Buckinghamshire Healthcare NHS Trust

Stoke Mandeville Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Stoke Mandeville Hospital is part of Buckinghamshire Healthcare NHS Trust and provides a wide range of services to Buckinghamshire and surrounding areas including 24 hour accident and emergency, maternity, cancer care and outpatient services. Services also include the regional burns and plastics units, the specialist spinal unit and is the base for eye care for the area.

Stoke Mandeville, treats over 48,000 inpatients and 219,000 outpatients a year and has 479 beds

We carried out a focused unannounced inspection visit on 6 September 2016. We inspected the medical, surgical and end of life care services provided at this location. During the inspection, we also followed up issues identified at the inspection in February 2014 and March 2015 relevant to the service types inspected.

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

Our key findings were as follows:

Are services safe?

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

- Staff felt confident and able to report incidents. The trust recognised the importance of learning from incidents to improve the care provided to patients. However, staff could not always describe where learning from incidents had changed clinical practice. Staff demonstrated a good understanding of duty of candour and gave examples where they had used this to support patients.
- Staff did not always follow the trust's medicine management policies and procedures.For example for controlled drugs orders and monitoring medicine fridge temperatures. Staffing shortages in the pharmacy department resulted in reduced support to departments and we found evidence of some unsafe practices, including out-of-date medicines.
- In general, all clinical areas were visibly clean. There was some variability in infection control standards. The mortuary trolley was found to be dirty with no agreed cleaning schedule in place and deceased clothing was not appropriately stored while awaiting collection.On ward 8 we found some items of equipment had a layer of dust. Theatre staff did not always collect a new set of scrubs to change into when returning to the operating department from another area in the hospital, in line with the trust's uniform policy and as good infection control practice. In most areas equipment was labelled to indicate it had been cleaned and was ready for use.
- Systems were in place to enable staff to assess and respond safely to deterioration in patients' health. The trust used an electronic warning system to prompt staff to take the necessary action to help prevent further deterioration in patients' health. Staff completed relevant risk assessments for patients and shared information about patients' care and treatment needs at handover meetings.
- In the operating departments, the anaesthetic logbooks were not complete, to provide assurance staff had completed the daily safety checks and equipment was fit for purpose, prior to patients having surgery. On some of the wards, staff had not completed the daily checks on the resuscitation equipment in line with the trust policy, to ensure it was ready for use in an emergency.

Summary of findings

- Overall, staffing levels met the planned levels staffing. The trust achieved this using bank and agency staff for some shifts. Managers followed the trust escalation procedures when they identified staffing shortages for their department. In some areas this meant staff on occasions were under pressure to meet patients' needs particularly when patients were assessed with high needs and required one to one care.
- Staff completion ofstatutory and mandatory training was variable and not in line with the trust's target in some areas, this included safeguarding children and vulnerable adults level 2, duty of candour, infection control, medicines management, basic life support and tissue viability.
- Patient's safety and daily staffing information was prominently displayed for patients, staff and visitors to read, as part of the trust's open and honest approach.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.However, not all staff were up-to-date with their level 2 safeguarding children and vulnerable adults training.
- There was variability in the standard of record keeping.In some areas they were clearly written, and generally well organised. They included information about patients' medical history and social situation, as well risk assessments, care plans and observations. They also included entries from different disciplines.This was not consistent and we also found records that had not been fully completed. This included no care plan or goals or documentation of how the patient had been involved in this and no record of discharge planning. Some DNACPR forms we inspected were not completed according to national guidelines.

Are services effective?

