the CQC adult inpatient survey (2013) for patients being given enough information about their condition or treatment in A&E, but were about the same as other trusts for being given enough privacy when being examined or treated.
- Patients told us they felt staff were caring and kind and kept them informed.

# Accident and emergency

- Throughout our visit, we saw patients were offered food and drink at mealtimes, and their dignity and privacy were respected.
- Call bells were not available in all rooms. However, when they were used, they were answered quickly for most patients.

## Patient involvement in care

- Most patients told us they felt involved in their care and were offered advice regarding their discharge.
- Patients waiting in the waiting room for assessment told us they were not informed of waiting times and what would happen during their visit.

## Emotional support

- We saw staff supporting relatives of seriously unwell patients by offering them refreshments and a private area to sit in. However, reduced staffing during part of our visit had an impact on their ability to achieve this consistently. One family member told us they felt the staff could not support them and their family because they were busy caring for other sick patients.

## Are accident and emergency services responsive to people's needs? (for example, to feedback?)

Inadequate 

The A&E department was full and was struggling with capacity issues while patients waited for an available bed. The number of hospital beds had been restricted due to Norovirus. A&E doctors often identified patients informally for admission, but the decision to admit patients was done by the inpatient speciality teams. There were delays with this approach, with patients waiting on A&E trolleys for several hours, and some patients had waited over 12 hours for a bed to become available on the ward. We saw several patients waiting over six hours before a decision to admit was taken. This was often due to a lack of available beds in the acute medical unit and the surgical assessment unit.

## Access to services

- Patients who arrived by ambulance were assessed by the nurse in charge and streamed to appropriate areas of the department. Patients who arrived through reception were greeted by a receptionist and assessed

by a triage nurse or by a trained senior nurse who worked as the navigator to provide experienced assessment of patients. The navigator role had been trialled as a pilot.

- Patients were streamed to appropriate areas within the department or to the acute medical unit (AMU) or surgical assessment unit (SAU). Patients could be referred by GPs directly to the AMU or SMU.
- The clinical decision unit (CDU) had opened in November 2013 to enable A&E patients to receive further monitoring, investigations and prompt discharge. Twenty beds were available with 10 allocated to specialty teams to allow short-stay patients to be discharged quickly.
- During July 2012 and January 2014, the trust was struggling to meet the 95% target for the admission, discharge or transfer of patients within four hours of attendance at A&E. There was a local agreement for the 4-hour target reported by the trust to include data from the minor injury and illness unit at Wycombe Hospital, which was managed by a different provider. This had significantly improved the trust performance overall but the trust was still, at times below the national average, the lowest being 85.5% in March 2013.
- During November 2012 to November 2013, the percentage of patients leaving A&E before treatment was higher than the national average of 2%. It peaked at 5% and was now meeting the national average in November 2013.
- The trust had submitted data nationally on number of patient's waiting between four and 12 hours in A&E following the decision to admit.
- The trust reported that time to initial treatment was below the national target of less than 60 minutes. During our visit, the initial assessment time by the navigator or triage nurse in the waiting area was 30–40 minutes and patients were waiting over three hours to see a doctor.
- Patients who were wrongly admitted to Wycombe Hospital were transported to Stoke Mandeville but there could be delays if they were admitted through A&E. We observed that this had occurred for two patients, with one patient waiting a long time for pain relief medication.

# Accident and emergency

- GPs were sent a discharge summary of a patient's attendance at A&E. Timescales for sending these varied because they needed to be signed by clinicians before posting. A doctor told us they could take up to 11 days if clinicians were on leave.
- The lead nurse told us they had recently begun to have discussions with GP providers to reduce admissions from nursing homes. No actions had yet been agreed.

## Managing patient flow through the hospital

- During our visit, the A&E department was full and was struggling with capacity issues whilst patients waited for an available bed.
- The A&E department had done work to ascertain peak times for admissions to both A&E and specialty teams, and a second consultant physician of the day (POD) and advanced nurse practitioner staffing had been adjusted to reflect peak admission times to decrease patient waiting times. During our visit, however, we observed that patients were waiting over four hours to be seen by a doctor from the inpatient team after referral.
- The department had an administration assistant called a 'tracker' who assisted nursing staff to monitor waiting times and liaised with doctors to improve the timeliness of assessment and treatment. Doctors told us they felt the tracker did not 'push' patients through the system and the nurse in charge often had to intervene.
- The A&E doctors often identified patients informally for admission the decision to admit patients to the hospital was done by the inpatient speciality teams. There were delays with this approach. Some patients were waiting on A&E trolleys for several hours. We witnessed several patients waiting over six hours before a decision to admit was taken and a few patients had waited over 12 hours for a bed to become available on the ward. One 91-year-old patient waited over 16 hours on a trolley in A&E for a bed in the hospital.
- There was a lack of available in beds in the AMU and SAU and patients were being kept in A&E for their assessment and treatment. Patients were being transferred to the CDU instead of an available inpatient bed and 18 patients who required admission occupied beds in the CDU that were needed for short stay.
- Emergency patients were in AMU, SAU and CDU and the inpatient teams had a large geographical area to cover to see, review, treat and discharge patients and this further delayed the assessment and treatment of new patients coming into A&E.

## Children's accident and emergency

- We observed that paediatric patients in A&E were seen by practitioners and, when appropriate, discharged within four hours.
- During our unannounced visit, there were no paediatric nurses in A&E after 10pm. Children were seen by staff in A&E but paediatric triage was taking longer than 15 minutes, with some children waiting between 30 and 40 minutes.

## Meeting people's individual needs

- The lead nurse told us they had met with providers of services to people with learning disabilities and were planning to introduce personal plans.
- One of the cubicles in majors had been identified for use as a specialist dementia room and procurement had begun to furnish it with memorabilia.
- Signage had been added in picture format for patients with visual impairment or reading difficulties; examples were pictures of toilets on toilet doors.
- Advice leaflets were available in different languages; however, these were not displayed in the department and staff took over 10 minutes to find them in reception when we asked. We did not see language or interpreter services being used during our visit and no information about these was displayed in patient areas.
- Alternative meal choices were available for special diets, and during our visit we observed nurses accessing a halal meal for a patient.
- Mental health patients were cared for in the main department or clinical decision unit if a bed was available. The relatives' room was used for assessments. A new psychiatric liaison service had been planned to start in April 2014.

## Complaints

- All complaints were handled by the lead nurse in line with trust policy; informal complaints could be made to the nurse in charge. Patient Advice and Liaison Service (PALS) advice leaflets were available at the reception desk.
- Complaints were responded to within the trust target of 25 days.
- There was evidence of learning and patient involvement to improve service outcomes for patients. We saw correspondence following a complaint whereby a patient had agreed to contribute to the education of doctors regarding a rare but serious infection.

# Accident and emergency

## Are accident and emergency services well-led?

Requires improvement 

Because of nursing shortages, senior nurse managers were often involved in clinical work and told us they did not get management time to focus on their team responsibilities. Staff told us they felt as if they were being ‘watched’ by senior management and that they felt under pressure because of demands on capacity. A vision and strategy for the department to improve staffing and patient flow had been developed. However, it was clear from pressures identified during our visit that some units were not functioning as planned and this was having an impact on the A&E’s ability to move patients through the hospital.

### Vision and strategy for this service

- A vision and strategy for the department to improve staffing and patient flow had been developed after an emergency care intensive support team (ECIST) visit in March 2013. This includes strategies for:
- Recruitment across consultant grades, advanced nurse practitioners and junior nurses had this recruitment had started and was ongoing.
- Refurbishment of the department, which had started, and the opening of the new IAT and resuscitation areas.
- Development of the new psychiatric liaison service, due to start in April 2014.
- Closer work with commissioning groups to develop integrated emergency pathways.
- Training for nurse practitioners to see patients with minor illnesses, although during our visit no information was available regarding courses accessed.
- There were trust strategies for enabling flow through the hospital that included the opening of the acute medical unit and surgical admissions unit in June and November 2013, respectively. However, it was clear from pressures identified during our visit that these units were not functioning as planned and this was having an impact on the A&E’s ability to move patients through the hospital.

### Governance, risk management and quality measurement

- There were structured monthly governance meetings where complaints, incidents, audits and service

performance measures were discussed and actions agreed. Not all staff could attend these and the lead nurse in A&E attended governance and senior team meetings and fed back on investigations and actions from incidents.

- Results from the departmental quality dashboard were displayed in the patient areas and included hand hygiene audits and complaints about the service.
- The A&E risk register identified areas of concern including recruitment and retention, isolation of patients in the clinical decision unit, effect of equipment failure on access to A&E x-ray facilities, timely assessment of mental health patients and achievement of the quality indicators for A&E. There were actions indicated in response but these had not yet been effective in mitigating these risks. The risk register did not identify risk areas around the supervision and workload of staff, infection control and the availability of equipment.
- Band 7 nurses said that sickness and absence management was inconsistent because of clinical demands. They told us return-to-work meetings with staff were often missed. This meant that senior nurses were unable to support their staff appropriately. Concerns relating to staff sickness and absence had not been highlighted on the A&E risk register.

### Leadership of service

- The five consultants and lead nurse provided senior leadership within the A&E.
- Four band 7 nurses managed the junior nursing team. However, because of nursing shortages, they were often involved in clinical work and told us they did not get management time to focus on their team responsibilities.
- The medical director now chaired the A&E recruitment and retention group.

### Culture within the service

- Some staff told us they felt as if they were being ‘watched’ by senior management and that conversations were sometimes ‘threatening’ because of demands on capacity.
- The REACT team told us they felt under pressure to discharge patients too early, and that targets set for how many patients needed to be discharged were unrealistic. They told us they were often referred inappropriate patients and felt they ‘got the blame’ if patients could not be discharged.








# Accident and emergency

- Staff told us there was an open culture with sharing incidents and complaints, and the lead nurse and consultants used monthly newsletters and emails to inform staff of changes in practice. Senior nurses told us they shared information with their mentor teams.
- Improvement within the department was difficult to assess during our visit because there was no evidence of strategy for lead roles by band 7 team nurses.
- There was minimal engagement from junior nurses and doctors to develop and improve service delivery for patients.

## **Innovation, learning and improvement**

- There was engagement from band 7 team nurses who led on governance, infection control and performance management of junior nurses. Pressures due to staffing meant staff were unable to achieve the level of management required in lead roles.

# Medical care (including older people's care)

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

## Information about the service

Stoke Mandeville Hospital provided inpatient medical services. There were six wards and an acute medical unit. Specialities covered general medicine, gastroenterology, diabetes, respiratory, acute medicine and acute medicine for older people. There were approximately 152 medical beds.

We visited the following wards: acute medical unit (AMU or Ward 10), short-stay ward (Ward 9), medicine for older people (Ward 8), respiratory (Ward 6) and gastroenterology (Ward 4). We spoke with over 20 staff of different grades of nurses, doctors, pharmacists, therapists, administrators, housekeepers and porters. We spoke with 22 patients and five relatives. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

Patients received compassionate care and we saw that patients were treated with dignity and respect. There was regular monitoring of key safety measures, and ward areas were clean. There was no procedure for sharing learning about incidents among the medical staff. Patients were treated according to national guidelines but local guidelines were out of date. There was a lack of patient care plans, and there was a risk that patients could have inconsistent care due to staff, especially temporary staff, not being aware of the individual plans for their care. There were still concerns, however, about the presence of senior medical staff out of hours and at weekends, and the number of medical patients that a junior doctor had to cover out of hours. Some medical outlier patients were not seen at the weekend.

The trust had a dementia strategy and a dementia specialist nurse had been appointed to provide leadership and expert advice across the trust's hospitals. However, patients living with dementia had inconsistent support. Discharge was delayed for patients with complex needs.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement 

There was regular monitoring of key safety measures, and ward areas and equipment were clean. However, the use of bank and agency staff was having an impact on the continuity of care for patients, and resulting in some delays to treatment. Senior medical presence and the number of junior doctors at night and at the weekend needed to improve. There was no procedure for sharing learning about incidents among the medical staff. Some medicines were not appropriately correctly in locked cupboards and some areas did not have safes to store controlled drugs. Avoidable harms such as falls, catheter urinary tract infections, and medication errors needed to be reduced.

### Incidents, reporting and learning

- There had been no recent 'Never Events' (incidents that should never occur) reported in the division of medicine. For the period December 2012 to January 2014, there had been 19 serious incidents. These had been investigated and action taken to prevent reoccurrence.
- All the staff we spoke with said they were aware of how to report incidents. However, unless staff were involved in an incident, they did not receive feedback and lessons learned from incidents were not widely shared.

### Safety Thermometer

- The trust-wide performance for new venous thromboembolism (VTE) and new catheter-related urinary tract infections was generally higher than the average for England; performance for new pressure ulcers for patients aged over 70 was generally better than the average for England and falls with harm for patients over 70 were variable over the year.
- NHS Safety Thermometer information for a ward was clearly displayed at the ward entrance. This included information about falls, new VTE and new pressure ulcers. These key measures of safety were monitored regularly and made available to staff and patients.
- The trust was demonstrating improvements in some areas. Since January 2014, no new VTEs or avoidable pressure ulcers had been reported for the medical wards. The VTE risk assessments were 94.1% compared

with a target of 95%. However, figures for falls were higher than expected for the division and ranged from two on Ward 4 (gastroenterology) to 11 on Ward 8 (medicine for older people).

### Cleanliness, infection control and hygiene

- Ward areas were clean, but cluttered.
- Staff followed the trust infection control policy. Staff wore clothes that allowed their arms to be bare below the elbow, and they regularly washed their hands and used hand gel between patients.
- The medical division's hand hygiene audit indicated it was performing at 97.9%, which was above the trust target of 95%.
- Infection rates for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile for the trust were within an acceptable range.

### Environment and equipment

- The wards were well lit, clean and tidy.
- Equipment was clean and functional. Items were labelled with the last service date and large green stickers identified when equipment was cleaned.
- Patient boards were positioned behind every bed as a reminder to staff of patients' needs.
- Staff told us there was sufficient equipment available but that they would borrow from other wards as and when necessary.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.

### Medicines

- Some medicines were not appropriately stored in locked cupboards.
- Most ward fridge temperatures were checked regularly and adjusted if found to be outside the accepted range. However, some were not regularly checked and this did not ensure the efficacy of the medicines they contained.
- There was a ward pharmacy service and a wide range of audits conducted on medicines management, including audits on the prescription of antibiotics. A pharmacist attended the ward daily and met with patients to discuss their medication before discharge.
- Medication errors were reported monthly on the ward scorecard. In January 2014, there had been few reported

# Medical care (including older people's care)

errors on the medical wards and this ranged from zero to five errors per ward. This was an improvement compared to previous months and the trust was monitoring to ensure further improvements.

- Patients were given appropriate medicines on discharge. However, on Ward 6, staff said they were concerned that patients were given their discharge medicines in addition to any of their own medicines that may have been stopped by the doctor during their hospital stay. Patients were not being asked for their consent to discontinue their own medicines when these were not needed. This practice was inconsistent with the pharmacy information on the trust website: 'If your medicines are changed we will inform you and ask to take your old medicines away so when you leave the hospital you have only what you need.'
- Serious and moderate medicine incidents were reviewed. One serious incident involved the delay in administration of an intravenous (IV) drug because a suitably trained nurse was unavailable.

## Records

- All records were in paper format and all healthcare professionals used the same documents so that a clear chronological record for patient care was maintained.
- Documentation audits were undertaken and monitored at the monthly clinical governance meetings.
- The confidentiality of sensitive information was not maintained; confidential documents in waste bags were not secure.
- Nursing documentation covered risk assessments. It was appropriately completed but it did not include care plans. There was a risk that patients could have inconsistent care due to staff, especially temporary staff, not being aware of the individual care plans for their care.
- A trust 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) audit of 88 forms in January 2014 showed that the decision had been made and recorded in 95% of cases and by the appropriate clinician in 91% of cases. We saw a sample of DNA CPR records that had been completed appropriately.

## Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

- Patients were asked for their consent to procedures appropriately and correctly. We saw examples of

patients who did not have capacity to consent. The Mental Capacity Act 2005 was adhered to appropriately and the Deprivation of Liberty Safeguards (DoLS) were applied.

- The Trust DNA CPR audit identified that one of the main areas that was not always completed was associated mental capacity assessments, only 20% of forms were completed.

## Assessing and responding to patient risks

- The medical wards used the national early warning score tool to escalate care for acutely ill patients. There were clear directions for escalation printed on observation charts.
- Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring and action were identified and cared for appropriately.
- We looked at a sample of completed charts on the medical wards and saw that staff had escalated correctly, and that repeat observations were taken within the necessary time frames.
- Monthly ward national early warning system (NEWS) audits were undertaken of the compliance with scoring and the medical response within one hour. Ward 6, an acute respiratory ward, consistently scored 100% compliance but the medical response within one hour was 83.3% in January 2014. On Ward 8, after a poor audit result of 82%, teaching was arranged to improve compliance. The January 2014 score had increased to 94%.
- Nursing handovers occurred three times a day at the start of each shift. Staffing for the shift was discussed as well as any high-risk patients or potential issues. A formal medical handover also took place at the start of each shift. Staff on duty were familiar with the needs of patients under their care.

## Nursing staffing

- Nursing staffing levels had been reviewed and were assessed using the National Safer Nursing Care Tool. There were minimum staffing levels in the division and required and actual staffing numbers were displayed on every ward and reviewed regularly.
- There were high numbers of staff registered nurse and healthcare assistant vacancies on Ward 9 (short stay)

# Medical care (including older people's care)

and Ward 10. Approximately one third of nursing posts were vacant and 40% of healthcare assistant posts. These vacancies were filled whenever possible, with regular bank and agency staff.

- The skills and experience of temporary staff differed and it was not always possible to provide care from the same staff. This was having an impact on the continuity of care. There were, for example, delays in treatment because agency nurses were not routinely allowed to administer IV medications unless they had undertaken the trust's IV training.
- Staff were redeployed across the medical wards to reduce the risk of unsafe staffing levels when temporary staff were unavailable. When staffing levels were below the minimum, ward managers alerted the site shift coordinator and completed an incident form. Staff on Ward 9 said, "Staff come to this ward from all over the trust."
- Two patients on Ward 4 noticed a difference in the day and night care. One patient said of the night staff, "I don't feel quite as confident they will do things right."
- Nurse staffing was recognised as a priority for the trust as a whole and substantial investment had been agreed in 2014 for an international recruitment drive.

## Medical staffing

- Consultants were present in the acute medical unit (AMU) 12 hours a day, 7 days a week. On other medical wards, consultants undertook ward rounds daily. There were two physicians of the day (PODs) to ensure cover on the AMU and to attend to patients on the medical wards who needed to be seen by a consultant.
- There was a small number of consultant vacancies, which were primarily filled with trust staff. Three new acute physician consultant posts had been approved and appointments were in the process of being made.
- There was one junior doctor (foundation year 1 [FY1]) to cover the medical inpatients (approximately 200 patients) at night and weekends. The trust told us the FY1 was well supported by a second year trainee (FY2), registrar and critical care outreach nurse practitioner. However it was the number that one trainee was required to cover which was excessive and unacceptably high. Some junior doctors expressed a concern that covering 200 patients over the breadth of the wards made them feel very stretched "due to the volume and

geographical location of patients". They welcomed the recently introduced support of a registrar. However, for a new foundation year doctor (FY1) the situation was considered "difficult to manage".