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

- Staff planned and delivered people's care and treatment in line with current evidence based guidance, standards and best practice across the medical and surgical services. While there was some evidence of evidence-based care for end of life care this was not constantly applied across the hospital. For example the trust did not have a protocol for withdrawal of treatment, which was not in line with national guidance
- The hospital participated in national and regional audits and undertook a local audit programme. For the surgical services results from these audits showed patient outcomes were in keeping with the national average. The results of a number of national audits showed medical services performed worse than the national average. For example, the results of the myocardial ischaemia national audit project (MINAP) national audit 2013/14, National Institute for Cardiovascular Outcomes Research (NICOR) heart failure audit and National Diabetes Inpatient Audit (NaDIA) and national inpatient falls audit showed performance worse than the England average.
- Staff assessed and managed patient's pain appropriately and had access to the acute pain service for advice and support. However, for patients receiving end of life care staff did not use a standardised pain assessment tool to ensure staff delivered a consistent approach to pain measurement or management.
- Patients told us they had made an informed decision to give consent for surgery. The most recent informed consent audit showed medical staff were not completing all consent forms and patient care records to the expected trust and national standards.
- There was some variability in staff awareness of their responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLs). Patient's capacity was not always formally assessed and decisions were made on behalf of patients who were deemed to lack capacity.
- Multi-disciplinary working was embedded across all the wards. Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs.

Summary of findings

- The hospital had systems in place to ensure they provided care for inpatients seven days a week. This included access to on-call theatre and diagnostic imaging staff in an emergency and consultants carried out ward rounds seven days a week. The hospital performed above the national and regional average for most standards set out in the NHS services, seven days a week guidance.
- Staff had good access to training and professional development. The specialist palliative and end of life care staff were skilled and competent to perform their roles effectively. End of life care was not included in the hospital's core training package for all staff which was not in line with national guidance. The trust did not provide standardised or formal training in end of life care for porter or mortuary staff.

Are services caring?

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

- In all areas, patients and relatives were positive about the caring attitude of staff, their kindness and their compassion. All patients we spoke with would recommend the service to their friends and family.This was supported by data collected for the Friends and Family Test.
- Staff took time to ensure patients and their relatives understood their care and treatment. Patients told us they felt involved in their care and understood their treatment plans. Medical and nursing staff showed sensitivity when communicating with patients and relatives.
- Staff we spoke with valued and respected the needs of patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered.

Are services responsive?

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

- The trust worked in partnership with local commissioners to plan and deliver services, to meet the needs of local people. This recognised the local geography, population and neighbouring services.
- There were services to improve the access and flow of patients through the hospital, to promote shorter lengths of stay. The trust is an integrated trust which provides acute and community services. This facilitated the development of improved pathways of care, for example the respiratory pathway and the creation of the division of integrated elderly and community care.
- Patients had timely access to emergency treatment and the trust was taking action to minimise the waiting time for elective surgery.
- Staff took account of the needs of different people, including those with complex needs, when planning and delivering services. Staff showed good understanding and made reasonable adjustments to meet patients' individual needs. However, patient assessments, measuring the suitability of the environment for people with dementia and people with a learning disability, were consistently low scoring. There were adequate facilities to meet individual's spiritual and cultural needs.
- Ward staff and the discharge team started to consider and plan patient discharges from the date of admission. The trust worked with partners to improve the coordination of patient discharges and transfers to remove barriers to delays where possible. Trust data showed a significantly higher percentage (44.2%) of patients waiting for a residential home placement, contributed to the delayed transfers of care, compared with the national average of 10.2%.
- In the surgical division, there was a significant backlog of patients requiring pre-operative assessment. The division had not achieved 90% of patients being seen and admitted within 18 weeks of referral.

Summary of findings

- The trust operated a rapid discharge home to die pathway which served to discharge a dying patient who expressed wanting to die at home within 24 hours. However, there were some external delays with funding and care packages for patients with complex needs and patients who expressed a wish to die at home, did not always get to do so.
- Complaints were investigated thoroughly to improve the quality of care.

Are services well led?

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

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

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must ensure:

- Pharmacy staffing is provided to planned levels so that medicines management is safe and clinical pharmacy support is available to departments.
- Staff comply with all aspects of the trust's medicine management policy and associated standard operating procedures.
- The management of controlled drugs is improved and staff comply with the misuse of drugs regulations.
- All medicines are stored within the manufacturer's recommended temperature ranges and that records are maintained to demonstrate that medicines are safe for administration to patients.
- Daily checks of the anaesthetic machines and resuscitation equipment are completed and documented to confirm the equipment is safe for use.