## Mandatory training

- Overall, 75% of staff were up to date with annual mandatory training (including 80% for infection prevention and control, and 72% for adult safeguarding). This was not meeting the trust target of 100%.
- All staff we spoke with said they were up to date with their mandatory training.

## Are medical care services effective? (for example, treatment is effective)

Good 

National guidelines were used to treat patients although local policies were out of date. Patient care and treatment was delivered by a multi-disciplinary care team and outcomes for patients with stroke and heart disease were similar or better than expected when compared to other trusts. Teaching for junior doctors needed to improve.

## Evidence-based care and treatment

- The medical department used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Local policies were written in line with this and were intended to be updated every two years or if national guidance changed. However, 77 clinical guidelines were more than six months past their review date.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for community-acquired pneumonia and acute coronary syndrome.
- There were monthly clinical governance meetings where changes to guidance and the impact that it would have on clinical practice were discussed by medical and nursing staff.
- The trust participated in all the national clinical audits they were eligible for, except for the cardiac arrest audit. In 2012/13, the trust reviewed 16 national clinical audits to report on outcomes.

# Medical care (including older people's care)

- The department also had an annual clinical audit programme.

## Patient outcomes

- The trust was an outlier for mortality for congestive heart failure and non-hypertensive and nephrological conditions in 2012/13. Since the Keogh Mortality Review in 2013, the trust had changed its clinical governance structure. Mortality reviews of all unexpected deaths were carried out by consultants and this included independent oversight. If the death was considered to be potentially avoidable, an action plan was developed.
- In March 2014, the trust had no mortality outliers and overall mortality rates were within expected range.
- Emergency readmissions, which could be an indicator of the quality of care and discharge, were similar to those in other trusts.

## Hydration and nutrition

- A safety triangle was in place above some patients' bed as a visual reminder to staff of the patient's specific needs (for example, diabetes, risk of falling or assistance required with eating and drinking).
- Red trays, jugs and coloured beakers were in use for patients who needed their food and drink intake monitored. This ensured they received adequate nutrition and fluids as part of their treatment plan.
- Trust-wide audits of patients who had a jug of water within easy reach had significantly increased from 60% in September 2013 to a current average of 99%.
- Trust-wide audits of the percentage of patients with an appropriately completed fluid balance chart reached a peak of 80% on average in February 2014.

## Competent staff

- The core teaching programmes were in place for junior doctors (foundation year 1 [FY1] and 2 [FY2] trainees) and attendance was recorded as 64% and 57% respectively. The trust reported that alternative educational activities had been provided but junior doctors said they were concerned at the number of cancelled teaching sessions, which was approximately 50%.
- The National Training Scheme Survey, GMC, 2013, for general medicine, indicated that the trust performed worse than expected in six areas including clinical supervision and providing adequate experience for junior doctors.

- Staff said they had regular appraisals and were supported to undertake development to meet identified needs. For the year to date, appraisals were completed for 78% staff which was higher than the division's target of 70%
- Clinical supervision for nursing staff was being introduced for assessing competency, reflective learning and supportive practice.

## Multidisciplinary working

- There was input from physiotherapy, occupational therapy, speech and language therapy, and psychology. Therapy staff provided instructions, displayed above patients' beds to assist nursing staff in the care of the patient: for example, soft or puréed food only (speech and language therapy) or assistance needed to transfer from bed to chair (physiotherapy).
- Staff contacted the palliative care team or end of life team for support in meeting the needs of patients and their families if appropriate.
- There were good links with the integrated respiratory service. This meant there was effective support for patients discharged into the community with respiratory conditions.
- The gym on Ward 8 had been refitted to accommodate patients to manage capacity. It was no longer used for therapy to provide rehabilitation support to patients.

## Seven-day services

- There was a daily ward round on the acute medical unit (AMU) including at weekends. An on-call consultant saw all new admissions on the daily post-take ward round.
- Staff said, "Consultant presence at weekend makes a big difference to safety."
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

## Are medical care services caring?

Good 

Patients received compassionate care and we saw that patients were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their

# Medical care (including older people's care)

care. Patient feedback on care on the Wards 8 and 9 (the respiratory wards) and the neurology ward was below the national average and patient care and patients were not always involved in decisions about their care.

## Compassionate care

- The NHS Friends and Family Test was variable for the medical wards. In December 2013, there were three wards with scores that were lower than national average, the neurology ward and respiratory wards (W8 and W9).
- Throughout our inspection on all the wards, we witnessed that patients were treated with dignity and respect by all staff. We saw call bells answered promptly and patients we spoke with were very positive about the care they had received. One remark exemplified the compassionate care: "I was upset...the nurse noticed, drew the curtain and sat with me. I felt so much better."
- We saw that doctors and nurses introduced themselves appropriately and that curtains were drawn to maintain patient privacy.
- All patients appeared to be well cared for: for example, they looked comfortable and were washed and dressed in day clothes.
- 'You said, We did' boards were displayed on every ward with examples of how the ward had responded to patients' feedback.

## Patient involvement in care

- Patients and relatives we spoke with said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them. Two relatives on Wards 8 and 9 said it was difficult to "see the doctor to get an update".

## Emotional support

- Patients told us staff were supportive although could be busy at times.

**Are medical care services responsive to people's needs?**  
(for example, to feedback?)

Requires improvement 

The trust had a dementia strategy and a patients living with dementia specialist nurse had been appointed to provide leadership and expert advice across the trust's hospitals.

However, patients living with dementia had inconsistent support. Initiatives by the Alzheimer's Society to inform staff about patients living with dementia (such as the 'This is me' booklet) were optional and not widely used by staff. In addition, support for patients with a learning disability was inconsistent because of the recent departure of the learning disability nurse. Discharges could be delayed because of the lack of care packages or nursing or residential home placements to meet the complex and extensive needs of some patients. Discharge was also delayed as some medical patients were not seen in a timely way.

## Access to services

- Patients were admitted via the accident and emergency department (A&E) or referred by their GP, in which case they were directed to the acute medical unit (AMU). After triage, if assessed as short stay (less than 72 hours) they were transferred to the short-stay ward (Ward 9). Alternatively, if the length of stay was expected to be longer than 72 hours, the patient was referred to the care of an appropriate consultant and transferred to the designated specialist medical ward, if a bed was available.
- Bed occupancy, was consistently higher than the 85% target, ranging between 85% and 100%. Occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally. This meant that there were regular bed shortages, which affected access to care.
- The short-stay ward had recently changed from a medicine for older people ward. However, half the patients required stays of much longer than 72 hours. Staff said short stay was a nice idea in principle but was not working due to the clinical needs of patients and delays in discharge arrangements.
- There were a total of 150 beds on the medical wards. The hospital usually accommodated 200 medical inpatients. This was managed by using beds on the surgical wards and in the spinal unit for medical outliers. The medical outliers were cared for by the appropriate specialist nurses or medical staff, particularly out of hours and at weekends.
- The trust achieved its referral to treatment times of 95% of patients waiting less than 18 weeks for a procedure. Diagnostic waiting times and cancer waiting times were within the expected targets.

# Medical care (including older people's care)

## Meeting people's individual needs

- A trust dementia strategy was in place with an action plan. A dementia specialist nurse had been appointed to provide leadership and expert advice across the trust hospitals. However, patients living with dementia had inconsistent support. Initiatives by the Alzheimer's Society to alert and inform staff about patients with dementia (such as the 'This is me' booklet and the butterfly scheme to identify and meet the needs of patients living with dementia) were optional and not widely used by staff. We saw some used on Ward 8 (a respiratory ward).
- Support for patients with learning disabilities was inconsistent because of the recent departure of the learning disability nurse.
- Interpretation services were available. However, staff said they often used family members to translate if necessary.
- There was no relatives' room on every ward. This meant more sensitive conversations could not be undertaken in privacy.
- Visiting times were flexible to accommodate families who wanted to stay with their relative, if appropriate, and for patients at the end of their lives

## Discharge planning

- The average length of stay for the medical division was 7.8 days, which was higher than the trust's own target and the national average of 4.7 days. This affected the capacity and flow of patients through the hospital.
- Every ward had a discharge coordinator and discharge planning was started as soon as patients were admitted to the ward.
- Daily discharge meetings were undertaken seven days a week on the AMU and five days a week on all other medical wards. Medical staff, physiotherapists, occupational therapists, nursing staff and discharge coordinators attended. Some wards reported inconsistent attendance from some disciplines and effective discharge planning was not always achieved.
- Discharges were delayed because of the lack of care packages or nursing or residential home placements to meet the complex and extensive needs of some patients. On Ward 8, staff said, "Patients are medically fit for discharge, wait weeks and then get hospital-acquired infection: for example, pneumonia and then have to start again."

- There was a discharge lounge, staffed from 8.30am to 6pm weekdays. This was for ambulatory patients who were primarily waiting for their discharge medicines or transport. Patients were normally accommodated for 2 hours, but occasionally longer if the discharge summary or medication was not ready.
- A paper discharge summary was sent to a patient's GP by post. This detailed the reason for admission and any investigation results, treatment and discharge medication.

## Complaints

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Complaints leaflets were available at the entrance to the hospital and outside the wards.
- Patients were confident to raise their concerns with ward managers without fear of reprisals.
- The medical division, however, only responded to 71% of complaints within the trust's 25-day target. This was below the trust target of 85%.

## Are medical care services well-led?

Requires improvement 

All nursing staff spoke highly of the ward managers and matron as leaders. The medical division had a strategy and this included priority areas for each service. However, risks registers did not identify how the division would respond to immediate priorities of as junior doctor cover arrangements, managing patient flow which included the support to A&E, the use of medical wards or improvements to discharge planning. The results of the 2012 NHS Staff Survey showed that the trust was worse than expected for the percentage of staff able to contribute to improvements at work. This was replicated in the medical division, where staff shortages and workload meant that many staff were not involved in quality improvement projects.

## Vision and strategy for this service

- The trust's vision was encapsulated in the strapline 'Safe and compassionate care every time'. This was visible on every ward.



# Medical care (including older people's care)

- The medical division had a strategy and this included priority areas for each service. For example, medicine for older people included the development of pathways to improve health and avoid admission.
- Service strategies did not identify how the division would respond to immediate priorities of junior doctor cover arrangements, managing patient flow, including the support to A&E, the use of medical wards or improvements to discharge planning.
- A trust dementia strategy was in place with an action plan. A dementia specialist nurse had been appointed to provide leadership and expert advice across the trust hospitals. Patients living with dementia, however, were inconsistently identified and care did not always respond to their needs.

## Governance, risk management and quality measurement

- Structured monthly governance meetings were held within each service delivery unit consistent with the new overall trust clinical governance framework. Complaints, incidents, audits and service performance information were discussed and actions agreed. However, there was not a systematic approach to reviewing clinical guidelines.
- The division had quality dashboard for each service and ward areas this showed performances against quality and performance targets and these were presented monthly at the clinical governance meetings.
- Bi-monthly division performance review meetings took place and were reported to the trust board. These were chaired by the director of operations and involved senior divisional leaders. Quality, risk and performance issues were discussed and actions agreed.

- The integrated medicine risk register highlighted risks across all the trust's medical departments, and actions in place to address concerns: for example, bed capacity.
- Staff said there was a robust system to ensure changes to practice were communicated to all staff in writing and at team meetings.

## Leadership of service

- A medical leadership programme and leadership training to support staff at different levels of the organisation were provided.
- Ward sisters had attended a leadership training programme.
- All nursing staff spoke highly of the ward managers and matron as leaders.






## Culture within the service

- All staff within the directorate spoke positively about the service they provided for patients. Since the Keogh Mortality Review in 2013, quality and patient experience were seen as top priorities and everyone's responsibility.
- The results of the NHS Staff Survey 2012 indicated that the trust was worse than expected for the percentage of staff reporting good communication between senior management and staff.

## Innovation, improvement and sustainability

- The results of the NHS Staff Survey (2012) indicated that the trust was worse than expected for the percentage of staff able to contribute to improvements at work. This was replicated in the medical division where staff shortages and workload meant that many staff were not involved in quality improvement projects.

# Surgery

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

## Information about the service

Stoke Mandeville Hospital provided inpatient surgery services. There were two surgical wards on a surgical floor, a day surgical unit, surgical assessment unit and operating theatres. The hospital provided emergency and elective surgery for a range of specialties including general surgery, trauma and orthopaedic surgery, ophthalmology, plastic surgery and oral surgery. There were approximately 42 surgical beds.

We visited four surgical wards in the hospital. We talked with 8 patients, 4 relatives and 25 members of staff. These included nursing staff, junior and senior doctors, and managers. We observed care and treatment and looked at 8 care records. Before the inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

The use of the Five Steps to Safer Surgery checklist was being monitored and action was being taken to improve compliance which was currently 88%. Medicines were not always managed appropriately. Medical handovers were not consistently formal and structured. Staff told us that they were worried about understaffing. The wards did not have care plans to identify what care should be given to patients. This meant that agency nurses who were new on the wards did not have access to information on how to care for a patient.

National guidelines were used to treat patients and care pathways to support and speed patient recovery were followed. Patients, however, were not meant to be in the surgical assessment unit for longer than 23 hours, but we found instances where patients were there for more than four days waiting for their surgery. The trust was not meeting national waiting times of less than 18 weeks for patients having operations or procedures.

# Surgery

## Are surgery services safe?

Requires improvement 

Surgery staff told us they were encouraged to report any incidents, and these were discussed at weekly meetings. However, there was no reporting of the themes underlying these at ward level so that common issues could be addressed. The use of the Five Steps to Safer Surgery checklist was being monitored and action was being taken to improve current compliance which was 88%. The treatment room on Ward 16B was not appropriate for the preparation of medicines and resulted in treatment delays. Medical handovers were not consistently formal and structured. Staff told us that they were worried about understaffing.

### Incidents, reporting and learning

- There have been three “Never Events” in the trust between December 2012 and January 2014. One these were in surgery in December 2012. A Never Event is an incident that is so serious it should never occur. Each Never Event led to a full root cause analysis. The results of this were shared with members of staff.
- Between June 2013 and July 2013 there had been 147 incidents in surgery reported to the National Reporting and Learning System (NRLS). More recent figures from January to February 2014, the surgical division had had eight incidents. The majority were moderate harm and one was severe. These reports were for avoidable harms such as pressure sores and falls and staffing levels that caused a failure to monitor patients effectively.
- Information provided by the trust showed that for the surgical division there were a large number of incidents that had not been addressed in a timely manner.
- All staff we spoke to said that they were encouraged to report incidents. Incidents were discussed at weekly meetings. However, there was no reporting of the themes underlying the various incidents at ward level.

### Safety Thermometer

- NHS Safety Thermometer information was displayed at the entrance to each ward. This included information about infections, new pressure ulcers, new urinary tract infections (UTIs) and new blood clots.

- The surgery division was not meeting its targets for pressure ulcers, blood clots and medication errors. Targets were met for patient falls.
- The surgical wards had taken action, for example, to improve risk assessments of patients with a potential blood clot.

### Cleanliness, infection control and hygiene

- The ward areas appeared clean and cleaning schedules were clearly displayed on the wards.
- Staff followed the trust policy on infection control. Staff regularly washed their hands and use hand gel between patients, and the bare arms below the elbow policy was adhered to.
- The surgical division’s hand hygiene audit indicated it was performing at 98%, which was above the trust target of 95%. The results of this audit were on display in the ward areas.
- Rates for meticillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile for the trust were within an acceptable range.

### Environment and equipment

- The environment on the surgical wards was safe. We did, however, have concerns about the treatment room in Ward 16B where intravenous (IV) medications were being prepared in a small space. The working area was small and congested. We saw two nurses preparing IV medications at the same time. They were interrupted on several occasions while other doctors and nurses went into the room to get medicines from the controlled drug cupboard. They were also interrupted by doctors and other nurses requesting information on care for other patients. These interruptions could result in an error in preparation of medication and put patients at risk from drug errors. We observed that the nurses restarted procedures if they considered their preparations so far had been unsafe. This resulted in delays to treatment.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards to ensure safe care.

### Medicines

- Medicines were stored correctly, including in locked cupboards or fridges when necessary.

# Surgery

- The temperature of medication fridges was monitored but we saw a record that showed that a fridge temperature was above the normal range but no action had been taken. This could reduce the efficacy of the medication given to patients.

## Records

- The wards did not have care plans for patients. Patient notes were available when required and nursing records were within the patient notes.
- There were no audits on documentation undertaken.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguarding

- Patients were asked for their consent to procedures appropriately and correctly. We saw examples of patients who did not have capacity to consent and the Mental Capacity Act 2005 was adhered to appropriately.

## Assessing and responding to patient risks

- The Five Steps to Safer Surgery checklist should be used at each stage of the surgical pathway from when a patient is transferred to theatre until return to the ward. The trust was monitoring its use monthly. The latest audit in February 2014 showed the use of the checklist was improving and there was 88% compliance. The department had an action plan to improve compliance.
- The surgical wards used the national early warning score. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these.
- We looked at three completed tools and saw that staff had escalated concerns in line with the directions. Repeat observations were taken within the necessary time frames.
- Nursing handovers occurred three times a day. Staffing for the shift was discussed as well as any high-risk patients or potential issues.
- Medical handovers were not consistently formal and structured. During our announced visit we observed a medical handover took the form of an informal handover. The handover covered care of patients based on the severity of their condition. The handover was not structured or documented. During our unannounced visit we observed a formal handover that included all the on-call surgical junior staff with a list of patients and their details and anticipated problems.

## Nursing staffing

- Nursing numbers were assessed using the National Safer Nursing Tool and there were identified minimum staffing levels. The use of the tool began in January 2014 and required and actual staffing numbers were displayed on every ward. Staff reported that they were understaffed and vacancies were filled with bank and agency staff.
- Patients on Ward 16B were being treated by nurses who were sometimes not from the appropriate specialty. The ward had recently changes and the trust had developed the surgical floor to improve staffing levels. However, patients who had undergone plastic surgery were cared for by nurses who usually cared for patients undergoing gynaecological or eye surgery. The wound care support required for patients undergoing plastic surgery was therefore not always available. This affected the quality of care for patients because their wound care was not treated by an expert member of staff. The trust had acknowledged that issues with skill mix were of concern and the surgical floor arrangements were under review.
- Staff in the surgical assessment unit told us that the unit was understaffed. The middle shift of the day was never covered except on Wednesdays. They did not get regular breaks. When a nurse escorted a patient to theatre, the unit was left with only one trained nurse.
- The wards did not have care plans to identify what care should be given to patients. This meant that agency nurses who were new on the wards did not have access to information on how to care for a patient. There was a plan to introduce care plans in the near future.
- Nursing documentation was kept at the end of each patient's bed and completed appropriately. It included, for example, an assessment of nutrition, risk of falls and hydration. However, we checked the records of four patients and found records were not always completed.

## Medical staffing

- Surgical consultants from all specialties were on call for a 24-hour period.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support.

## Mandatory training

- We looked at staff mandatory training records. The surgical wards' performance report for April 2013 to

# Surgery

February 2014 showed staff were up to date on mandatory training. However, because of shortages of staff on the surgical assessment unit, study days were frequently cancelled.