Summary of findings

- All patients thought to lack capacity to make decisions about their care and treatments have a formal assessment of their capacity.
- There is a clear process in placewith clear accountability for the cleaning of the mortuary trolley.
- Suitable sealed storage is in place for deceased patients' belongings in the bereavement office.
- The new end of life care plans "Getting it right for me" and the associated "Getting it right for me patient held record" are used by clinical staff for all end of life care patients in the trust.
- Patients who are subject to deprivation of liberty have current and valid authorisation documentation in place.
- The end of life care strategy is completed and published and all clinical staff are aware of this strategy.
- The use a standardised pain assessment tool across the hospital to ensure end of life patients have their pain accurately assessed and responded to.
- A protocol for withdrawing treatment as recommended in the 2015 National Institute of Clinical Excellence guidelines is in place and clinical staff are trained in its use.

In addition, the trust should also ensure

- The pharmacy service does not supply out of date British National Formularies.
- Audits completed by the pharmacy service are used to drive improvements and progress should be demonstrated over time.
- All staff working in theatres comply with the trust's uniform policy, in particular changing their scrubs, if they leave and then return to theatre.
- The standard of record keeping is monitored through regular audits and action taken for areas of non- compliance.
- All staff understand the Mental Capacity Act (2005) and are confident to apply this in the clinical setting to safeguard patients.
- Compliance with the trust informed consent audit shows continued improvement, with further action taken to address areas of non-compliance.
- Minutes are recorded for all meetings held within the division of surgery and critical care, with an action log included to provide assurance that concerns are being addressed.
- Medical records are maintained securely on care of the elderly wards.
- Staffing levels are as planned to meet all patients' needs.
- Staff on ward 8 comply with infection control procedures to reduce the risk of infection.
- The high proportion of delayed transfers of care attributed to patients waiting for a residential home placement is reduced.
- Advanced care plans are fully documented in order to comply with patient's wishes.
- Porters, cleaners and mortuary staff receive standardised formal end of life care training.
- The views of bereaved relatives is obtained to make care change to improve to the service
- All staff are aware of the up to date list of telephone numbers for calling different faith ministers to visit the hospital out of hours.

Summary of findings

- Information leaflets regarding advance care planning, what happens when someone dies and how to register a death are printed and distributed in all the clinical departments, with a named lead responsible for ensuring they are accessible for patients and families and are up to date.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Requires improvement 	Overall, we rated medical care as 'requires improvement' because: We found the pharmacy service was not able to provide an effective service, particularly on the elderly care wards. There were vacancies in the pharmacy department, which impacted on the performance of the service. There were delays in patients receiving discharge medicines, medicines reconciliation targets were not met and pharmacists were not always part of the multidisciplinary team. Ward staff were responsible for ensuring medicines were handled in accordance with the trust medicines management policies. However, we found expired medicines on the ward and staff did not consistently record fridge temperatures We found staff did not always maintain medical records securely. During our visit we saw both paper and electronic records were left unattended and accessible to unauthorised people. Although staffing levels had improved since the previous inspection, we found the elderly care wards were not always staffed to the optimum staffing levels. This meantstaff were under pressure to meet patients' needs, particularly when patients were assessed with high needs and required one to one care. The system to ensure patients with a deprivation of liberty safeguard (DoLS) authorisation was in place and up to date was not effective. The trust had been in discussion with the local authority to improve the process and was monitoring the situation. We observed some poor compliance with infection control procedures. For example, on ward 8 we found equipment had a layer of dust, the linen store door was open and staff told us patients often wandered in to the room, which posed an infection control risk. We also witnessed an incident where a member of staff had displayed poor infection control practice. The results of a number of national audits showed medical services performed worse than the national average.

Summary of findings

Patients and relatives were positive about the care they received. They told us staff were caring and treated them with respect. They felt involved in their care and recommended the hospital to others based on their own experiences.

Staff demonstrated an understanding of how to care for vulnerable patients including those with a learning disability or with dementia. Staff were supported by specialist teams in the trust to meet patients' needs. They used tools to assess patients' mental capacity and understood the procedures to follow if patients were at risk of a deprivation of liberty if they were restricted or restrained.

New staff underwent an induction process before there were assessed as competent to work on their own. Junior doctors were satisfied with their training opportunities and support available. Staff said they had effective access to professional development and in August 2016 90% of staff in the division of elderly care were up to date with mandatory training and 82% in integrated medicine. The annual appraisal uptake was 89% for integrated elderly care and for integrated medicine was 90% against a trust target of 90%. Staff said their managers provided good support and senior staff were approachable and accessible.

There was high level of bed occupancy trust wide. The service closely monitored bed capacity and had plans in place to manage demand if needed.

There was a culture of collaborative working and staff said they worked well together in multidisciplinary teams to coordinate patient care. We observed effective multidisciplinary meetings between staff, which showed they considered patient's individual risks and needs.

Patient records were clearly completed and documented patient's risk assessments and management plans.

The divisional leads had an agreed vision and strategy for services and a clinical governance framework. They had recognised the need to improve their management of risks, and had started to use a new approach to monitoring service risks.

Staff reported incidents, and understood how to use

the incident reporting system. Staff carried out root cause analysis to investigate incidents and learn from them. The service had a high proportion of harm-free care.
The services took part in national and local audits to check they provided care and treatment in line with good practice guidance. They developed action plans and worked with other health and social care providers to improve care pathways. For example, for patient suffering falls.
Wards were visibly clean and the infection control team carried out regular audits to identify any areas for improvement.

Surgery **Requires improvement**

We rated this service as requires improvement because:
The pharmacy service did not have planned staffing levels and could not deliver an effective service, including to surgical patients.The service did prioritise patients with the greatest need but some key performance indicators were not achieved.
Staff on the wards did not always dispose of out of date medicines promptly. They did not always follow the trust's controlled drugs policy when documenting receipt of controlled drugs. We found medicines that had not been stored at the correct temperature and gaps in temperature log books.
We found incomplete records for the anaesthetic machine logbooks in the operating departments and for the resuscitation equipment on the wards. It was not clear if staff completed the daily safety checks and the equipment was safe to use .
Theatre staff did not always comply with the trust's uniform policy to minimise the risk of infection.
Staff did not have a good understanding of the principles of Mental Capacity Act and associated Deprivation of Liberty Safeguards and their responsibilities in relation to these areas, to support people whose circumstances made them vulnerable and who could not always give consent.
Patients' record keeping was not to a consistent standard. Although patients told us they made informed decisions about their surgery, medical staff did not always document the conversation fully.
The division had not achieved the 18-week referral to treatment time indicator for 90% of patients admitted for an operation over the last five months.

Summary of findings

Three trust policies and standard operating procedures were out of date for review. .
Not all departmental and managers' meetings had minutes recorded. Therefore, the formal and permanent record of decisions that teams reached and actions staff agreed to take were missing.
The surgery service had enough staff with the right training and experience to keep patients safe. Although they used agency staff, they tried to make sure they used staff who were familiar with the service and its procedures. When wards needed more staff, the hospital followed the escalation policy and procedures to manage busy times.
Staff knew the process for reporting incidents. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
Areas we visited were visibly clean and tidy, we saw most staff following good infection prevention and control practices.
There was good multidisciplinary working across teams at the hospital so patients received co-ordinated care and treatment. Staff planned and delivered patients' care and treatment using evidence based guidance and audited compliance with National Institute Health and Care excellence (NICE) guidelines.
Nursing staff completed risk assessments for patients. If a patient became unwell, there were systems for staff to escalate these concerns and refer them to another hospital if necessary. The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
We saw staff care and treat patients with compassion. They were kind and treated them with dignity, and respect. There were systems to support patients with additional or complex needs. Patients felt informed and involved in their care. They said they would recommend the service to others.
Staff followed the governance processes to monitor the quality and risks of the surgical service. They completed audits and monitored patient outcomes, making changes to practice when necessary.
Outcomes for patients were similar to the England

average compared to data from national audits such as the bowel cancer audit. The divisional leads used the monthly quality reports and dashboards to support this.
Feedback from patients and staff had been used to develop and improve the service. The divisional leads and executive team considered the sustainability of the service and had a strategy in place to support this.
Staff told us the leadership across the service was good and the senior team were visible and accessible. Staff had an annual appraisal and could access additional training to develop in their role.