## Are surgery services effective? (for example, treatment is effective)

Requires improvement 

National guidelines were used to treat patients and care pathways to support and speed patient recovery were followed. Standards were monitored and outcomes in surgery were good and improving. Day surgery rates were higher than national average. However, nursing staff on the surgical floor (Ward 16B) were not always appropriately trained to care for patients with some of the specialities they faced and staff clinical supervision and appraisal needed to improve.

### Evidence-based care and treatment

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. We found the Royal College of Surgeons' standards for emergency surgery/surgery out of hours were consultant led and delivered.
- The surgical directorate contributed to all national audits, for example, the Trauma Audit and Research Network. However, we found the data for the National Joint Registry was not always completed. This Registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations, and monitors the performance of joint replacement implants. The completion rate was 75%. This would not provide a full picture of how the hospital was performing

### Patient outcomes

- The division had a performance dashboard that it used to monitor the quality of care provided.
- Surgical mortality reviews were completed. There were no mortality outliers and overall mortality rates were within expected range.
- Outcomes in surgery were good and improving, for example, 75% of patients with fractured neck of femur were operated on within 24 hours and 90% within 48 hours in 2012/13. This was an improvement compared to previous years.

- Overall, day case surgery rates (91%) were performed above national expectations (the British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases).
- Enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, orthopaedics and ENT. This focused on thorough pre-assessment, less invasive surgical techniques, pain relief and the management of fluids and diet, which helped patients to recover quickly post-operatively.
- The trust was meeting its elective length of stay target of three days in general surgery and urology.

### Pain relief

- Patients were assessed pre-operatively for their preferred pain relief post-operatively.
- Patients told us they were provided with pain relief when required.

### Competent staff

- The surgical floor (Ward 16B) included patients from gynaecology, plastic surgery and ophthalmology. Nursing staff were not always appropriately trained to care for patients from these different specialities.
- Clinical supervision was being developed for staff practice, peer review and reflection and not all staff had received an annual appraisal. Currently only 76% of staff across the surgical wards had had an appraisal and this was below the trust target 95%.
- The National Training Scheme Survey, GMC, 2013 indicated that the training given to junior doctors in trauma and orthopaedics was overall similar to other trusts but was worse than expected for overall satisfaction, adequate experience and access to educational resources.

### Multidisciplinary working

- There was input from physiotherapy and occupational therapy. Daily ward rounds were undertaken five days a week on all surgical wards. Medical staff and nursing were involved in these but we did not observe any physiotherapists or occupational therapists attending these rounds.
- There was a satellite pharmacy near the ward and this had help to speed up patient discharges with take home medicine. Pharmacists told us antibiotic prescribing was very closely monitored.

# Surgery

## Equipment and facilities

- There was appropriate equipment to ensure effective care could be delivered.

## Seven-day services

- There was no physiotherapy and occupational therapy support out of hours and at weekends.
- Access to medical advice at night came from the hospital at-night team. Nurses told us they were very responsive.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

## Are surgery services caring?

Requires improvement 

Patients received compassionate care and we saw that patients were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care. Patient feedback on care on the Wards 16A and 16B (general surgery wards) was below the national average and staff told us there were not always able to respond to patient need when wards were busy. Patients were not always given the necessary emotional support in sensitive situations.

## Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. However, because of the number of patients on the wards, we found call bells were not answered promptly. Patients told us that “nurses are very caring and would do anything for you but they are very busy”.
- The NHS Friends and Family Test results for December 2013 showed that most wards in surgery scored higher than the national average. There were two surgical wards, Ward 16A and 16b that scored lower and were wards that patients would be “extremely unlikely” to recommend.
- Comfort rounds or intentional rounding (where nursing staff regularly check on patients every few hours) were undertaken, but the use of agency staff was affecting the quality of continuing care provided to patients. While

the cover for nursing was available, staff told us there were instances when the patient experience was poor and staff were unable to respond to patient needs in a timely way.

- We observed a ward round and saw that doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- The ward had introduced protected time when visiting was not allowed. This was during meal times. However, during our inspection we observed visitors on wards during these times. This could affect the patient experience. When we spoke to visitors, they told us they came during lunch time to help their relative eat because there weren't enough members of staff during meal times to do this.
- There were ‘red trays’ and ‘red jugs’ to identify patients who needed help in eating and drinking. We observed one patient with a red tray but did not see any support provided. When we asked three members of staff on the ward what the red jugs and red trays meant, they were unable to tell us.

## Patient understanding and involvement

- Patients and relatives we spoke with said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- The CQC adult inpatient survey (2013) demonstrated the trust was similar to other trusts for staff explaining operations and procedure, information on pain relief and informing patients about how their operation or procedure had gone.

## Emotional support

- Ward 16B, which had a number of different specialties, also gave care to patients who were being admitted for termination of pregnancy following miscarriage. Patients receiving care while undergoing termination would require additional support but this was not available on this ward.
- There was a room where more sensitive conversations could be undertaken.
- We looked at patient records and found they detailed discussions that had been had with patients and relatives.

## Are surgery services responsive to people's needs?

# Surgery

(for example, to feedback?)

Requires improvement 

The directorate had established a surgical assessment unit, which meant patients were seen by a designated consultant within four hours of referral. Patients were not meant to be in this unit for longer than 23 hours, but we found instances where patients were there for more than four days waiting for their surgery. Nurses told us this was not unusual. It also meant that these patients were not able to eat and drink at appropriate times in preparation for their operation and fasting guidelines were not being followed. The trust was not meeting the national target for patients to wait less than 18 weeks for operations or procedures. Specialist support for people with a learning disability was unavailable and information leaflets were only printed in English.

## Access to services

- Bed occupancy, was consistently higher than the 85% target, ranging between 85% and 100%. Occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally. This meant that there were regular bed shortages, which affected access to care.
- The directorate had established a surgical assessment unit, which meant patients were seen by a designated consultant within four hours of referral. Nurses told us that patients should not be in this unit for longer than 23 hours. We found instances where patients were in the unit for more than four days waiting for their surgery. Nurses told us this length of stay was not unusual.
- The trust scored similar to expected when compared with other trusts for cancelled operations. However, patients who were waiting in the surgical assessment unit for up to four days were not able to eat and drink at appropriate times in preparation for their operation and fasting guidelines were not being followed.
- Any medical patients who remained on the surgical unit because there were no beds available on the medical wards were under the care of the medical team. Nurses ensured that the medical teams saw these patients daily during the week (Monday to Friday). They were not seen at weekends and care was provided by nurses from the surgical division.

- The trust had different length of stay targets for surgical specialities. The trust was meeting its targets for all specialties except for general surgery where emergency length of stay was 5.3 days against a target of 3.3 days.
- Following pressure on beds over the winter 2013/2014, The trust was not meeting the national waiting time target for 90% of patients waiting 18 weeks or less for elective and day case surgery. In December 2013 only 75.1% of patients had surgery within national waiting times. Diagnostic waiting times also were slightly over the six weeks waiting times. The trust was reviewing how it could reform elective care procedures.
- A nurse led vascular outreach service had been developed and this was helping to prevent admissions to hospital.

## Meeting people's individual needs

- There was support available for patients living with dementia and learning disabilities. Nurses told us how they would access the support for these patients. The orthopaedic unit had a named dementia and learning disability champion but there were no such champions on the general surgical wards.
- There was a discharge coordinator who ensured that discharge planning started as soon as a patient was admitted onto a ward. A paper discharge summary was sent to a patient's GP by post. This detailed the reason for admission and any investigation results, treatment and discharge medication.

## Complaints

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- There was information on wards about how to complain.
- The surgical matron received all the complaints relevant to her unit. She would then speak directly with the staff member involved. A response would be sent to the complaints department and they would arrange for a response from the trust. Lessons from complaints were shared with the department.
- The division responded to 67% of complaints within the trust's 25-day target. This was below the trust target of 85%.

# Surgery

## Are surgery services well-led?

Requires improvement 

There was a matron responsible for the wards surgery and members of staff told us she was visible and approachable. Staff we spoke with worked well together. The service had a strategy but risks were not identified for immediate priorities. There were concerns raised about Ward 16B where the culture was described as “challenging” because staff were unhappy with these changes and felt that they had not been listened to. The trust’s vision was encapsulated in the strapline ‘Safe and compassionate care every time’ but some staff were not aware of this.

### Vision and strategy for this service

- The trust’s vision was encapsulated in the strapline ‘Safe and compassionate care every time’. This was visible on every ward. The trust had introduced this in January 2014 and staff we spoke with were not aware of this vision.
- The division had a strategy and this included priority areas for each service area (or service delivery unit).

### Governance, risk management and quality measurement

- The division held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed.
- The division had quality dashboard for each service and ward area and this showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- Risk registers did not cover all issues identified such as the staff skill mix on Ward 16B, the treatment room on Ward 16B, fasting guidelines and improving the patient experience.

### Leadership of service

- Each ward had a manager who provided day-to-day leadership to members of staff on the ward. There was an overall matron responsible for surgery. Members of staff told us she was visible and approachable.
- All ward managers attended a clinical leadership and management programme.

### Culture within the service






- Staff within the directorate spoke positively about the service they provided for patients.
- There was a culture developing whereby quality and patient experience were seen as priorities after the trust was put into special measures.
- Staff we spoke with worked well together. However, there were concerns raised about Ward 16B where the culture was described as “challenging” because staff were unhappy with these changes and felt that they had not been listened to.

### Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Junior doctors were involved in audits and the results shared within the department.
- Specialist nurse were encouraged to undertake research. A vascular specialist nurse had undertaken research undertaken which identified patients who could be helped earlier on for their health condition: for instance, patients in whom appropriate care of their legs could help prevent amputation. This was shared as an example of learning.
- Improvements were not shared across hospital site. There were improvements in ensuring safer surgery procedures observed at Wycombe Hospital that were not implemented at Stoke Mandeville Hospital.



# Intensive/critical care

Safe	Good 
Effective	Good 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 

## Information about the service

The intensive therapy unit (ITU) and high dependency unit (HDU) in Stoke Mandeville Hospital were located together and 12 beds. An intensive therapy unit outreach team assisted with the care of critically ill patients who were on other wards throughout the hospital. The critical care service had consultant cover 24 hours a day. The unit admitted approximately 620 patients a year.

We visited the ITU and HDU and all the inpatient wards in the hospital. We talked with three patients, two relatives and 17 staff. These included nursing staff, junior and senior doctors, a physiotherapist, a pharmacist, domestic staff and managers. We observed care and treatment and looked at four care records. Before the inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

Patients we spoke with gave us examples of the outstanding care they had received in the unit. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. There was strong local leadership of the units. Openness and honesty was encouraged at all levels.

The unit had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality improvement projects and audit. There was good multidisciplinary team working. Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes.

# Intensive/critical care

## Are intensive/critical services safe?

Good 

Overall critical care services were safe. All staff we spoke with said they were encouraged to report incidents and received direct feedback from their matron, and themes from incidents were discussed at staff meetings. The environment was clean and hygienic, and most medicines were stored correctly. Nursing handovers occurred twice a day and were conducted well. Staffing levels were appropriate and risks to patients whose condition may deteriorate were escalated appropriately. All professionals involved with a patient during their admission to the unit added their notes to the same records and this ensured continuity and a team approach to delivering care.

### Incidents, reporting and learning

- There had been one “Never Event” on the intensive/critical care unit in 2014 (a “Never Event” is an incident that should not occur). This had led to a full root cause analysis. The results of this had led to a change in the way information about a procedure was recorded in the notes to ensure that the incident did not reoccur.
- Between June 2013 and July 2013 there had been 53 incidents in anaesthetics and critical care reported to the National Reporting and Learning System (NRLS). More recent figures from January to February 2014 identified that critical care had three incidents. All were moderate harm and described delays to treatment because of a lack of available intensive care beds.
- All staff we spoke with said they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at staff meetings.

### Safety Thermometer

- NHS Safety Thermometer information was clearly displayed at the entrance to the intensive/critical care unit. This included any new pressure ulcers or whether a patient had a blood clot, known as ‘venous thromboembolism’ (VTE) or catheter urinary tract infection. The unit was performing as expected for these.
- Risk assessments for patients for pressure ulcers and VTE were being completed appropriately on admission.

### Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. The bare arms below the elbow policy was adhered to and hygienic hand washing facilities and protective personal equipment, such as gloves and aprons, were readily available and used by staff between patients.
- There were effective arrangements for the safe disposal of sharp and contaminated items.
- The unit contributed their patient data and outcomes to the Intensive Care National Audit and Research Centre (ICNARC) and so was evaluated against similar departments nationally. ICNARC data showed infection rates: for example, meticillin-resistant staphylococcus aureus (MRSA) rates were low and below the national average.

### Environment and equipment

- The environment on the unit was safe.
- Equipment was appropriately checked and cleaned regularly.

### Medicines

- Most medicines were stored correctly, including in locked cupboards or fridges when necessary. However, intravenous (IV) fluids were stored in cupboards without locks and were accessible to patients or visitors to the unit.
- Fridge temperatures were not always checked daily, and there was a risk that medication was being stored at an incorrect temperature, which could reduce its efficacy.

### Records

- Nursing documentation was kept at the end of a patient’s bed. Observations were well recorded.
- All records were in paper format. They were all filed in an identical way, which meant information could be found easily.
- All professionals involved with a patient during their admission to the unit added their notes to the same records. This ensured continuity and a team approach to care delivery.
- The unit used a daily ward round proforma that was completed during the morning ward round. There were clear records of the treatment people had received and any further treatment or follow-up they required.

# Intensive/critical care

## Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

- Patients were asked for their consent to procedures appropriately and correctly. Staff were able to provide examples of patients who did not have capacity to consent. The Mental Capacity Act 2005 was adhered to appropriately.

## Assessing and responding to patient risks

- There was a critical care outreach team that was present on site 8am to 8pm 7 days a week.
- Ward staff told us they knew how to contact the outreach team and that when contacted they responded within 30 minutes.
- The National Early Warning Score (NEWS) escalation Process for the management of acutely unwell adult patients was used to identify patients who were becoming unwell, ensuring early, appropriate treatment from skilled staff.
- Nursing handovers occurred twice a day. A short handover where staff were updated on a patient's condition initially took place in a room with a closed door to maintain patient confidentiality. This was followed by an individual handover at the bedside, which ensured key pieces of information were communicated: for example, what medication the patient had received.
- Visiting professionals to the units (for example, a physiotherapist or speech and language therapist were also given an update on the patient's condition and progress before giving any treatment.
- NHS Safety Thermometer information was clearly displayed at the entrance to the intensive/critical care unit. This included information about whether there were any infections such as methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile. It also included any new pressure ulcers or whether a patient had a blood clot, known as 'venous thromboembolism' (VTE). The unit was performing as expected for these.
- Risk assessments for patients for pressure ulcers and VTE were being completed appropriately on admission.

## Nursing staffing

- The unit had staffing levels that met the needs of patients. All level 3 patients were nursed one-to-one, and all level 2 patients one to two. There was also a supernumerary nurse and either one or two healthcare assistants per shift.

- If staffing levels were not met from permanent staff, the unit used agency or bank staff to cover absences. There was a regular cohort of bank and agency staff, most of whom had experience of working on the unit before.
- There was a supernumerary senior nurse who led each shift.
- The critical care outreach team was available 8am to 8pm 7 days a week. There were plans to make this service 24 hours, 7 days a week.

## Medical staffing

- Care in the ITU/HDU was led by a consultant in intensive care. A consultant was present on the unit from 8am to 9pm 7 days a week. Outside these hours, a consultant was able to attend the unit within 30 minutes if required.
- The consultant to patient ratio was 1:12 and this did not exceed the national recommendations of 1:14.
- The consultants worked in ITU in consecutive five day blocks, as recommended in national guidelines for intensive care. They undertook ward rounds twice daily. All potential admissions had to be discussed with a consultant and all new admissions were reviewed in person by a consultant within 12 hours of admission.
- Consultants were supported by a team of other doctors that included a specialist registrar and junior doctors.
- All potential admissions to the unit were discussed with a consultant.

## Mandatory training

- Training records confirmed that 73% of surgery and critical care staff were up to date with their mandatory training. The trust target was 100%. The trust did not hold separate information about training compliance relating to only critical care staff.

## Are intensive/critical services effective? (for example, treatment is effective)

Good 

The unit had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality improvement projects and audit. There was good multidisciplinary team

# Intensive/critical care

working. Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes.

## Evidence-based care and treatment

- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment it provided. Local policies were written in line with this.
- There were care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.
- The unit had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality improvement projects and audit. Clinical audits in 2013, for example, had shown improvements in infection control and fluid balance monitoring.

## Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. This demonstrated that mortality was below the national average and unplanned readmissions were similar to those in other trusts.
- ICNARC data was displayed in the unit so that patients, their relatives/carers and staff could see the quality of care on the unit.
- The critical care outreach team had data to demonstrate that the number of ward cardiac arrests had declined (from 25 in February 2013 to 13 in August 2013) because of the improved monitoring of patients whose condition was deteriorating.

## Hydration and nutrition

- The 'Evian Project' was led by critical care outreach nurses and this had improved the hydration of patients in the trust. The outreach team had raised staff awareness around hydration levels, how to monitor patients effectively and use food and fluid balance charts correctly.

## Competency

- Fifty-seven per cent of the nursing staff had achieved a post-registration award in critical care nursing.

- The National Training Scheme Survey, GMC, 2013 indicated that the training given to junior doctors in anaesthetics was overall similar to other trusts but was worse than expected for clinical supervision but better than expected for regional teaching.

## Multidisciplinary working

- There was a daily ward round that had input from nursing and microbiology. Members of the multidisciplinary team (for example, the pharmacist and physiotherapist) had a handover every time they visited the unit.
- There was a weekly multidisciplinary meeting on the unit that had input from medical, nursing, pharmacy, speech and language therapy and physiotherapy.
- Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes. There was a dedicated team of physiotherapists for the unit.
- There was a dedicated critical care pharmacist and all patients with a tracheostomy were assessed by a speech and language therapist. In addition, a dietitian provided support to the unit.

## Seven-day services

- A consultant was present on the ITU/HDU from 8am to 9pm at the weekend and undertook ward rounds twice daily. Consultants were supported by a senior registrar and junior doctor.
- All potential admissions had to be discussed with a consultant and all new admissions were reviewed in person by them within 12 hours of admission.
- A physiotherapist was on duty at weekends.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications

## Are intensive/critical services caring?

Outstanding 

Patients we spoke with gave us examples of the outstanding care they had received in the unit. Staff built up trusting relationships with patients and their relatives by

# Intensive/critical care

working in an open, honest and supportive way. Patients and relatives were given good emotional support, and throughout our inspection, we saw patients being treated with compassion, dignity and respect. Staff provided outstanding care, by understanding what was significant to patients and making arrangements to ensure patients retained what was special in their lives.

## Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients and relatives we spoke to were highly complimentary about all the staff in the unit.
- Privacy and dignity arrangements were acceptable. The ward was a mixed-sex ward. There were five side rooms which meant male and female patients could be cared for separately most of the time. There had been one mixed-sex breach in the past 12 months.
- The patient centred culture was highly visible. Patients we spoke with gave us examples of the outstanding care they had received in the unit. For example, staff on the unit made arrangements for a patient to go home to celebrate a child's significant birthday. They were provided with medical and nursing support during their time away from the unit. Another example was when staff had arranged for a couple to have a meal together on Valentine's Day. They had arranged a pizza delivery and provided as much privacy as was possible on the unit.
- We observed a patient who had been in the unit for several months being discharged home. We saw the medical and nursing team, including some staff who were off duty, gather to say goodbye.
- Relatives were encouraged to visit and routine visiting hours were from 10am to 9pm. Flexible visiting time was at the discretion of the nurse in charge for new admissions and patients who were at their end of life.