End of life care — **Requires improvement** 

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

Summary of findings

examples of staff providing care that maintained respect and dignity for individuals. There was good care for the relatives of dying patients, and staff showed sensitivity to their needs.
The trust had on going engagement with a people panel to ask for opinions and suggestions in what mattered to them regarding developing plans for end of life care. The panel were consulted regarding the trust wide end of life patient care plans called "Getting it right for me" We saw that the care plans were not consistently used for end of life care patients during the inspection. The trust wereaware of the concern and had appointed an end of life care facilitator to improve end of life care education for clinical staff and to ensure the care plans wereused correctly.
Patients' needs were mostly met through the way end of life care was organised and delivered. However, a rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way due to external delays with funding and care packages for complex needs
The people panel were consulted on the trust wide end of life care strategy, which was complete but not published at time of inspection. Staff we spoke with was aware of end of life care priorities and described high quality patient care as the key component of the trust's vision.

Stoke Mandeville Hospital

Detailed findings

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

Detailed findings

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Background to Stoke Mandeville Hospital

Stoke Mandeville Hospital is part of Buckinghamshire Healthcare NHS Trust and provides a wide range of services to Buckinghamshire and surrounding areas including 24 hour accident and emergency, maternity, cancer care and outpatient services. Services also include the regional burns and plastics units, the specialist spinal unit and the base for eye care for the area.

Stoke Mandeville, treats over 48,000 inpatients and 219,000 outpatients a year and has 479 beds

We carried out a focused unannounced inspection visit on 6 September 2016. We inspected the medical, surgical and end of life care services provided at this location. During the inspection, we also followed up issues identified at the inspection in February 2014 and March 2015 relevant to the service types inspected.

Our inspection team

Our inspection team was led by:

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

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out a focused unannounced inspection visit on 6 September 2016.

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

Detailed findings

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

Facts and data about Stoke Mandeville Hospital

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

Safe

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

Caring

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

Responsive

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

Well led

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

Medical care (including older people's care)

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

Information about the service

Stoke Mandeville hospital is the main provider of acute hospital services to a population of 505,000 in Buckinghamshire. The hospital provides acute medical care including respiratory, general medicine and care of the elderly. The hospital has approximately 130 beds for medical admissions, of which 42 were for respiratory and 47 for older people. From 1 March 2015 to 29 February 2016 there were 38,589 medical admissions by the trust of which 58% were to Stoke Mandeville hospital.

During the inspection of this core service at Stoke Mandeville Hospital we inspected the respiratory wards (wards 4 and 7) and care of the elderly wards (wards 8 and 9).

We spoke with 15 members of staff, including divisional leads, nurses at different grades, healthcare assistants, consultants, junior doctors, ward clerks and secretaries, housekeeping staff, pharmacists and therapists. We observed interactions between staff and patients, considered the environment, reviewed five patient records and spoke with 10 patients or their relatives. In addition, we reviewed documents relating to the management and performance of the service.

Summary of findings

Overall, we rated medical care as 'requires improvement' because:

- We found the pharmacy service was not able to provide an effective service, particularly on the elderly care wards. There were vacancies in the pharmacy department, which impacted on the performance of the service. There were delays in patients receiving discharge medicines, medicines reconciliation targets were not met and pharmacists were not always part of the multidisciplinary team.
- Ward staff were responsible for ensuring medicines were handled in accordance with the trust medicines management policies. However, we found expired medicines on the ward and staff did not consistently record fridge temperatures
- We found staff did not always maintain medical records securely. During our visit we saw both paper and electronic records were left unattended and accessible to unauthorised people.
- Although staffing levels had improved since the previous inspection, we found the elderly care wards were not always staffed to the optimum staffing levels. This meant staff were under pressure to meet patients' needs, particularly when patients were assessed with high needs and required one to one care.

Medical care (including older people's care)

- The system to ensure patients with a deprivation of liberty safeguard (DoLS) authorisation was in place and up to date was not effective. The trust had been in discussion with the local authority to improve the process and was monitoring the situation.
- We observed some poor compliance with infection control procedures. For example, on ward 8 we found equipment had a layer of dust, the linen store door was open and staff told us patients often wandered in to the room, which posed an infection control risk. We also witnessed an incident where a member of staff had displayed poor infection control practice.
- The results of a number of national audits showed medical services performed worse than the national average.