## Patient understanding and involvement

- Because of the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. However, whenever possible, the views and preferences of patients were taken into account.
- Also, whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.

## Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support. For example, one patient told us, "They [the nursing staff] seem to understand what we are going through. I have cried lots and there's always someone to give me a hug and have a chat."
- Staff made people aware of support groups they could access, or services such as the chaplaincy service.
- After admission, the consultant covering the unit would arrange to meet with relatives to update them on the patient's progress. When necessary, further face-to-face meetings were organised.
- All relatives we spoke with said they had been kept fully updated and had had opportunities to have all their questions answered.

## Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Good 

The critical care services were responsive to the needs of their patients. Support for patients with physical and learning disabilities was available if needed, and staff demonstrated a good understanding of people's social and cultural needs. Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those receiving them into their care.

## Access to services

- Between November 2013 and February 2014, figures showed that the combined bed occupancy for adult critical care beds across the trust was 82%. This was above the Royal College of Anaesthetists' recommendations of 70%. Persistent occupancy of more than 70% suggests a unit is too small and occupancy of 80% or more is likely to result in non-clinical transfers, with associated risks. The trust had recently made two further beds available at Wycombe Hospital.

## Intensive/critical care

- Patients from Stoke Mandeville Hospital were transferred to Wycombe Hospital when there was pressure on beds. ICNARC data showed that non-clinical transfers were slightly above the national average. There were protocols to manage the safe transfer of patients.
- The length of stay on the intensive/critical care unit was above the average for England. Sometimes patients stayed on the unit longer than required because of the lack of available bed space elsewhere in the hospital. This meant that some patients could not be admitted to the unit. We also noted that patients were occasionally treated in the recovery area in theatres. Staff were available to support patients.
- A trust survey of staff in 2014, staff said that the critical care outreach team was available within 30 minutes 70% of the time, and over 95% of staff were positive about the support they had received.
- Most discharges from the unit occurred during the day between 8am and 10pm, which followed national guidelines. Between November 2013 and February 2014, figures showed that 16% of discharges were out of hours to free bed space. This was above the national average of XX%.
- Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those receiving them into their care.
- All professionals involved with a patient during their admission to the unit contributed to the plan for their discharge.
- The critical care outreach team was involved in discharge planning and visited patients after discharge from the ITU to offer continued support.

### Meeting people's individual needs

- Support for patients with physical and learning disabilities was available if needed.
- Interpretation services were available both by phone and in person. Some written information was available in different languages.
- Staff demonstrated a good understanding of people's social and cultural needs and how these could be met in the intensive/critical care unit.

### Complaints

- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the shift leader.

Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.

- Complaints posters were displayed in the unit and information leaflets were available.
- People knew how to raise concerns or make a complaint.
- There had not been any complaints received in the past six months.

### Are intensive/critical services well-led?

Good 

There was strong local leadership of the units. The leadership team for ITU/HDU worked across Stoke Mandeville and Wycombe Hospital to provide critical care and there was shared learning and support for staff. Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty was the expectation for the unit and encouraged at all levels. Staff were encouraged to complete incident forms or raise concerns. Staff worked well together and there was obvious respect. Risks were being managed appropriately and staff were involved in quality improvement projects.

### Vision and strategy for this service

- A strategy for increasing overall bed capacity was in place. Two new beds had already been made available at Wycombe Hospital and a business case was being prepared to identify medium- to long-term proposals for resolving critical care capacity.
- There was a plan to improve the care of deteriorating patients by increasing the capacity of the outreach team to provide a 24 hour, 7 day a week service. Funding had been approved and the process of recruiting nurses had begun.

### Governance, risk assessment and quality measurement

- The division had monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were cascaded to staff during regular unit meetings and minutes of the meetings were available in the staff room.

## Intensive/critical care

- Risks inherent in the delivery of safe care were clearly identified on the trust's risk register: for example, the risk of insufficient critical care capacity to meet fluctuations in demand. Supporting actions were identified and discussed at governance and board meetings.

### Leadership of service

- The intensive/critical care unit was led by a manager, matron, consultant nurse and consultant clinical lead.
- There was strong local leadership of the units. The leadership team for ITU/HDU worked across Stoke Mandeville and Wycombe Hospital to provide critical care and there was shared learning and support for staff.
- Each shift was led by sisters who had supervisory responsibility for the staff working for them.

### Culture within the service






- Staff within the unit spoke positively about the service they provided for patients.

- Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty was the expectation for the unit and encouraged at all levels. We observed shift and unit leaders who were compassionate and led by example.
- Staff were encouraged to complete incident forms or raise concerns.
- Staff worked well together and there was obvious respect. Staff were engaged and worked well with other departments within the hospital.

### Innovation, learning and improvement

- Innovation was encouraged from all staff members across all disciplines. All staff, including student nurses, were involved in quality improvement projects and audit. Staff were able to give examples of practice that had changed as a result. For example, the Evian Project led by the critical care outreach team had led to improvements across the trust in the monitoring of patients at risk of dehydration.

# Maternity and family planning

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

The trust had one maternity service delivered across two main hospital sites and in the community. There were 5,684 births in 2012/13 across the trust. Of these births, 300 were delivered at Wycombe Hospital in the standalone midwife-led birth centre. This was for mothers whose pregnancy had been uncomplicated and whose birth was likely to be normal and low risk. Should more be required, mother and baby would be transferred to the labour ward at Stoke Mandeville Hospital. Stoke Mandeville Hospital had early pregnancy services, an outpatient day assessment unit, antenatal and screening services, a postnatal ward and a local neonatal unit for babies needing additional levels of support after birth.

We visited the hospital maternity services. We talked with 40 women and 40 staff. These included midwives, doctors, administration staff and managers. We observed care and treatment and looked at care records. Before the inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

The ward areas were modern and clean. Women and their partners said that the staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. The average ratio of births to midwives was higher than the national average, but this had improved recently. There were, however, some comments from women on the postnatal ward about insufficient staff and staff being under pressure.

There was good multidisciplinary team working and learning throughout the service. Staff development and continuing professional development in general was a priority within the service. The head of midwifery and her team were well focused and fully engaged. The service did not have a strategy and but there was a risk management strategy for operational and performance risks. Risks were appropriately managed but the delays for some women because of the lack of available postnatal care beds were not identified as a risk. Staff were good at implementing innovations in care.



# Maternity and family planning

## Are maternity and family planning services safe?

Good 

The maternity ward areas were modern and clean, and equipment was regularly checked. The service used the modified early obstetric early warning score to escalate care if women became acutely ill. Staff we spoke with were aware of the appropriate action to take if women scored higher than expected and required close monitoring or transfer for more specialised care. The average ratio of births to midwives was higher than the national average, but this had improved recently. The head of midwifery told us that there were always experienced staff on every shift to support the more recently qualified midwives, and there were additional resources to ensure that colleagues were well supported to take breaks.

### Incidents, reporting and learning

There had been three 'Never Events' (incidents that should never occur) in the trust between December 2012 to January 2014. One of these were for obstetric procedures and involved retained swabs after labour.

There had been four serious incidents in 2012/13, which was similar to other trusts. There had also been four serious incidents in 2014 but this increase was due to a change in the reporting criteria. Three of the four had involved the interpretation of cardiotocography (fetal heart beat) and this was being investigated.

All never events and serious incidents were reported and investigated and involved supervisors of midwives, medical staff and midwives. Action plans were prepared and discussed at the monthly governance meetings until all actions were completed. The lead midwife for governance explained how colleagues worked together to identify any recurring themes and had introduced changes to practice as a result, such as the use of simple new procedures to avoid the recurrence of retained swabs.

The service had a thorough reporting system and a strong culture of seeking to learn lessons from never events and serious incidents. One member of staff said they were "beginning to understand that it is not about looking for someone to blame".

### Cleanliness, infection control and hygiene

The maternity ward areas at Stoke Mandeville were clean and uncluttered.

Staff followed the trust policy on infection control. Staff wore clothes that allowed their arms to be bare below the elbow, and they regularly washed their hands and used hand gel between patients.

There were bi-annual assessments of hand hygiene techniques for staff and hand hygiene audits indicated that the unit was performing at 98%, which was above the trust target of 95%.

Infection rates for meticillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile were within an acceptable range.

### Environment and equipment

Equipment was appropriately checked and cleaned regularly. We saw green stickers on equipment that indicated 'I am clean' and so ready to use.

There was an adequate supply of equipment on the wards to support safe care; this included cardiotocography and resuscitation equipment.

The maternity wards at Stoke Mandeville were modern and clean. Accommodation for clinics was provided in a temporary annex but this was spacious and appropriately equipped.

Birthing pools were available and there were also birthing balls and birth mats. There was plenty of room for mothers to move around in labour during labour.

### Records

The trust was using the National Maternity Notes that would be carried by the expectant mother. This system was working well with additional notes available for cases where higher risks had been identified.

Several staff told us that timely access to historical records had become an issue because of the storage arrangements. This had been identified as a risk on the risk register because turnaround times were a problem for clinical appointments, dealing with complaints and litigation. Storage arrangements had been altered and the situation was improving.

The procurement for a new maternity information system had begun. This was a priority for the service because statistics could not be generated electronically.

# Maternity and family planning

## Medicines

Medicines were stored correctly, including in locked cupboards or fridges when necessary. Fridge temperatures were regularly checked and adjusted if necessary.

## Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

Women were asked for their consent to procedures appropriately and correctly. There were clear multidisciplinary procedures for safeguarding and child protection concerns. There was liaison with social care and other healthcare professionals, including GPs, and midwives for serious case reviews.

## Assessing and responding to patient risks

The service used the modified early obstetric early warning score (MOEWS) to escalate care if women became acutely ill. There was clear direction for escalation printed on observation charts and these were completed by midwives on the labour ward.

Staff we spoke with were aware of the appropriate action to take if women scored higher than expected and required close monitoring or transfer for more specialised care.

There was a multidisciplinary handover meeting daily at 8am. This meeting was used to reflect on activities in the labour ward in the past 24 hours, to identify any issues with women in the centre and to escalate concerns.

We observed staff were managing an electronic smart board for a number of high-risk cases.

## Midwifery staffing

The average midwife to birth ratio had been one midwife to every 37 births (1:37), for 2012/13. This was above the South of England average of 1:31 and the national recommendation of 1:28. The trust had appointed additional midwives and there had also been a slight fall in the birth rate in recent months. The trust ratio was now 1:30 and the service was providing 1:1 midwife care in established labour. The trust did not use agency staff but did have some midwives on fixed-term contracts to cover for colleagues on maternity leave.

The midwife to supervisor ratio was 1:14, which was within the required ratio.

The head of midwifery told us that there were always experienced staff on every shift to support the more recently qualified midwives, and there were additional

resources to ensure that colleagues were well supported to take breaks. She said that the service had not had to be suspended or diverted in the past four years and was 'safe and responsive'.

The postnatal Rothschild Ward was very busy. Staff told us it was "too busy" and there was no time to help new mothers with breastfeeding, for example. Women we spoke with following a caesarean section said that the care was good but there was a lack of support for showering or bathing.

At a handover session, we noted that the capacity issues on the postnatal ward were being managed, providing it was safe to do so, by delaying inductions and elective caesareans. Four women were waiting to be transferred to the postnatal ward when there were no beds available, and three women were waiting to begin the induction of labour.

The average caseload for midwives working in the community had been assessed as 'too large' by the trust in its risk register for women, children and sexual health and, although the average had fallen, it still remained above 1:150. This had been identified and documented as a risk with 'a potential for omissions in antenatal care provision'. A current best practice average was quoted in the risk register as 1:100.

## Medical staffing

There were 14 consultants in post covering obstetrics and gynaecology and four consultant anaesthetists. Consultants were present on the labour ward for an average of 83 hours per week. This was below the trust goal of 98 hours but within appropriate levels. We spoke with the lead who said that the department was short by three clinicians and there were plans to centralise early pregnancy services on the Stoke Mandeville site.

There was one-to-one obstetric care for mothers requiring high-dependency care before being transferred to the postnatal ward. There was access to theatres and an obstetric anaesthetist.

## Mandatory training

Compliance with mandatory training was at 92%. Newly qualified midwives had preceptorship for 12 months and there were four mandatory study days per year. In addition to this, all newly appointed midwives were required to

# Maternity and family planning

attend training for the management and administration of medicines including intravenous drug administration. Competence was assessed regularly by the supervisors of midwives.

Midwives attended mandatory training on safeguarding and the training was informed and updated by experience and learning from casework and serious case reviews. There was no data available for Level 3 training which is the level expected for staff that work with children or young people.

## Are maternity and family planning services effective?

(for example, treatment is effective)

Good 

The maternity service used evidence-based national guidance. The guidance available was up to date and there was a systematic process for updating it based on national updates and local review. There was good multidisciplinary team working and learning throughout the service and specifically between community and hospital midwives, clinicians and midwives and at the perinatal meetings between obstetricians and paediatricians. Staff development and continuing professional development in general was a priority within the service and programmes were updated with learning from complaints and incidents.

### Evidence-based care and treatment

- The maternity service used evidence-based national guidance from the Department of Health, NHS Choices, the National Institute for Health and Care Excellence (NICE), Royal College of Obstetrics and Gynaecology, and the UK National Screening Committee.
- Clinical and procedural guidance were also available for staff on the trust's intranet. The guidance was up to date and there was a systematic process for updating guidance based on national updates and local review. For example, guidance on 'perineal tear description and repair including management of packs' had been updated following an investigation into a recent Never Event.

- There was a rolling audit programme with a specialist midwife taking the lead. The maternity department dashboard was comprehensive and used to monitor outcomes and identify any that fell outside expected levels.
- A quarterly newsletter, 'Baseline: listening and learning: women's views, lessons from risk management, guidance for best practice', was produced and circulated within the department by the maternity practice development team. There was also a newsletter produced by the supervisors of midwives and this contained information on recent audits, surveys and continuing professional development.
- A breastfeeding network group audit highlighted the potential to improve the number of mother's breastfeeding their babies. Breastfeeding support volunteers had been engaged to support women and it was planned to make paid positions available to deliver this service, freeing up midwives to provide the other aspects of care and support.

### Patient outcomes

- Patient outcomes were monitored and outliers were targeted for review. Between July 2012 and July 2013, indicators for maternal readmission, perinatal mortality, elective and emergency caesarean sections and puerperal sepsis and other puerperal infections were within expected limits.
- Between July 2012 and September 2013, the trust normal delivery rate was lower than the England average and low forceps cephalic deliveries were higher when compared to the England average.
- Outcomes targeted for action included caesarean section rates that were just above the target level of 23% of all deliveries, the more frequent use of instrumental delivery and the higher rate for induction of labour. Staff were monitoring the service and taking action when necessary. Vaginal birth after a caesarean section in a previous pregnancy had been promoted for several years within the service and had helped reduce the numbers of caesarean births.
- Audit work was ongoing, aimed at reducing the numbers of caesarean sections. It included Keeping the first birth normal and reducing the number of maternal request caesarean sections.

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- The consultant midwife had used the 'Robson 10 group' classification system to categorise women and analyse delivery outcomes so that these can be compared nationally. An action plan was being delivered with the overall aim of improving the rates of 'normal' deliveries.

## Pain relief

- Pain relief was available for birthing mothers, such as entonox, pethidine and remefentanyl.
- Epidurals were available 24 hours a day and 7 days a week from a dedicated anaesthetist.

## Competent staff

- Staff development and continuing professional development in general was a priority within the service and programmes were updated with learning from complaints and incidents.
- There was good-quality professional education and training available and this was delivered via e-learning, face-to-face workshops and facilitated programmes of learning. There was also regular training available in areas such as fetal monitoring and antenatal screening.
- The staff we spoke with said that they felt 'engaged and supported'. For the year to date approximately 80% of staff had had an appraisal which was lower than the trust target of 95%.

## Multidisciplinary working

- There was multidisciplinary team working and learning throughout the service and specifically between community and hospital midwives, clinicians and midwives and at the perinatal meetings between obstetricians and paediatricians.
- Midwives worked closely with GPs and social care while dealing with safeguarding concerns or risks for child protection.
- Investigations of incidents and Never Events were multidisciplinary.
- The maternity training booklet for 2014 set out a range of multidisciplinary learning opportunities, such as the obstetric emergencies training day that 'is compulsory for all midwives, midwife care assistants and doctors of all grades, as well as anaesthetists, theatre staff and ambulance crew'.
- There were two vacancies for sonographers that the trust was finding hard to fill because of a national shortage. This was placing some limits on scanning for early pregnancy services and had been included as an item on the risk register. As a control measure,

20-minute appointments had been introduced, rather than the 30-minute appointments recommended, for early scans in pregnancy to check for any anomalies. It was proposed that midwives and radiographers should be trained to be sonographers.

## Equipment and facilities

- The labour ward was modern and clean and had a variety of equipment to alternative positions for birth.
- Birthing pools were available and there were also birthing balls and birth mats. There was plenty of room for mothers to move around in labour.

## Seven-day services

- The service was available seven days a week. There was a night-time rota for midwives with additional resources for covering breaks. There was also an experienced midwife providing 24/7 on-call support. Consultant on-call support was also in place.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

## Are maternity and family planning services caring?

Good 

Women and their partners that spoke with said that the staff were caring and friendly. There were, however, some comments from women on the postnatal ward about insufficient staff and staff being under pressure. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. We saw a high level of emotional support for women who had had an unplanned caesarean or other complications in labour and birth.

## Compassionate care

- The NHS Friends and Family Test for maternity services at Stoke Mandeville Hospital was positive with a score indicating that patients would be 'extremely likely' to recommend them to family and friends.
- The Survey of Women's Experiences of Birth, CQC, 2013, was for women who had had a live birth during February

# Maternity and family planning

2013 and were over 16 years old. Responses were received from 239 women from the trust, a response rate of 7.1%. The trust was performing similar to other trusts for questions on labour and birth and staff support.

- The trust also asked women for feedback and asked them to complete a 'birth reflections' questionnaire within one month of the birth if their child. In the period from 1 July to 31 December 2013, 181 questionnaires were returned and 175 contained positive comments. Some of the comments included: "should be proud of staff in antenatal, labour and postnatal wards" and "nothing was too much trouble."
- We spoke with women and their partners in all areas of the service including those awaiting day, antenatal and postnatal care. People we spoke with said that the staff were "caring and friendly" and "I was able to ask questions and they (midwives) took the time to explain what was happening."
- Comments from women on the postnatal ward, however, were about insufficient staff and staff being under pressure. In addition, some women were still expressing frustration about the time between admission and the actual start of the induction process.

## Patient involvement in their care

- Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. The 'place of birth' was discussed early on in pregnancy and a sticker had now been introduced into the notes to remind midwives to discuss it again at 36 weeks of pregnancy.
- A leaflet was available for women with information about 'your birth choices' on the website. Subject to appropriate risk assessment, women could choose a home birth, birth in the 'calm, homely environment' of a midwife-led unit, birth at the birthing unit located alongside the consultant-led labour wards at Stoke Mandeville or on one of its labour wards.
- The trust website included a wide range of up-to-date leaflets for patients on birth choices and services at the trust as well as information on particular concerns and issues such as screening options, multiple birth and induction of labour. These leaflets were also available in printed form at Stoke Mandeville Hospital and gave details of the facilities available (for example, at the day assessment unit or for antenatal screening for diabetes

in pregnancy). The leaflets were clear and informative and all had printed issue and review dates. There was also clear version control on the leaflets, which included dates of approval by the maternity guidelines group.

- The CQC Survey of Women's Experiences of Birth, (2013), was similar to trusts for the proportion of women who felt involved enough in decisions about their care.

## Emotional support

- We observed a high level of emotional support for women who had had an unplanned caesarean or other complications in labour and birth.
- Volunteers were available to support mothers with breastfeeding. Partners and family members were also encouraged to stay and offer emotional support as appropriate.
- One of the specialist midwives informed us about the additional emotional support that was available for women experiencing the loss of a baby through miscarriage, stillbirth or neonatal death. This included women at home receiving a phone call from a midwife, just so they did not feel 'so alone'. This information was captured in a series of sensitively written leaflets on the trust's website.
- Bereavement support was included in the maternity team training day and there were two named bereavement support midwives.

## Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Good 

The maternity and family planning services were responsive to people's needs. Mothers had access to the full range of options for birth, subject to the appropriate risk assessment. There was a social assessment undertaken by the community midwife at the first booking and this would identify, for example, any communication or language issues, difficulties with housing or the previous involvement of social services. Care was available for vulnerable patients through the community midwives in liaison with the family nurse partnership for young mothers

# Maternity and family planning

and specialist midwives for conditions such as diabetes. There were some delays for women in antenatal care, for induction of labour and elective caesarean section because of the lack of available postnatal care beds.

## Access to services

Mothers had access to the full range of options for birth, subject to the appropriate risk assessment.

The number of births at Stoke Mandeville Hospital in 2012/13 was just under 5,700. The service had capacity for 6,000 births a year and had not had to close or divert mothers to other services for at least four years.

However, the maternity bed occupancy rate between July and September 2013 was 60.9%, which was above the national average of 58.6%. Occupancy rates above 58.6% can start to affect the quality of care given to patients.

The department was managing capacity through careful risk management and, in some cases, delay or cancellation of elective cases or induction. We were informed, for example, that one elective caesarean had been cancelled because the labour ward was busy and there were no available midwives transfer the baby in the obstetric theatre. The pressure on beds on the labour and postnatal wards was not identified as a risk on the risk register for women, children and sexual health.

The clinical midwife specialist, who was in charge of the postnatal ward during the inspection, had been effective in managing discharge procedures. She had reduced the delay for women waiting for paediatric tests or to receive medication. However, on the day of our visit there were four women waiting to be transferred from the labour ward to the postnatal ward where there were no beds available. There were also three women waiting to begin their induction of labour.

One woman had an elective caesarean postponed until the next day because the labour ward was too busy. We noted that this highly pressured situation was not being escalated as a safety risk through the governance and risk process and the individual delays were not identified as 'incidents'

The general manager informed us that the antenatal clinics were "heaving". The day before she had been attempting to 'push' the postnatal ward to admit an antenatal patient but "they just had no beds

The patients we spoke with were all positive about their care but some were unhappy about the delays. One patient we spoke with commented on the long wait in the antenatal clinic but said, "I am satisfied with the care."

There was a care pathway for women from first contact with a GP and community midwife through to postnatal care and caring for the newborn baby. The pathway ensured women had choices whenever possible. Parent and antenatal education were available as well as additional support from the family nurse partnership for young mothers.

## Meeting people's individual needs

There was a social assessment undertaken by the community midwife at the first booking and this would identify, for example, any communication or language issues, difficulties with housing or the previous involvement of social services.

Care was available for vulnerable patients through the community midwives in liaison with the family nurse partnership for young mothers and specialist midwives for conditions such as diabetes. There were also close liaison with social care should there be any learning difficulties or mental health issues.

Interpreters were available and leaflets were available in the other languages that were spoken locally. One lady we spoke with was Polish and she and her husband indicated that they were happy that an interpreter had been available for their meeting with the obstetrician and midwife.

A discharge summary was automatically emailed to GPs when women were discharged from hospital. This detailed the reason for admission and any investigation results and treatment undertaken.

## Complaints and concerns

Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the senior midwife. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.

Complaints posters were displayed on the wards and information leaflets were available.

# Maternity and family planning

Women we spoke with knew how to raise concerns or make a complaint.

The service received an average of two complaints per month. We saw evidence that the service responded well and used complaints to improve. For example, a recent risk/audit meeting record sheet included the lessons learned from a complaint about care and treatment during which staff had been rude. One of the learning points was 'Having patients at the centre of our care means not taking things personally, but understanding their views. Patients' perception can be very different from our own.'

In November 2013, the obstetric department had responded to 83% of complaints within the trust's 25-day target. This was slightly below the trust target of 85%.

## Are maternity and family planning services well-led?

Good 

The leadership of the maternity services was described as strong and effective. The head of midwifery and her team were well focused and fully engaged and staff told us they felt well supported. Reporting arrangements to the board and within the division required improvement so that assurance could be effectively gained. The maternity service did not have a written vision or strategy but there was a risk management strategy for operational and performance risks. Risks were effectively managed but pressure on the postnatal ward was not identified as a risk. The service was good at implementing innovations in care.

### Leadership of this service

The leadership of the maternity services was described as strong and effective. We found that the head of midwifery and her team were well focused and fully engaged.

The consultant midwife said, 'We are all easy going and of equal standing; we are clear about our roles and that helps.' She also said that the head of midwifery had a "strong, inclusive, consultative style and that encourages good respectful listening all round".

The unit head of midwifery, senior clinical lead and general manager reported to different members of the trust leadership team, and there were examples that concerns

were not coordinated and escalated appropriately to board. For example, the board did not see the complete maternity services dashboard, data concerning the number of stillbirths, and an audit report by local supervisors of midwives was submitted to the board 10 months after the audit had taken place.

### Culture within this service

Leadership within the service prioritised safe, high-quality compassionate care. We found a keen sense of enquiry, enthusiasm for learning and improvement in maternity services, and a culture of professional respect.

The audit report by the local supervisors of midwives mentioned 'differences' in culture between community- and hospital-based midwives and that community midwives had a more inclusive style. This was actioned and a leadership programme was designed for hospital midwives to introduce the skills required for a more coaching style of leadership when appropriate.

The NHS Staff Survey (2012) results for the trust overall revealed that staff were reporting issues (but were within the bottom 20% of trusts nationally) to do with work pressure, working extra hours, support from managers and communication. Several staff we spoke with mentioned that, with the trust under such pressure in general and colleagues working so hard, they sometimes had a need for greater acknowledgement. We noted that colleagues in maternity services had recently received awards for 'going the extra mile'.

### Vision and strategy for this service

Several staff spoke about the need for greater overlap between community and hospital midwives to make better use of available resources and to reduce the size of caseloads. They also spoke about the need to build on the merger and centralisation of services, maintain high standards of care and treatment, and manage capacity in a more proactive rather than reactive way.

The maternity service, however, did not have a written vision or strategy.

There was a maternity risk management strategy that reinforced the approach within the service of managing risks, learning from mistakes, and the processes to obtain assurance.

# Maternity and family planning

## **Governance, risk management and quality measurement**

There were monthly governance meetings within the service. Complaints, incidents, audits and service performance measures were discussed and actions agreed.

Monthly academic half-day meetings were held to review cases and disseminate the learning on risk management briefings, current teaching and clinical audit. During these times, clinics and elective work were not scheduled to enable staff to attend. There were also monthly perinatal meetings involving a joint presentation from obstetricians and paediatricians, and the learning, training and actions discussed were shared with staff.

The maternity dashboard was regularly reviewed and there was target monitoring of performance and quality measures. Action was taken when necessary. For example, a consultant had identified a peak in the number of stillbirths in December 2013. Each case was examined, but no themes or patterns emerged that would link or explain the peak. Some, but not all, of these statistics were included in a composite dashboard for obstetrics and gynaecology that was examined at divisional level.

The risk register for women, children and sexual health included a risk relating to the heavy community midwife caseloads, but there was no risk recorded from the pressure on the service in the labour and postnatal wards.

## **Innovation, improvement and sustainability**






The maternity training booklet for 2014 set out a range of multidisciplinary learning opportunities such as the obstetric emergencies training day that was 'compulsory for all midwives, midwife care assistants and doctors of all grades'. Anaesthetists, theatre staff and ambulance crew were also invited.

There were innovations in care that were simple but effective adjustments or additions to processes as a result of learning from complaints and incidents (for example, changes to the care and support for women after a stillbirth and the introduction of a sticker to check that all swabs were removed).

The 'Reflections at Birth' initiative, which involved feedback from women one month after giving birth, had helped to inform management and improve the quality of care.



# Services for Children & Young People

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Information about the service

Children's services at Stoke Mandeville Hospital included a paediatric ward (Ward 3) accepting children aged up to 16, or 18 if under the care of the child and adolescent mental health services (CAMHS). The ward provided emergency care, a day care facility for those undergoing minor plastic surgery and a treatment area for outpatient chemotherapy. There was a paediatric decision unit (PDU) accepting patients via the accident and emergency (A&E) department and referred by GPs for assessment, a paediatric spinal rehabilitation unit (St Francis ward), and a neonatal unit that was part of the Thames Valley and Wessex area. The paediatric department had 5,690 admissions in 2013/14.

We visited all children's ward and outpatient areas. We spoke with three children and their parents and 16 members of staff including nurses, medical staff, healthcare assistants, a ward clerk, domestic staff and a manager. We observed care and treatment and the environment, and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

Services for children and young people were good throughout. Most parents told us the staff were caring, and we saw that children and their parents and carers were treated with dignity, respect and compassion. Ward areas and equipment were clean. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs.

The services were responsive to the needs of children and young people and their families and carers. The ward sisters communicated well with staff, and staff were positive about the service and quality. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements.

# Services for Children & Young People

## Are children's care services safe?

Good 

Services for children and young people were generally safe. Ward areas and equipment were clean. Patients at risk of, or suffering from, an infective illness were cared for in single rooms to reduce the risk of spreading infection. There were enough trained staff on duty to ensure that safe care could be delivered. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs. Children's or their parent's consent to treatment was obtained appropriately.

### Incidents, reporting and learning

There had been no "Never Events" reported (incidents that should never occur) during December 2012 and January 2014.

Thirty-two incidents were reported for the period September–October 2013. A trend was identified for sharps injuries. Action was taken to ensure that sharps bins were taken to a patient's bedside to reduce the risk.

Serious incidents were reported and managed appropriately. Two serious incidents had been reported in November 2013. Action plans had been put in place as a result of investigations. Actions taken included an audit of the paediatric early warning system (PEWs) charts, changing a process related to paediatric drug calculations in A&E and informing all medical staff of the criteria for reporting serious incidents. A further two incidents reported in January 2014 were also managed appropriately.

Between January 2014 and March 2014 there had been 21 incidents in paediatrics reported to the National Reporting and Learning System (NRLS). All were low or no harm and the majority were for unplanned readmission of babies.

All staff we spoke with told us they were encouraged to report incidents and learning from incidents was shared.

### Cleanliness, infection control and hygiene:

Ward areas and equipment were clean.

Staff followed the trust policy on infection control. Staff used hand hygiene gel and personal protective equipment, such as aprons and gloves, appropriately.

Patients at risk of, or suffering from, an infective illness were cared for in single rooms to reduce the risk of spreading infection.

Each service within paediatrics had an infection control nurse who was responsible for coordinating and performing audits. Audits of cleanliness were regularly performed.

There were minor concerns about the process for washing toys in the PDU and outpatient areas. Children with an unknown infection status played with toys in the waiting areas. Toys were cleaned daily but not between patients.

### Medicines

Medicines were stored appropriately. The treatment room was secure. Fridge temperatures were monitored and identified rises were dealt with appropriately to ensure that medicines remained effective.

Guidelines were available for paediatric medicines that were injected and sedation for children.

There was a paediatric pharmacist allocated to Ward 3, the neonatal unit and the PDU. They supported the correct prescribing of medicines.

On the neonatal ward, nurses who administered medication wore tabards to minimise the risk of being interrupted.

Medication errors were reported and we saw additional training had been implemented as a result of the relatively high number of recent events.

### Environment and equipment

There was sufficient equipment on the wards to ensure safe care.

Equipment was regularly checked and well maintained. Broken equipment was replaced.

The neonatal ward had procedures to replace older equipment on a rolling cycle.

### Records

All wards used multidisciplinary notes and all staff wrote in the same set of notes. This ensured that all disciplines had access to current and comprehensive information on each patient.

Notes were kept in a locked trolley or in a supervised environment to maintain confidentiality. Notes were tracked if removed so they could be located when needed.

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All patients had an admission sheet completed giving details of their religion, any language needs, who had parental responsibility, allergies, immunisations and previous admissions to hospital. These were generally well completed.

All patients had a care plan that identified specific care needs.

Audits of the quality of record keeping were performed and identified issues actioned for improvement.

Most notes were paper based but were being transferred to an electronic system.

## Safeguarding

Children's or their parent's consent to treatment was obtained appropriately.

The department had systems to safeguard patients. The local authority had undertaken a trust-level audit of safeguarding in November 2013. Some of the needs identified included a review of training plans and policies to ensure that they reflected the latest national guidance. The trust had an action plan to respond to these issues. Progress on the action plan had been made and the safeguarding board was monitoring progress.

There were clear policies and procedures for handling potential safeguarding concerns. Children identified as a potential safeguarding concern had a specific care plan. Birth plans included details of child protection issues. All patients with a safeguarding concern or on the at-risk register were seen by a consultant who approved their discharge.

Multidisciplinary safeguarding meetings were held with health visitors, GPs, dietitians and speech and language therapists.

## Assessing and responding to patient risks

There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs.

There were clear pathways for managing deteriorating patients. Staff used the PEWS system, which included the escalation pathways printed on the reverse of observation charts. Staff were aware of the appropriate action to take to ensure that children who became ill were quickly and appropriately managed.

The ward published key performance indicators covering incidence of falls, medication errors, pressure ulcers, meticillin-resistant staphylococcus aureus (MRSA) bacteraemia, and hand hygiene. Medication errors were within expected levels; however, action had been taken to reduce these further.

## Nurse staffing

There were enough trained staff on duty to ensure that safe care could be delivered. Duty rotas showed staffing levels were generally good.

There were approximately 22 staff vacancies across the paediatric services for 2014/15. Funding for these additional posts had recently been agreed and recruitment was under way.

## Medical staffing

A consultant was present in the neonatal unit and on the paediatric ward from 9am to 5pm Monday to Friday and 8.30am to 2pm at weekends. At night and at weekends after 2pm, there were consultants on call.

Patients were seen by a paediatric consultant within the first 24 hours of their admission to the hospital.

Consultants did daily ward rounds including at weekends. There were daily handover meetings between medical staff to ensure continuity of care.

The junior doctor rota had two vacancies at senior house officer (SHO) level and two at registrar level. Cover was provided by locums from within the trust.

## Mandatory training

Training records showed staff were compliant with completing mandatory trust training. All staff had completed level 2 safeguarding training. There was no data available for Level 3 training which is the level expected for staff that work with children or young people.

## Are children's care services effective? (for example, treatment is effective)

Children were treated according to national guidance. At the monthly departmental meetings, any changes to guidance and their impact on current practice were discussed and agreed. The services had an annual clinical

# Services for Children & Young People

audit programme to monitor that guidelines were being adhered to. All patients had an initial assessment that involved discussion with both the child and their parent/carer. Daily ward rounds were performed to ensure ongoing needs were assessed.

## Evidence-based care and treatment

Children were treated according to national guidance included those from the National Institute of Health and Clinical Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH). Local policies and procedures used within the department were based on national guidelines and were up to date.

The paediatric governance reports showed the use of new National Institute for Health and Care Excellence (NICE) guidelines that had been issued recently: for example, 'Managing overweight and obesity among children and young people', October 2013; 'Depression in children and young people', September 2013.

Children's protocols were developed that were specific to the needs of children when trust-level documents were not appropriate.

At the monthly departmental meetings, any changes to guidance and their impact on current practice were discussed and agreed.

A breastfeeding network group audit highlighted the potential to improve the number of mother's breastfeeding their babies.

## Patient outcomes

Paediatric services had an annual clinical audit programme to monitor that guidelines were being adhered to. In August 2013, the management of headaches in young people and adults was recorded as compliant, and treatment of feverish illness in children was shown as compliant in May 2013.

Practices were changed and actions taken in response to audit findings. A recent change required two people to check children's weights, with the second checker being a parent.

The monthly governance meeting in September 2013 described newly approved pathways: for example, the bronchitis pathway and bronchiolitis pathways were noted as approved.

The national paediatric diabetes audit performed in 2011/12 resulted in recommendations for cholesterol and retinal screening to be done at yearly check-ups and for blood pressure to be recorded in words rather than numbers. Practice had been changed as a result of these findings.

The neonatal ward had participated in a national survey run by the PICKER Institute into parents' experiences of neonatal care.

The neonatal unit had participated in the South Central Neonatal Network's benchmarking activities. The areas reviewed in 2013 included care environment, discharge planning, wound care, care at the time of death, cord care and behavioural cues. The unit compared well with other units, with no results below expected performance.

## Pain relief

Pain control included age-appropriate methods and both analgesic and non-analgesic interventions were considered: for example, distraction, comfort or a change of position.

## Competent staff

Practice development nurses were involved in designing dedicated paediatric training modules. They supported staff to complete the required training by using reminders and setting up study days.

Senior nurses provided supervision to student nurses and healthcare associates.

Training for paediatric doctors had been accredited by the Oxford Deanery.

Play specialists had been invited to share their expertise with doctors and nurses to help them better understand how to interact well with children.

Staff told us they felt supported and most had attended clinical supervision where they could discuss and reflect on incidents occurring at work.

Staff had a yearly review to discuss progress and training needs. As at February 2014, 82.7% of staff had had an appraisal which was lower than the trust target of 95%.

## Multidisciplinary team working

The paediatric ward had specialist paediatric physiotherapists and occupational therapists, and there was a dedicated pharmacist with specialist training in paediatric dispensing. All staff participated in multidisciplinary ward rounds.

# Services for Children & Young People

A hospital teaching service was provided by the local authority and were based on the ward to support children to continue their education while in hospital. The service worked as part of the multidisciplinary team caring for the patient, and it had been graded as outstanding by Ofsted.

Diabetes and oncology nurse specialists were available to support patients, parents and staff.

Multidisciplinary meetings were held for case reviews and discharge planning.

## Equipment and facilities

The ward had a play area for younger children with a sensory room. There were three video players that could be moved around the wards and televisions were available in the lounges.

There was a lounge for adolescents with a play station console and some games. Internet was available during school hours in the school room.

Adolescent patients told us there were not enough age-appropriate activities for older children of 11 years or more. The DVDs available were aimed at younger children. There was no internet access in the ward areas so young people did not have easy access to their friends and family.

Parents could sleep on beds next to their child, and they had a lounge and a place to make themselves refreshments. On the neonatal ward, two side rooms were available for parents.

Facilities were available for the expression and storage of milk.

There was a safe outside play area on the ward and the outpatients department had its own play room.