However,

- Patients and relatives were positive about the care they received. They told us staff were caring and treated them with respect. They felt involved in their care and recommended the hospital to others based on their own experiences.
- Staff demonstrated an understanding of how to care for vulnerable patients including those with a learning disability or with dementia. Staff were supported by specialist teams in the trust to meet patients' needs. They used tools to assess patients' mental capacity and understood the procedures to follow if patients were at risk of a deprivation of liberty if they were restricted or restrained.
- New staff underwent an induction process before there were assessed as competent to work on their own. Junior doctors were satisfied with their training opportunities and support available. Staff said they had effective access to professional development and in August 2016 90% of staff in the division of elderly care were up to date with mandatory training and 82% in integrated medicine. The annual appraisal uptake was 89% for integrated elderly care and for integrated medicine was 90% against a trust target of 90%. Staff said their managers provided good support and senior staff were approachable and accessible.
- There was high level of bed occupancy trust wide. The service closely monitored bed capacity and had plans in place to manage demand if needed.
- There was a culture of collaborative working and staff said they worked well together in multidisciplinary teams to coordinate patient care. We observed effective multidisciplinary meetings between staff, which showed they considered patient's individual risks and needs.
- Patient records were clearly completed and documented patient's risk assessments and management plans.
- The divisional leads had an agreed vision and strategy for services and a clinical governance framework. They had recognised the need to improve their management of risks, and had started to use a new approach to monitoring service risks. Staff reported incidents, and understood how to use the incident reporting system. Staff carried out root cause analysis to investigate incidents and learn from them. The service had a high proportion of harm-free care.
- The services took part in national and local audits to check they provided care and treatment in line with good practice guidance. They developed action plans and worked with other health and social care providers to improve care pathways. For example, for patient suffering falls.
- Wards were visibly clean and the infection control team carried out regular audits to identify any areas for improvement.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

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

We rated safe as 'requires improvement' because:

- We found the pharmacy service was not able to provide an effective service, particularly on the elderly care wards. There were vacancies in the pharmacy department, which impacted on the performance of the service. There were delays in patients receiving discharge medicines, medicines reconciliation targets were not met and pharmacists were not always part of the multidisciplinary team.
- Ward staff were responsible for ensuring medicines were handled in accordance with the trust medicines management policies. However, we found expired medicines on the ward and staff did not consistently record fridge temperatures
- We observed some poor compliance with infection control procedures. For example, on ward 8 we found some items of equipment had a layer of dust, the linen store door was open and staff told us patients often wandered in to the room which posed an infection control risk. We also witnessed an incident where a member of staff had displayed poor infection control practice.
- We found staff did not always maintain medical records securely. During our visit we saw both paper and electronic records were left unattended and accessible to unauthorised people.
- Although staffing levels had improved since the previous inspection, we found the elderly care wards were not always staffed to the optimum staffing levels. This meant staff were under pressure to meet patients' needs particularly when patients were assessed with high needs and required one to one care.

However

- Staff reported incidents and systems were in place to investigate and disseminate learning through newsletters and meetings. Staff gathered and displayed NHS safety thermometer data on the ward.
- Staff were aware of the duty of candour legislation and the service had a system for tracking incidents that triggered a duty of candour response.
- Systems were in place to enable staff to assess and respond safely to deterioration in patients' health. The trust used an electronic warning system to prompt staff to take the necessary action to help prevent further deterioration in patients' health. Staff completed relevant risk assessments for patients and shared information about patients' care and treatment needs at handover meetings.
- The majority of staff were up to date with mandatory training. Managers monitored compliance and supported staff to remain up to date with training.