## Seven-day services

Ward 3 and the neonatal ward were open seven days a week. However, the outpatients department and spinal rehabilitation ward were open Monday to Friday only. Plans had been approved to recruit additional staff to enable the spinal rehabilitation ward to open seven days a week.

The specialist nurses for diabetes and oncology worked Monday to Friday.

Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.

The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications

## Are children's care services caring?

Good 

Most parents told us the staff were caring and we saw many cards displayed that expressed thanks to ward staff.

Children and their parents/carers were treated with dignity and respect, and compassion. We saw a nurse encouraging parents to support their child's needs and to overcome their fear of 'getting it wrong'. Patient records were completed sensitively and detailed the discussions with children and their parents. The ward had open visiting times for family. Parents could stay overnight; there was a lounge room for their use and facilities for making refreshments. This helped parents to support their child in adapting to the hospital setting.

## Compassionate care

Results from the NHS Friends and Family Test were displayed on the wards and were consistently above the England average.

Most parents told us the staff were caring and we saw many cards displayed that expressed thanks to ward staff.

We observed that children and their parents/carers were treated with compassion. We saw a nurse encouraging parents to support their child's needs and to overcome their fear of 'getting it wrong'.

Patients and parents/carers were treated with dignity and respect. Patient records were completed sensitively and detailed the discussions with children and their parents.

## Patient involvement in their care

Children and their parents/carers were involved in decisions about their care and treatment.

Play specialists were used to support children to understand their illness and any procedures. This helped them to make informed decisions and choices.

All patients had an initial assessment that involved discussion with both the child and their parent/carer. Daily ward rounds were performed to ensure ongoing needs were assessed.

# Services for Children & Young People

## Emotional support

The ward had open visiting times for family. Parents could stay overnight; there was a lounge room for their use and facilities for making refreshments. This helped parents to support their child in adapting to the hospital setting.

Play specialists worked with children to help them adapting to the new environment and to the hospital experience.

Parents on the neonatal unit were able to access support via the local support group, Baby Unit Relatives and Parent Support (BURPS), which was set up to give support and practical help to parents with babies on the neonatal ward.

Private rooms were available for sensitive discussions.

## Are children's care services responsive to people's needs?

(for example, to feedback?)

Good 

The services were generally responsive to the needs of children and young people and their families and carers. Access was good, and the needs of all different kinds of child patients were met appropriately. There were multidisciplinary networks that supported the early discharge for children. These included links to community nursing and children's outreach services.

## Access to services

Children were referred to the paediatric ward either via accident and emergency (A&E) or the paediatric decision unit (PDU). GPs could refer patients directly to the PDU for observation and assessment. If a child needed admitting, they were transferred to the paediatric ward. All children had a first consultation within 24 hours.

Some patients had access to the Children's wards directly via an open-door policy. This policy applied to those with long-term illnesses such as epilepsy or cystic fibrosis. Some patients had a 24–48 hour open-door policy after discharge. This policy enabled parents to obtain advice directly by phoning the ward.

Stoke Mandeville was part of a national burns network for paediatric burns patients; referrals were received from

other hospitals and the children admitted via the PDU. All children with burns of less than 20% and not needing ventilation were referred to Stoke Mandeville for specialist treatment.

The oncology services provided a regular day for the administration of chemotherapy on the ward.

The spinal unit was a national referral unit for children's rehabilitation. Before admission from other health authorities, multidisciplinary meetings were held to plan the transfer.

The paediatric ward supported the work of the cancer network, cared for feverish patients and gave blood transfusions.

The neonatal unit was a level 2 unit for babies born before 35 weeks who required specialist care. Those born before 27 weeks or who required complex specialist treatment were transferred to another hospital with a larger specialist neonatal unit. The regional neonatal centre was the John Radcliffe Hospital in Oxford.

## Meeting the needs of all children

Children with special needs were assessed on admission and a nursing care plan developed to address their needs. Staff told us parents or carers tended to stay with the patient. There was a lead paediatrician for those with learning disabilities.

Translation services were available if needed; however, generally, a member of staff or the parents were able to help translate.

A specific care plan was developed to support children to move from young people to adult services. The timing and method of support was based on the individual assessments and needs of the child.

Educational needs of children were met by the on-site hospital teaching service.

All patients were discharged as soon as they were considered fit, so as to minimise risks as a result of extended time in hospital. The average stay on Ward 3 was 1.5 to 1.8 days.

There were multidisciplinary networks that supported the early discharge for children. These included links to

# Services for Children & Young People

community nursing and children's outreach services. Staff nurses told us there was close cooperation with the community via GPs, health visitors, education, occupational therapy and physiotherapy services.

Multidisciplinary meetings were used for more complex discharges requiring ongoing support in the community.

The neonatal unit compared well with other neonatal units in the South Central Neonatal Network for length of stay and discharge planning arrangements.

A discharge letter was sent to the patient's GP and these included details of the reason for admission, investigation and treatment. A copy of the letter was also given to the patient. GPs were involved in multidisciplinary case discussions for children who would have complex discharge arrangements and/or safeguarding concerns.

## Complaints

All complaints were responded to by a senior nurse. They were investigated and the investigations were timely and appropriate. Complainants were invited to face-to-face meetings or received a phone call to discuss their issues. The lessons learned from complaints were communicated to the department via team meetings and notice boards, and incorporated into training modules if necessary.

We saw good examples of changes made as a result of complaints received. These included the development of leaflets explaining certain treatments, and a leaflet explaining waiting times in the PDU.

All complaints had been responded to within the trust target of 25 working days.

## Are children's care services well-led?

Good 

The ward sisters communicated well with staff, and staff were positive about the service and quality. Children's experiences were seen as the main priority. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements. The service had many examples of innovative practices. Risks were managed appropriately and learning from events, incidents and complaints was incorporated into training where required.

## Leadership of this service (and links to trust divisional structure)

There was a matron responsible for the overall service and each area had a ward sister in charge.

A clinical lead was responsible for managing the medical staff including those in training posts.

The trust had an initiative that promoted exemplar wards. An exemplar ward was one that was achieving very high standards of clinical care: for example, between 95% and 100% in various assessments, such as hand hygiene practices, high levels of staff and patient satisfaction, and high standards of care. Ward 3, St Francis ward and the paediatric decision unit (PDU) were exemplar wards within the trust.

## Culture within this service

The ward sisters were fully aware of their service and communicated well with staff.

Staff were positive about the service and quality, and children's experiences were seen as the main priority.

Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements. We were told about an initiative to develop a stronger team environment or department for the play specialists on the different wards.

Staff worked well together in multidisciplinary teams to provide holistic care to children.

## Vision and strategy for this service

The service did not have a vision or strategy and the trust did not have any long-term service plans.

The service had planned changes around capacity issues. There was a recent agreement for more staff to be recruited to enable the spinal rehabilitation ward to open seven days a week. The staffing of the PDU and accident and emergency (A&E) was currently shared and discussions were ongoing about how to streamline the delivery of A&E services for paediatrics.

## Governance, risk management and quality measurement

Monthly clinical governance meetings were held to assess the outcome of any audits, complaints or incidents.

A ward dashboard showing the current status of a variety of indicators was available online.

## Services for Children & Young People

One nurse had 50% of their time dedicated to governance activities.

There was a wide range of audit and governance activities including serious injury reviews, complaints reviews, infection control audits and isolation precaution audits.

Learning from events, incidents and complaints was incorporated into training if required.

### **Innovation, improvement and sustainability**

Many innovations had come about as a result of feedback received. Some examples include:

The development of standard pathways, in association with the commissioning groups and the Institute for Innovation, to try to reduce the number of admissions for gastroenteritis, fever in children under five and bronchitis. Posters had recently been circulated to all primary care services.

The outpatients department used bleeps for parents so they could move about the hospital when waiting for outpatient appointments.

There was a sensory room on the paediatric ward to provide a calm environment for children.






There was ongoing work to enable iPad usage on the ward so that children could have better access to their friends and be able to play games they were familiar with.

There was a programme to enable midwives to give intravenous medication to babies on the postnatal unit. This would be more convenient for both parents and staff.

Staff were encouraged to innovate. However, we were told that responsiveness to suggestions could be slow, especially if funding was needed for implementation.



# End of life care

Safe	Requires improvement 
Effective	Inadequate 
Caring	Requires improvement 
Responsive	Requires improvement 
Well-led	Requires improvement 

## Information about the service

End of life care at Stoke Mandeville Hospital was provided by ward staff in inpatient areas. There was a specialist palliative care team to support patients requiring complex symptom management. The team consisted of two consultants and six specialist palliative care nurses. The Florence Nightingale Hospice inpatient unit, day hospice and outpatient services on the Stoke Mandeville site also provided symptom management and care for complex cases.

The specialist palliative care service provided 24-hour symptom management information and advice for staff caring for patients requiring end of life care and their families. End of life care was also provided by other members of the multidisciplinary team: for example, acute oncology, chaplaincy, clinical nurse specialists and the bereavement office.

We talked with four patients receiving end of life care, three relatives and 22 staff, including nursing, medical staff, management and other members of the multidisciplinary team. We observed three episodes of care and looked at seven patients' care records. Before our inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

The specialist palliative care team provided a safe, effective and responsive service. However, end of life care was consistent across the hospital ward areas and patients were not always appropriately referred to the specialist palliative care team. Some aspects of end of life care were not provided in line with national guidance, for example, access to medicines. We saw that there were delays in providing pain relief to patients. Ward staff were not appropriately trained in end of life care and essential nursing care was not delivered appropriately, for example, assessment and monitoring, pressure ulcer management, pain relief, comfort and managing distress.

Patients were not consistently involved in decisions about their care and some did not receive the compassionate care and emotional support they needed. The end of life care for patients was not monitored appropriately.

# End of life care

## Are end of life care services safe?

Requires improvement 

The specialist palliative care team offered consistent and safe care to patients but there were concerns in ward areas. Charts used to monitor a patient's general health and wellbeing such as food and fluid intake and skin condition were not accurately completed. Therefore, staff did not have sufficient information to identify changes in a patient's condition. Appropriate medicines were not always available. Assessments of a patient's mental capacity to make decisions were not consistently completed or documented before decisions about the care that was in their best interests were made.

### Incidents, reporting and learning

There had been no recent "Never Events" (incidents that should never occur) in the specialist palliative care service between December 2012 and January 2014.

The most recent serious incident in the specialist palliative care service was in January 2014 and it was fully investigated. The incident involved the inaccurate recording of a patient's own medicines on admission to the hospice. The investigation resulted in changes to the procedure for medicines management.

Staff understood their responsibilities with regard to reporting incidents. They told us they did not always receive feedback on the outcome of incidents.

### Cleanliness, infection control and hygiene

Ward areas within the hospice were clean. We saw that staff regularly washed their hands and used hand gel between patients.

Staff followed the trust policy on infection control. Staff observed the hospital's 'bare arms below the elbow' policy. Personal protective clothing in the form of gloves and aprons was available and staff were seen wearing these when delivering personal care.

Infection prevention and control policies and procedures were in place and accessible to staff on the intranet. Staff applied protective isolation principles to protect at-risk patients from infection.

The transfer policy for deceased patients with an infection was not consistently adhered to: for example, the mortuary told us of a recent incident where a body bag had not been used for an infected patient. This was a potential infection risk to both patients and staff.

### Environment and equipment

In 2011, the National Patient Safety Agency recommended that all Graseby syringe drivers should be removed by the end of 2015. The trust had a business plan to replace these but this had yet to be approved. Interventions to reduce the risk had been implemented, such as removal of other types of Graseby syringe drivers.

The hospice planned to replace lighting equipment after a health and safety audit in February 2014. The audit identified that the overhead lamps were a risk to patients and staff because they were old and had metal shades that quickly became hot.

### Medicines

Medicines in the hospice were stored safely. Record keeping was in line with legal requirements.

Three of the five ward areas we visited did not keep the appropriate dose of sedative required for syringe driver use (a method of continuous delivery of medicines). There was a risk that treatment could be delayed.

### Records

The trust audited the 'do not attempt cardio-pulmonary resuscitation (DNA CPR)' forms annually to ensure that they were always completed properly.

We saw a sample of DNA CPR forms that had been completed appropriately in ward areas. A trust DNA CPR audit of 88 forms in January 2014 showed that the decision had been made and recorded in 95% of cases, and by an appropriate clinician in 91% of cases.

Charts were used to monitor a patient's general health and wellbeing such as food and fluid intake and skin condition. However, patients were not formally assessed as to the appropriate use of these charts at the end of life. The charts were also not accurately completed and staff therefore did not have accurate assessments of a patient's condition, such as if they were properly hydrated.

Ward care plans to support patients' end of life care needs did not reflect national guidance. They did not provide sufficient information for staff to provide safe, effective

# End of life care

care. Care plans for patients' specific end of life care needs, such as management of pain or distress, were not completed. Care plans were not used in some areas, such as surgery.

Some care plans in the hospice were pre-printed with information and were not patient centred.

## Consent, Mental Capacity Act, and Deprivation of Liberty, Safeguarding

Assessments of a patient's mental capacity to make decisions were not consistently completed or documented before best interest decisions were made.

The Trust DNA CPR audit identified that one of the main areas that was not always completed was associated mental capacity assessments, only 20% of forms were completed.

We looked at patient records and found some examples of documented discussions with patients and relatives about treatment decisions. However, they showed that patients were not consistently involved in DNA CPR decisions. They also demonstrated that patients were not consistently informed of their prognosis before medical staff had discussions with family members.

Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults.

## Staffing

Staff in all ward and outpatient areas told us they were short staffed at times, which had an impacted on providing end of life care, particularly on the time available to give emotional support.

Staff in the mortuary told us there was not enough staff to cover sickness and annual leave. They worked alone instead of in pairs. This meant some mortuary activities were unsafe because they required two staff but were undertaken by one.

The bereavement office was short of staff. Staff described the only service they were able to offer as "just dishing out death certificates".

A peer review undertaken by the lead cancer clinician in 2012 identified that there were insufficient palliative care consultants to cover the multidisciplinary teams and

annual leave. There had been no changes to the staffing levels following the review, despite a recommendation to increase the number of consultants from two clinicians to three.

## Mandatory training

Staff in the specialist palliative care service were up to date with their mandatory training.

## Are end of life care services effective? (for example, treatment is effective)

Inadequate 

The specialist palliative care team coordinated multi-disciplinary care. However, some aspects of end of life care were not provided in line with national guidance, for example, access to medicines. We saw that there were delays in providing pain relief to patients. The hospital contributed to the National Care of the Dying Audit to compare end of life care provision with that of other healthcare providers. The trust was in the lowest 25% of hospitals for the prescribing of medicines for the main symptoms at end of life and also access to patient information, but there was no evidence to show that actions for improvement had been undertaken or that they were regularly monitored. Some nursing staff we spoke with were not clear about the trust's definition of end of life care. Ward staff were not appropriately trained in end of life care and essential nursing care for assessment and monitoring, pressure ulcer management, pain relief, comfort and managing distress, was not delivered appropriately.

## Evidence-based care and treatment

End of life care did not consistently follow national guidance. Some provision of end of life care followed national guidance: for example, the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults' (2011; updated 2013). There were also examples of how standards had been applied, specifically, specialist palliative care provision and 24-hour chaplaincy support.

However, some aspects of end of life care were not provided in line with national guidance, for example, access to medicines. We observed that there were delays in providing pain relief to patients. Patients on the wards told

# End of life care

us they were in pain because there were delays in the administration of prescribed pain relief. One patient, recently healed from a pressure ulcer, assessed as at high risk of pressure ulcer development and currently in discomfort, was not on the appropriate pressure-relieving equipment; nor did they have a care plan to manage their pain or skin.

Patients in the last few weeks of life continued to have monitoring of their vital signs. This may have been appropriate to the acutely ill patient but it was not necessary for patients at the end of life. This could cause misunderstanding and disruption to both patients and their relatives.

Local policies for managing certain palliative care emergencies were written in line with NICE guidance. However, care was not regularly audited to assess compliance.

Some nursing staff we spoke with were not clear about the trust's definition of end of life care. A number of staff defined it as care in the last few days of life and not care in the last 12 months of life. This had implications for the support patients received.

On one ward, staff were not aware that they had two patients who required end of life care and who were supported by the specialist palliative care team. The patients had not received the support they needed.

In response to the national withdrawal of the Liverpool Care Pathway, the trust had rolled out replacement guidance to all inpatient areas. However, one ward had leaflets about the Liverpool Care Pathway still available in information racks for relatives and patients to read. This could cause confusion and distress to some patients and relatives.

## Patient outcomes

The hospital contributed to the National Care of the Dying Audit (Royal College of Physicians, 2013) to compare end of life care provision with other healthcare providers. The evidence from the 2011/12 audit showed that the hospital was in the top 25% of hospitals for access to specialist palliative care support. However, the hospital was in the lowest 25% of hospitals for prescribing of medicines for the main symptoms at end of life and access to patient information. The recommendations included raising awareness of spiritual care to be available for end of life

care, carers' support and ensuring anticipatory prescribing in acute areas. This audit was two years ago but is noted here as some areas, for example, around access to medicines were still outstanding.

The actions taken as a result of this audit were not regularly monitored to demonstrate improvement. Data from the most recent audit in 2013 was not yet available for comparison.

The specialist palliative care service participated in an internal validation (peer review) of the service to evaluate their performance against the NHS England National Cancer Peer Review themes. The results indicated 92% compliance with the standards. The recommendation made was to increase the number of palliative care consultants.

## Pain relief

Appropriate medication was not always available in the ward areas and outpatients, and there were examples that anticipatory prescribing was not being managed.

Patients on the wards told us they were in pain because there were delays in the administration of prescribed pain relief.

## Competent staff

Staff within the specialist palliative care team had clinical supervision to support them in their role and all staff had had an appraisal.

Some wards had palliative 'link' nurses as act as a resource to improve knowledge and skills for ward staff but we did not have evidence of how this worked effectively in practice and how these staff were trained and supported.

Training sessions had been delivered in ward areas by the specialist palliative team. However, some nursing staff were not aware that new guidance was available and should be used. Essential nursing care was not delivered appropriately, for example, appropriate assessment and monitoring, pressure ulcer management, pain relief, comfort and managing distress. .

## Multidisciplinary working

A specialist palliative care multidisciplinary team (MDT) meeting with input from the chaplain and other specialities took place weekly to discuss hospital inpatients' treatment plans. The teams also held ward rounds.

# End of life care

The specialist palliative care team worked closely with acute oncology clinicians to coordinate treatment for cancer patients, and with nurse specialists (in the areas, for example, of cancer and heart failure) to avoid overlap and facilitate well-coordinated care.

The specialist palliative care nurses attended some cancer site-specific MDT meetings (for example, lung and upper gastro-intestinal tract) although attendance was less than 65% for both. They told us attendance was difficult because of the number and timing of meetings.

The palliative care consultant was working with consultants from other specialties, for example in A&E and critical care to determine ceilings (limits) of treatment for patients at the end of life.

## Seven-day services

Ward staff told us the specialist palliative care team was a responsive, supportive service.

The specialist palliative care team were available at the Stoke Mandeville Hospital site 9am to 5pm, Monday to Friday. A specialist palliative care nurse was available at weekends and out-of-hours advice was provided by the hospice.

The specialist palliative care team told us that they ensured patients referred to them had a plan of care to meet their needs over weekends.

Medical cover at the weekend was provided by the on-call doctors from other specialities who were not necessarily familiar with the patients.

Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.

The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications. Staff told us this sometimes meant there were delays in discharging patients.

The chaplaincy service provided 24-hour on-call support for patients and relatives.

## Are end of life care services caring?

Requires improvement 

Patients told us they were satisfied with the service and were involved in their care. We observed staff treating patient with dignity and respect but we also observed examples where care needed to improve. Patient's feedback or their views on their experiences were not regularly collated and information on do not attempt resuscitation was not always discussed with patients or their relative/ carer. Patients had good emotional support from the specialist palliative care team and chaplaincy and psychology services but staff on the wards told us it was difficult to provide emotional support when wards were busy and they were short staffed.

## Compassionate care

Overall, patients and their relatives on the wards were satisfied with the care they had received. One patient said, "It's like a five-star hotel in here compared to some of the wards." A relative told us, "The nurses are nice. I have confidence in most of them."

There were clear examples of staff treating patients and relatives with dignity and respect. For example, a pathology technician reminded staff about the need to check if relatives were present before entering the mortuary viewing area.

We observed some examples of care that could have been improved.

One patient was given the news that he was dying without his family being present. He told us he wanted his family present and they had been unaware and were waiting on the ward

Staff did not communicate with a distressed patient who was shouting out while care was given.

A patient was left unshaven after personal care and an infected area on the patients' mouth was not being adequately treated.

One patient told us they had had to call home at night because they were distressed. Their call bell was placed

# End of life care

out of reach behind their end. Their family had been told by staff that they had had a good night. Staff told us that patients were checked and that this should not have happened.

Staff closed curtains when a patient was distressed.

Normal visiting times were waived for relatives of patients who were at the end of their life.

The specialist palliative care team evaluated the hospice inpatient service on a regular basis. Patient and relative feedback for the hospice was positive. There was limited patient feedback regarding the hospital specialist care team and the process of collecting that information was under review.

## Patient involvement in care

Patients and relatives we spoke with said they felt involved in their care. However, five of the seven records we looked at showed that patients were not involved in the development of their care plans.

Patients told us that they did not always have access to appropriate information.

A trust 'do not attempt cardiopulmonary resuscitation; (DNA CPR) audit of 88 forms in January 2014 showed that the main areas that were not always completed were discussions with the patient (68%) and relative (39%).

Bereavement packs were available in the accident and emergency (A&E) department with information about access to support.

## Emotional support

The specialist palliative care team, the chaplaincy, nurse specialists and psychologists provided emotional support to patients and relatives.

Staff told us there were insufficient ward areas for patients who were dying to have privacy with their families.

Patients at the end of their life did not always have access to side rooms.

Staff in all ward and outpatient areas told us they were short staffed at times, which had an impact on providing end of life care, particularly on the time available to give emotional support.

The bereavement office was short of staff. Staff described the only service they were able to offer as "just dishing out death certificates".

## Are end of life care services responsive to people's needs? (for example, to feedback?)

Requires improvement 

Patients referred to the specialist palliative care team were seen promptly according to their needs. However, not all patients were referred appropriately and the specialist palliative care nurses told us that shared care for patients at the end of their lives was more difficult in some areas, for example, in A&E and critical care. We spoke to three patients who had been moved three times during their inpatient stay, which had contributed to a lack of coordinated care. The trust had not monitored data on meeting patients' preference on where they wanted to die, to see if it had improved.

## Access

Patients requiring specialist palliative support were referred through one single point of access to reduce the risk of missed referrals. The team supported patients with a range of life-limiting illnesses including dementia. However, not all patients that required specialist palliative care support were being identified for referral by ward staff.

Patients referred to the specialist palliative care team were seen promptly according to need. The specialist palliative care team quarterly audit consistently demonstrated 100% compliance with response to referral times (within 48 hours of referral).

The specialist palliative care nurses told us there were some areas of the hospital where shared care for patients at the end of life was more difficult: for example, in A&E and critical care. This was developing and they gave examples of effective team work in these areas when making decisions about life-sustaining treatment.

Support for cancer patients was provided in the A&E department, but this support was not available for other patients in resuscitation because it was currently not part of their role.

The palliative care consultant was working with consultants from other specialties to determine ceilings (limits) of treatment for patients at the end of life.

# End of life care

The end of life register (details of patients at the end of life) was ready to roll out in April 2014. This would assist practitioners in providing timely support to those at the end of life.

We spoke to three patients at the end of life who had moved three times during their inpatient stay. This had contributed to a lack of coordinated and continuity in their care.

## Meeting people's individual needs

The chapel had resources to support members of multifaith groups to worship in keeping with their religion.

There was written information in different languages in the mortuary. These were not available in ward areas.

The trust had a rapid response service for discharge to a preferred place of care. This was a team approach facilitated by the discharge coordinator. However, recent data about preferred place of death was not available. The only data available was from 2010 and 60% of patients had expressed a preference to die elsewhere; the trust had not monitored this to see if this had improved.

The hospice had its own discharge coordinator. On discharge, a letter was sent to all other healthcare providers informing them of the patient's care requirements. Data on the timeliness of rapid discharges was not collected.

An electronic records system, shared with a regional cancer centre, provided staff with up-to-date information on patient chemotherapy treatment and progress.

## Complaints

Complaints about the specialist palliative care service were handled by the matron in line with trust policy. There were few complaints, and actions were reviewed at the monthly risk meeting. The minutes from the risk meeting in February 2014 showed a negative comment on a patient feedback survey form, and this was discussed at the staff meeting to ensure learning from the event.

Information was available in the hospital to inform patients and relatives about how to make a complaint.

The hospice staff engaged with recently bereaved families by writing to them within six weeks of the death of their relatives. They used this feedback to consistently improve their service.

## Are end of life care services well-led?

Requires improvement 

The matron of the specialist palliative care team was described by staff as a good leader. There was a trust strategy for adult palliative and end of life care. However, hospital staff we spoke with were not aware of its contents or how it had an impact on patient care and the strategy was not based on the latest guidance. The specialist palliative care team were passionate about the service they offered and they monitored and improved the quality and safety of the services that they offered. End of life care, however, was not monitored across the hospital in ward areas to ensure standards were being met. Patient health and wellbeing records were not reviewed regularly to ensure staff had accurate information with which to make informed decisions about patients' care.

## Vision and strategy for this service

There was a trust strategy for adult palliative and end of life care. However, hospital staff we spoke with were not aware of its contents of the strategy and how it had an impact on patient care.

The Adult Palliative and End of Life Care Strategy (2014) was based on the End of Life Care Strategy (Department of Health [DH], 2008) and did not reflect the strategy and progress made to achieve the Quality Standard for End of Life Care for Adults (NICE, 2011; updated 2013) Action plans regarding the progress made for each work stream identified in the trust strategy were not available.

## Governance, risk management and quality measurement

The specialist palliative care team held regular team governance meetings. Complaints, incidents, audits and quality improvement projects for the specialist palliative care service were regularly monitored and actions implemented for their service.

There was, however, no evidence of a trust-wide audit programme to assess compliance with the Quality Standard for End of life care for Adults' (NICE, 2011; updated 2013) and other national guidance.

## End of life care

Patient care on wards was not monitored to ensure patients were having their essential end of life care needs met by, for example, pain relief. Patient survey data was presented to specialist palliative care staff to make them aware of patient's experiences of care.

Patient health and wellbeing monitoring records was not reviewed regularly to ensure staff had accurate information with which to make informed decisions about patients' care.

The service risk register did not include risks identified, for example, the concerns about standards of care for patients receiving end of life care in ward areas.

### **Leadership of service**

The specialist palliative care lead clinician was represented on the medical division board.

The matron of the specialist palliative care team was described by staff as a good leader.

The trust had an initiative that promoted exemplar wards. An exemplar ward was one that was achieving very high standards of clinical care: for example, between 95% and

100% in various assessments, such as their hand hygiene practices, high levels of staff and patient satisfaction and achieving high standards of care. The Florence Nightingale Hospice was an exemplar ward within the trust.

### **Culture within the service**

Staff within the specialist palliative care service were passionate about the quality of end of life care provision and said they were well supported by the matron and team members.

Hospital staff described good, supportive working relationships with the specialist palliative care team.





There was a culture of sharing knowledge between specialist palliative care and other services through formal and informal teaching opportunities.

### **Innovation, improvement and sustainability**

A palliative care coordination system, which enabled service providers across care boundaries to share information about patients nearing the end of their life, was due to be rolled out in April 2014.



# Outpatients

Safe	Good 
Effective	Not sufficient evidence to rate
Caring	Good 
Responsive	Requires improvement 
Well-led	Requires improvement 

## Information about the service

Stoke Mandeville Hospital had outpatient clinics for medical, surgical and specialist services. There was a dedicated gynaecology outpatient area where minor procedures were performed such as colposcopy. An early pregnancy clinic was also held in this area. The general outpatient area catered for a variety of specialisms including plastics and orthopaedics. The Mandeville Wing was the main location for ophthalmology and ear, nose and throat (ENT) outpatients. Specialist services such as oncology held outpatient clinics in other areas of the hospital. Allied healthcare professionals, such as physiotherapists, also held outpatient clinics at this hospital. The trust had over 430,000 outpatient appointments in 2012/13.

We visited the general outpatient area, the gynaecology outpatients, the breast clinic and the physiotherapy department. We spoke with 13 patients and relatives and 23 staff, including nurses, healthcare assistants, assistant practitioners, a matron, medical staff, administrators and receptionists. We observed care and treatment, and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

Patients received compassionate care and were treated with dignity and respect. Patients told us that staff were kind and supportive, and they felt fully involved in making decisions about their care. Medicines and prescription pads were securely stored. The outpatient areas we visited were clean and equipment was well maintained.

However, many clinic appointments were cancelled at short notice. Clinics were busy and patients had to wait a long time. Patients and staff told us one of the biggest challenges was clinics running late. Outpatient clinics were over-booked; there was not enough time to see patients, so clinics often over-ran. Although there had been recent improvements, many staff, particularly in the general outpatient area, said they had not been listened to on key service changes and that outpatients had not been a priority for the trust.

# Outpatients

## Are outpatients services safe?

Good



Medicines and prescription pads were securely stored. The outpatient areas we visited were clean and equipment was well maintained. Staff vacancies were being managed appropriately and staff had appropriate mandatory training. Staff discussed the outcome of any incidents at ward meetings although lessons learnt were not shared across the trust.

### Incidents, reporting and learning

- There had been 21 patient safety incidents in the outpatient department reported to the National Reporting Learning System (NRLS) between December 2012 to January 2014. Most of these were of low or no harm but there were five serious incidents. These were investigated and action taken to prevent reoccurrence.
- All the staff were aware of their responsibility to report incidents and how this was to be done.
- Staff discussed the outcome of incidents at ward meetings. However, there was no evidence that incidents were analysed for trends or lessons learned shared across the trust.

### Cleanliness, infection control and hygiene

- All the outpatient areas we visited were found to be clean.
- Infection control practices were monitored through audits, and action planned and followed up when required.
- Staff followed the trust policy on infection control. Staff observed the hospital's 'bare arms below the elbow' policy. Personal protective clothing, such as gloves and aprons, were used by staff to deliver personal care.
- Infection prevention and control policies and procedures were available and accessible to staff on the hospital's intranet.
- In the general outpatient area, consulting rooms, where clinical work could be undertaken, were carpeted. The carpet had only been removed from five of the rooms. The paint on the walls in the consulting rooms was chipped and scuffed and the covers on some chairs were split. All these factors had the potential to increase the risk of infection.

### Environment and equipment

- The ophthalmology outpatient department was well maintained and well equipped.
- The environment in the general outpatient area was 'tired' with damage to the walls in the consulting rooms.
- Fixed, obsolete equipment remained in the consulting rooms in the general outpatient department because the fabric of the building was such that it was not possible to remove it safely.
- Extension leads and wires were fixed across consulting-room walls to ensure the power supply was accessible where needed. No attempt had been made to cover the wires up.
- Equipment in the department was regularly serviced, tested if electrical and appropriately cleaned.
- Resuscitation trolleys were located in or close to each outpatient area and regularly checked.

### Medicines management

- Medicines and prescription pads were securely stored and appropriately managed.
- There were systems to ensure medicines were in date.
- Staff told us that generally patient records were available for clinics in a timely manner. The trust however, did not monitor the percentage of patients' records that were available for patients attending clinics.

### Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

- Patients' consent to procedures was obtained appropriately. All the staff we spoke with were clear about their responsibilities to safeguard patients and to report any concerns, including to an external agency if required.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.
- Staff were required to complete safeguarding training. Training records confirmed that staff had completed the required training.
- Information on how to report safeguarding concerns was displayed in the outpatient areas we visited.

### Staffing

- There were 16 staff vacancies across the trust in the booking team, called the 'access team'. Staff worked flexibly to ensure cover was provided.

# Outpatients

- Sickness had placed a strain on the staff team in the general outpatient department. The team had continued to staff the unit through cross-site flexible working and the sister and matron working clinical shifts.
- In the general outpatient area, a document called 'staff mapping' was used to help staff in ensure there were enough staff to meet the needs of the clinics for that day.
- Staff told us they felt there was enough staff, although patients told us that on occasions staff appeared to be rushed.

## Mandatory training

- In all the areas we visited, staff told us they were supported to complete their mandatory training, which was mostly e-learning with some face-to-face sessions.
- Mandatory training was monitored for individual staff and other training was scheduled when required.

**Are outpatients services effective?**  
(for example, treatment is effective)  
**Not sufficient evidence to rate**

We report on effectiveness for outpatients below. However, we are not currently confident that overall CQC is able to collect enough evidence to give a rating for effectiveness in outpatients departments.

## Evidence-based care and treatment

National guidance was used to inform practice and in the review of policies and procedures. This was particularly evident in the ophthalmology department (for example, the pathway for the diagnosis and treatment of patients with glaucoma).

## Patient outcomes

The trust monitored the new patients to follow-up patient ratio for outpatient clinics. These figures could be benchmarked nationally and indicate whether patients were being effectively managed and if outpatient appointments were being used efficiently to reduce repeated attendances and longer waiting times. Most clinics were within expected targets with the exception of Dermatology, neurology, ENT and orthopaedic clinics.

The trust had recently introduced a service where, if appropriate, patients could be followed-up over the phone at home. This improved the timeliness of follow-up and capacity in the outpatient areas.

## Competent staff

Staff told us that they had annual appraisals. Records showed that appraisals had taken place or were scheduled and that staff were supported with their development needs.

A member of staff in the ophthalmology department was complimentary about the support they had been given to develop in their role, including completing further education.

## Multidisciplinary working

In the urology clinic, the medical staff were supported by a physiotherapist.

Specialist nurses supported medical staff in clinics (for example, dermatology and plastic surgery).

Ophthalmology clinics were always multidisciplinary with medical staff, nurses and optometrists working side by side. These clinics were also supported by volunteers.

Medical staff reported there was good access to radiology and pathology services.

## Equipment and facilities

The ophthalmology and ear, nose and throat (ENT) outpatients took place in the Mandeville Wing. There was a dedicated waiting area for children attending these clinics, as recommended in the Children's National Service Framework.

## Seven-day services

The outpatient service was a 5-day service and extra clinics were held during the week if necessary.

**Are outpatients services caring?**

Good 

Patients received compassionate care and were treated with dignity and respect. Patients told us that staff were kind and supportive, and they felt fully involved in making decisions about their care.

# Outpatients

## Compassionate care

- Patient consultations took place in private rooms and chaperones were available if required.
- Patients in the ophthalmology outpatient area were positive about the kindness shown to them by volunteers who had helped them learn how to put in their eye drops.
- Patients and their families told us that they had been treated with dignity and respect.
- We observed staff talking to patients respectfully while ensuring that they and their families were kept fully informed as to what was happening.

## Patient involvement in care

- Patients told us they had enough information, at a level they could understand, to ensure they were fully informed and involved in making decisions about their care.
- There was written information available for patients. Some of these leaflets had been produced by the trust and other items had been provided by external agencies such as the Royal College of Ophthalmologists.

## Emotional support

- Patients told us that staff had a patient, pleasant and supportive attitude, and there was good cultural awareness.
- We were told by patients that reception, nursing and physiotherapy staff were nice, efficient and helpful.

## Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires improvement 

Many clinic appointments were cancelled at short notice. Some patients told us they had waited up to six months to get the appointment they needed. Clinics were busy and patients had to wait a long time. Patients and staff told us one of the biggest challenges was clinics running late. Outpatient clinics were over-booked; there was not enough time to see patients, so clinics often over-ran. For some specialties, such as ophthalmology, patients told us they could wait for up to two hours. Written information was only available in English.

## Access to services

The number of new and follow up outpatient attendances were lower than national average.

The overall percentage of patients who did not attend (DNA) outpatient clinics at Stoke Mandeville Hospital in 2013 was 6.0%, which was slightly lower than the national average of 8.5%. Medical and administrative staff told us it was trust policy that patients were referred back to their GP if they did not attend an appointment twice. This was a consultant or senior medical staff decision.

Overall, the trust was meeting the national waiting time of two weeks for urgent cancer referrals and 95% patients waiting less than 18 weeks for routine appointments. The 18 week target was not met for oral surgery, ENT and orthopaedic clinics. Diagnostic waiting times were within expected limits.

Patients, however, had reduced flexibility when choosing an appointment and only 19% of outpatient appointment bookings were done by the electronic 'Choose and Book' system. Senior staff told us that this was a historical problem with GPs choosing not to use the system and this had also extended the time from referral to booking an appointment. New patients waiting times for appointments had increased from 4.2 weeks in July 2013 to 8.8 weeks in January 2014.

Patients and staff told us one of the biggest challenges for the outpatient department was clinics running late. Outpatient clinics were over-booked; there was not enough time to see patients, so clinics often over-ran. For some specialties, such as ophthalmology, patients told us they could wait for up to two hours. This was a planned arrangement because the letter sent to patients included a statement on this waiting time.

The number of appointments cancelled by the hospital was below the national average. Clinics, however, were being cancelled at short notice, mainly because consultant medical staff were not giving the requisite 6 weeks' notice for annual leave as required by the trust's policy.

The cancellation of clinics meant a patient could have an appointment cancelled by the hospital on more than one occasion. Some patients told us they had waited up to 6 months to get the appointment they needed.

# Outpatients

The trust had a new system to alert staff to any attempt to cancel clinics or appointments. This included the number of times a patient's appointment had been cancelled previously. The impact of this had not yet been established.

The access team was working with the operational team to try and reduce the number of cancelled outpatient clinics and thereby to increase their capacity

There was a one-stop ophthalmology and breast clinics. This enabled patients to attend for one appointment and to have both tests and consultation at the same time.

The ophthalmology clinic had good links with the community in that its consultants were running clinics at community hospitals across the county.

Letters were not being sent to the patient and their GP within one week of their outpatient clinic attendance. Some patients told us it could take over a month to receive a letter.

## Meeting people's individual needs

Access to the outpatient department was via a lift; once in the department, the area was open and accessible to patients with mobility needs.

One patient who was using a wheelchair told us that they had no problems with accessing the hospital and the department.

Written information was only available in English. This included information on the back of leaflets, which said they could be requested in other languages.

There was a system in place for alerting staff to any special needs a patient had, including the need for an interpreter, at the time of an appointment being booked. Request for interpreters at short notice could be arranged via a telephone.

## Complaints

Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.

In all the areas we visited information on how to make a complaint was displayed.

Patients told us that, if necessary, they would not hesitate to raise a concern.

## Are outpatients services well-led?

Requires improvement 

Although there had been recent improvements, many staff, particularly in the general outpatient area, said they had not been listened to on key service changes and that outpatients had not been a priority for the trust. Quality, risk and patients' experiences were not monitored consistently. There was no agreed vision or strategy for the general outpatients department.

### Leadership of this service

- Staff were positive about local leadership but identified longstanding problems with senior leadership and staff in some areas did not feel listened to.
- There were now new management arrangements. Staff were positive about this change because they felt more supported with their daily challenges and more informed about the service. The change had yet to make an impact in some areas.
- Staff reported that they did not see the trust-level leadership team; however, they did receive emails and regular newsletters.

### Culture within this service

- Staff in all outpatient areas we visited were clear that the patient's experience was important and they worked hard to ensure that this was positive.
- Services in the outpatient department had recently been restructured to improve capacity. Staff told us that they had been involved in the consultation but they had not been listened to during the change process. In the general outpatient area, staff told us they had struggled to maintain a good service following a recent service restructure.
- Staff told us the changes to the management within the general outpatient department and the access team were beginning to have a positive impact: some changes that had not been effective were being stopped and some systems, such as having a central team for patients to contact, were being reinstated.
- Staff worked well together as a team to coordinate patient care.

# Outpatients

- Staff told us that, in general, they felt supported in their role. Some staff felt unsupported and that they had not been listened to with regard to the pressures of running their department.

## Vision and strategy for this service

- Senior staff we spoke with were informed about the issues with in the general outpatient department, which included concerns about capacity and cancellation. However, there was no agreed vision or strategy for the outpatients department and services.
- The ophthalmology department had a clear strategy to develop sustainable services that were accessible to all across the county.

## Governance, risk management and quality measurement






- There were monthly governance meetings within each specialty and staff were encouraged to attend. Complaints, incidents, audits and quality improvement projects were discussed.
- There was no governance meeting in the general outpatient department.
- Matron rounds were conducted to monitor the quality of the service. We viewed the results for the general outpatient department for the past 12 weeks. On four occasions, the matron round had not taken place because the Matron was working clinically; for the other occasions, the results had been 98% and above.

- There was no risk register for the general outpatient department. There was one entry on the corporate risk register for outpatients and this related to an inadequate booking system. The new general manager and clinical lead had started to explore ways to address this identified risk.
- The risk register for the dermatology department contained one item that related to issues with the telephone system. There were no entries relating to staffing levels or changes in the service provided.
- The outpatient services did not have examples of consultation and did not obtain feedback from patients. A questionnaire was being implemented to obtain patients feedback. The physiotherapy department was undertaking a patient survey to capture patients opinions in a review of appointment times.

## Innovation, improvement and sustainability

- The outpatient services were increasing their capacity and efficiency by reducing the number of follow-up face-to-face consultations and introducing telephone and email follow-ups instead. Seven specialties, including urology and respiratory medicine, were using telephone calls for some of their follow-ups and the pain clinic had started to use emails. The impact of this new process on patient experience, as well as the efficiency of the department, had yet to be determined.

# National Spinal Injuries Centre (NSIC)

Safe	Good 
Effective	Outstanding 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 

## Information about the service

Buckinghamshire Healthcare NHS Trust provided a national service for acute and rehabilitation care for patients with spinal cord injury. It offered diagnosis, treatment and rehabilitation for patients with acute spinal cord injuries and non-traumatic spinal cord lesions that sometimes occur in patients. Patients were referred from all over the UK and from many countries around the world. There were four wards St Andrews and St Francis for acute and paediatric spinal injury respectively, and St George, St David and St Joseph for spinal rehabilitation.

We visited the acute and rehabilitation wards in the hospital. We talked with 30 patients, four relatives visiting the unit and 20 staff. These included nursing staff, junior and senior doctors, and managers. We observed care and treatment and looked at 10 care records. Before the inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

The NSIC is a national centre for spinal injuries and develops guidelines for other units in the UK to follow. It has been internationally accredited. Staff built up trusting relationships with patients and their relatives through their interactions. Patients and relatives told us that they received considerable support. There was a sense of belonging for them. Care plans for patients with spinal injury identified goals set by the patients and these were monitored by them in partnership with the staff. There was support for current patients from former patients of the unit.

Staff within the Centre spoke positively about the service they provided for patients. There was enthusiasm and energy for providing a high quality of care for patients with spinal injury. The drive to recruit more nurses and healthcare assistants was seen as an example of positively and making a difference to the culture within the service.

# National Spinal Injuries Centre (NSIC)

## Are National Spinal Injuries Centre services safe?

Good 

The services provided by the NSIC were safe. NHS Safety Thermometer information was displayed at the entrance to each ward. This included information on infections, new pressure ulcers, new urinary tract infections (UTIs) and new blood clots. Ward areas were clean and cleaning schedules were clearly displayed on the wards. Equipment was appropriately checked and cleaned regularly. Care plans that identified what care was to be provided to a patient during their stay were kept in the patient's notes. There was a very clear understanding about how to recognise and manage a patient whose condition was deteriorating. Nurses and doctors both identified the actions they would take to ensure the safety of patients.

### Incidents, reporting and learning

There have been no "Never Events" (incidents that should never occur) in the National Spinal Injuries Centre (NSIC) between December 2012 and January 2014.

All staff we spoke to said that they were encouraged to report incidents. Incidents reported were discussed at monthly team meetings and weekly multidisciplinary team meetings.

### Safety Thermometer

NHS Safety Thermometer information was displayed at the entrance to each ward. This included information on infections, new pressure ulcers, new urinary tract infections (UTIs) and new blood clots. The trust was performing within expected ranges for these measures except for UTIs. Patients with spinal injury were more likely to get a UTI. Staff we spoke with told us they provided specific assistance to patients to prevent UTIs.

### Cleanliness, infection control and hygiene

Ward areas were clean and cleaning schedules were clearly displayed on the wards.

Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to and

staff regularly washed their hands and used hand gel between patients. We observed nursing staff reminding doctors and relatives to use hand gel when entering and leaving the ward.

Meticillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile rates trust were within an acceptable range.

### Environment and equipment

The environment on the NSIC was safe. We found there was space to manoeuvre, which was important for patients with spinal injury who require considerable space.

Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards to ensure safe care.

Specialist equipment that might be needed was readily available.

### Medicines

Controlled drugs were safely stored. The treatment room had a combination lock to ensure medications were stored securely.

Medicines were stored correctly, including in locked cupboards or refrigerators when necessary. On St Andrews Ward, we found refrigerator records incomplete. When the records showed that a refrigerator was warm, no action was taken by ward staff to rectify this.

Medical gas cylinders were stored in a cylinder store area and not in a trolley or chained to a wall in line with national guidance.

### Records

Care plans that identified what care was to be provided to a patient during their stay were kept in the patient's notes. Patient notes were available when required.

Nursing records were filed within the patient notes. Regular checks on nursing documentation were undertaken to ensure that information was recorded.

Nursing documentation was kept at the end of a patient's bed and completed appropriately. It included for example, assessments of nutrition, falls and hydration. There were both paper and electronic records. We



# National Spinal Injuries Centre (NSIC)

checked the records of four patients and found that records of only three were completed on the paper system while records on the electronic system were completed in a timely manner.

## Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

Patients were asked for their consent to procedures appropriately and correctly. When patients did not have the capacity to give their consent personally, staff gave us examples of how the Mental Capacity Act 2005 was adhered to appropriately.

## Nursing staffing

In January 2014, nursing numbers were assessed using the national Safer Nursing Care Tool. Required and actual staffing numbers were displayed on every ward. Staff reported that they were understaffed and that vacancies were filled with agency staff.

Agency staff did not always have the skills to help with the personal care of patients with spinal injury, so the centre had to allocate other nursing duties to agency staff to maintain safe care.

Ward managers were in place on some wards. There was an ongoing recruitment process to recruit managers for other wards.

The unit was sometimes used to provide care for medical patients when the medical wards were full. This meant that medical patients were cared for alongside patients with spinal injuries. A result of this was to stretch the resources of highly trained nurses treating patients with spinal injury because they were caring for other more seriously ill medical patients. They also did not have up-to-date skills for all medical conditions.

## Medical staffing

Consultants were on call for a 24-hour period. The rota for doctor cover had recently changed and this had improved access to medical cover.

Junior doctors told us there were adequate numbers of doctors on the wards out of hours and that consultants were contactable by phone if they needed any support. They told us that they liked coming to work at this unit because of the experience and knowledge they gained from their rotation.

## Assessing and responding to patient risks

There was a very clear understanding about how to recognise and manage a patient whose condition was deteriorating. Nurses and doctors both identified the actions they would take to ensure the safety of patients. There was a protocol in place and nurses knew what they would do in such situations.

There was access to medical staff who covered the hospital at night for patients whose condition deteriorated at night.

Nursing handovers occurred three times a day. Staffing for the shift was discussed as well as any high-risk patients or potential issues. The care of acutely ill patients with other medical conditions on the ward was also discussed at these meetings. Nurses told us that these meetings were very structured.

Medical handover took the form of an informal handover. Junior doctors told us that the handover covered care of patients based on the severity of their condition. The handover for patients with spinal injury was detailed and comprehensive. The handover for acutely ill patients with other medical conditions was not part of this handover.

## Mandatory training

Matrons on the wards ensured that all members of staff completed their mandatory training. This was also followed-up in monthly supervisions and six-monthly appraisals.

Staff told us they were up to date in their training. Mandatory training records confirmed that 72% of staff had had training.

## Are National Spinal Injuries Centre services effective?

(for example, treatment is effective)

Outstanding 

As a national centre for spinal injuries, the centre has developed guidelines for other units in the UK to follow. The centre has been accredited by the international Commission on Accreditation of Rehabilitation Facilities (CARF). The centre had a performance dashboard that was used to monitor the quality of care provided, and there were regular audits undertaken on the quality of

# National Spinal Injuries Centre (NSIC)

care. Care plans for patients with spinal injury identified goals set by the patients and these were monitored by them in partnership with the staff. There was support for current patients from former patients of the unit. The centre published a regular newsletter for patients and their families. The newsletter provided an overview of the achievement of various patients who had received treatment at the centre.

## Evidence-based care and treatment

As a national centre for spinal injuries, the centre has developed guidelines for other units in the UK to follow. There were many guidelines in place for the treatment of patients with spinal injuries including, for example, bowel management following spinal cord injury.

The centre was developing national service standards for adult patients with spinal cord injury and was presently working on standards for paediatric patients with spinal cord injury.

## Patient outcomes

The centre was accredited by the international Commission on Accreditation of Rehabilitation Facilities (CARF). The accreditation was valid for three years and allowed experts in the field of rehabilitation to judge the quality of the service. The centre received its first accreditation in 2008 and had since been re-accredited in 2011. The next CARF visit was planned for late 2014.

Quality improvement plans that the NSIC had submitted for re-accreditation detailed the outcomes that were being monitored, including the various protocols for the treatment and rehabilitation of people with spinal injuries.

The centre had a performance dashboard that was used to monitor the quality of care provided.

There were regular audits undertaken on the quality of care. The results of these audits were shared with staff at regular multidisciplinary meetings.

## Pain relief

Nursing staff had had training to assess patients' pain.

Patients told us they were provided with pain relief when required. There were protocols in place for the safe use of pain relief medication.

## Multidisciplinary working

There was multidisciplinary team working on the unit that included regular input from physiotherapy, psychology, school support and occupational therapy.

Daily rounds were undertaken five days a week on all wards depending on the severity of a patient's condition. The ward rounds were multidisciplinary.

Multidisciplinary meetings were held weekly and these focused on the care of the different patients on the ward.

Access to medical advice at night came from the hospital at-night team. Both doctors and nurses told us the team was very responsive.

There was support available for patients with other medical conditions such as diabetes and specialist nurses would treat patients accordingly.

## Equipment and facilities

There was appropriate equipment to ensure effective care could be delivered.

The unit had a state of the art rehabilitation and spinal gym.

Patients had access to specific kitchen facilities designed for patients with a spinal injury, and this helped them learn how to be independent.

## Seven-day services

Medical cover at the weekend was provided by on-call consultants for patients with spinal injuries.

Physiotherapists were on duty at the weekends.

The children's spinal rehabilitation unit (St Francis ward) was currently open Monday to Friday. Children who remained on the ward were transferred to the paediatric department at the weekend. There were plans for the unit to remain open at weekends.

Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend. Medical resonance imaging (MRI) scans were done out of hours for spinal injuries.

The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications

# National Spinal Injuries Centre (NSIC)

## Are National Spinal Injuries Centre services caring?

Outstanding 

Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. Staff built up trusting relationships with patients and their relatives through their interactions. Patients and relatives told us that they received considerable support. There was a sense of belonging for them. We spoke with children using the service and their parents and found that they received a high level of support. Volunteers who had previously been patients at the unit shared examples of support given to patients with spinal injury. One volunteer told us that compassionate care was part of the recovery process and staff knew how to support patients in their journey to recovery.

### Compassionate care

Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. Most patients and carers we spoke with told us that staff were caring and supportive.

The NHS Friends and Family Test showed a high level of satisfaction and all ward areas were above the national average. We spoke with children using the service and their parents and found that they received a high level of support. One parent told us, "The unit was my second home and staff here are like my family."

Comments and cards from family members provided us with further examples of compassionate care.

We spoke to volunteers who had previously been patients at the unit. They shared examples of support given to patients with spinal injury. One volunteer told us that compassionate care was part of the recovery process and staff knew how to support patients in their journey to recovery.

We observed a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity.

### Patient understanding and involvement

Patients and relatives we spoke to said they felt involved in their care. They had opportunities to speak with the consultant looking after them about their treatment goals.

Nursing staff told us that goal setting was an important part of the recovery process for patients with spinal injury, and that the philosophy and strategy adopted by the centre was effective. This enabled patients to be decision makers and completely involved in their care.

Care plans for patients with spinal injury identified goals set by the patients and these were monitored by them in partnership with the staff.

The centre published a regular newsletter for patients and their families. The newsletter provided an overview of the achievement of various patients who had received treatment at the centre. It also highlighted the developments taking place at the centre, including renovation of different wards and the various research projects being undertaken.

### Emotional support

Staff built up trusting relationships with patients and their relatives through their interactions. Patients and relatives told us that they received considerable support. There was a sense of belonging for them, and they did not feel all alone.

Patients and relatives were given further emotional support because the centre regularly brought in previous patients with similar injuries. These volunteers gave both patients and relatives encouragement.

Members of staff worked with volunteers in helping patients on their journey to recovery.

Relatives told us that there were regular meetings with staff to update them on their relative's progress. Patients were also involved in these meetings.

# National Spinal Injuries Centre (NSIC)

## Are National Spinal Injuries Centre services responsive to people's needs? (for example, to feedback?)

Good 

The services provided by the NSIC were responsive to people's needs. There was support available for patients with spinal injury who had other medical conditions such as diabetes. The discharge planning process was part of the goal setting undertaken with the patient. It began as soon as the patient was admitted to the ward. One negative note was that a significant number of patients raised concerns about the quality of the food available to them. Patients told us it was tasteless. Staff were aware of these concerns but told us the trust had yet to act on them.

### Access to services

Access to the National Spinal Injuries Centre (NSIC) was by referral from other hospitals.

Any medical patients who remained on the NSIC because there were no beds available on the medical wards were placed under the care of the medical team. Nurses told us they ensured that the medical team saw those patients daily (Monday to Friday). They were not seen at weekends by a doctor unless there was deterioration in their health.

### Meeting people's individual needs

There was support available for patients with spinal injury who had other medical conditions such as diabetes.

A significant number of patients raised concerns about the quality of the food. Patients told us it was tasteless. Relatives told us that they sometimes had to go to the local convenience store on site to buy food. Staff were also aware of these concerns but told us the trust had yet to act on them.

The discharge planning process was part of the goal setting undertaken with the patient. It began as soon as the patient was admitted to the ward.

A comprehensive discharge letter that included information from all relevant healthcare professionals (psychologist, consultant, physiotherapist, occupational therapist and others) was sent together in one

communication to the patient's GP or referring organisation. This had been introduced recently to improve the communication between the hospital, the GP and/or the referring organisation.

### Complaints

Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.

There was information displayed throughout the centre on how to complain.

We spoke with patients and relatives and they knew how to raise concerns, make complaints and provide comments.

There were no outstanding complaints for the centre.

## Are National Spinal Injuries Centre services well-led?

Good 

There was a new senior management team in place. Staff within the Centre spoke positively about the service they provided for patients. There was a renewed sense of enthusiasm and energy for providing a high quality of care for patients with spinal injury. The drive to recruit more nurses and healthcare assistants was seen as an example of positively making a difference to the culture within the service. Staff we spoke with worked well together. Patients and relatives told us that the culture in the service was positive. The trust vision, "Safe and compassionate care every time" was visible throughout the wards and corridors, and staff were aware of this vision. The NSIC had a strategy for developing the service and continuing its national lead status.

### Vision and strategy for this service

The trust vision, "Safe and compassionate care every time" was visible throughout the wards and corridors, and staff were aware of this vision.

# National Spinal Injuries Centre (NSIC)

The NSIC had a strategy for developing the service and continuing its national lead status. Workforce planning, however, was not evident. One consultant was about to retire and there were plans in place about how the centre would continue until a new consultant was appointed.

## Governance, risk management and quality measurement

The centre held monthly meetings where quality issues such as complaints, incidents and audits were discussed and actions agreed.

There was a quality dashboard that identified the different measures of quality and the performance of the different departments within the NSIC. Members of staff told us that these were discussed at team meetings.

## Leadership of service

Each ward had a manager or acting ward manager who provided day-to-day leadership to members of staff on the ward. There was a recruitment drive in place to recruit two new permanent ward managers. There was an overall acting matron responsible for the National Spinal Injuries Centre (NSIC). Members of staff told us they were visible and approachable.

All ward managers attended a clinical leadership and management programme.

There was a new senior management team in place.

## Culture within the service

Staff within the Centre spoke positively about the service they provided for patients. There was a renewed sense of enthusiasm and energy for providing a high quality of

care for patients with spinal injury. The drive to recruit more nurses and healthcare assistants was seen as an example of positively making a difference to the culture within the service.

Staff we spoke with worked well together. Patients and relatives told us that the culture in the service was positive.

The trust leadership team identified the service as a “culture within a culture” and there was some dissonance between the NSIC and trust leadership. Staff in the NSIC reported feeling stressed by demands on the service because of pressure on hospital beds in the trust.

## Innovation, improvement and sustainability

As a national centre, there was a culture of undertaking research to improve the care provided to patients with spinal injury. The unit was involved in developing new technologies such as an exoskeleton to help spinal injury patients to walk.

The NSIC research had developed a new treatment of a commercial probiotic drink that significantly reduced the incidence of antibiotic-associated diarrhoea in spinal injury patients.

Staff were encouraged to present scientific posters of their work at local conferences.

Staff were involved in Schwartz rounds and these were effective in providing emotional support to staff and help staff to learn about the care they provide.

The NSIC had already prepared to reapply for external accreditation in 2014.