Incidents

- Between 1 April 2015 and 31 March 2016 the trust reported 6846 incidents on the national reporting and learning system (NRLS). This was lower than the England average, however, an increase on reporting compared to the previous year.
- There were no never events reported between 1 September 2015 to 31 August 2016 the division of integrated medicine or elderly care division. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, be implemented by all healthcare providers.
- In the division of elderly care between 1 September 2015 to 31 August 2016, staff reported 1791 incidents, of which 1078 were classified as no harm. There was one death, two incidents of serious harm, 41 moderate harm and the remainder low harm. We reviewed the incidents categorised as serious harm, 42% were related to pressure ulcers and 21% attributed to falls.
- In the division of integrated medicine, there were 3023 incidents reported of which 2092 were categorised as no harm. There were 14 incidents categorised as death, 5 severe, 116 moderate harm and the remainder low harm. We reviewed the incidents

categorised as serious harm; 28% were pressure ulcers and 21% falls. In response to the identified increase in falls and pressure ulcers, the trust had made improvements. For example, all falls were reviewed by the serious event group and all reported pressure ulcers were also reviewed by the tissue viability nurse.

- The trust had identified a trend in incidents relating to falls and pressure ulcers. In response the trust had implemented a 'stay in the bay' initiative since April 2016. This involved allocating computers in the bay for staff use and at least one member of staff, be it nurse, doctor, or therapist, present in the bay to supervise patients at all times. Patients were identified by a triangle against their name on the ward board to highlight to staff the patients at risk of falls. The initial findings of the report (September 2016) indicated a small, but not significant reduction in falls. However, two unobserved falls had taken place on the care of the elderly wards in the first two months of the project. The aim of the project was to reduce the number of falls by 25% over a three month period
- Staff we spoke with demonstrated an awareness of how to report incidents in accordance with the trust procedure using the electronic reporting system. Ward sisters told us they were responsible for reviewing incidents, investigating if appropriate, ensuring learning points were shared and implementing actions. The sister was responsible for 'signing off' or closing the incidents which related to their wards. Matron also reviewed incidents and they were reported through the service delivery unit clinical governance meetings..
- Staff we spoke with told us they received feedback from incidents by email, monthly e-newsletter and ward meetings. Incidents were also covered during the daily handover meeting.
- Staff were aware of the introduction of trust wide 'lessons learnt' meetings. These were advertised on the trust intranet held monthly and were open to all staff. Cases were presented around a specific topic. For example we saw the bulletin for February 2016 was titled 'Wandering as a behaviour of dementia'.
- Medical staff we spoke with told us they attended the fortnightly mortality and morbidity meetings, where medical staff presented patient cases and learning was discussed. These were multidisciplinary meetings where nurses and medical staff attended.
- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.The Matron for care of the elderly described a case where DoC had been triggered, the investigation found the patient had been non-compliant with their care plan which had resulted in a pressure ulcer. Trust data showed 72% of staff in integrated medicine had received duty of candour training and 88% staff in integrated elderly care. Staff we spoke with were familiar with the concepts of openness and transparency and some could give examples of how they or their colleagues had applied the DoC.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot of avoidable harms, which includes pressure ulcers (grades 2,3,4), catheter-related urinary tract infections (C-UTIs), venous thromboembolism (VTE, or blood clots) and falls (with harm).
- The ward managers we spoke with confirmed this data was collected monthly. We observed the data which related to falls and pressure ulcers was displayed on a ward safety board. This was alongside the ward's hospital acquired infections and daily staffing levels at the entrance to the wards we visited. For example, information displayed on ward 8 for September 2016 showed it had been 126 days since the last fall resulting in injury and 124 days since the last pressure ulcer.
- Data for medical services showed between June 2015 to May 2016, the total number of pressure ulcers was high (80) but consistent over the period, the total number of falls was 37 and peaked in April and May 2016, and there had been 70 catheter acquired urinary tract infections.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- The wards we visited were visibly clean. However, we observed some poor compliance with infection control procedures. For example, on ward 8 (elderly care), we witnessed an incident where a member of staff was not wearing a protective apron whilst transporting a used commode. The linen store door was open and staff told us patients often wandered in to the room which posed an infection control risk. On ward 8 we noted some equipment had a layer of dust, for example, an otoscope (medical device to look in ears), the resuscitation trolley and computer trolley, this was pointed out to staff on duty at the time of the inspection.
- We observed personal protective equipment such as gloves and aprons were available outside every bay and side room. Hand sanitiser was available for staff and patient use at appropriate points throughout the ward. Hand wash basins were in working order and hand hygiene posters were on display to remind staff and visitors on effective hand washing technique.
- On ward 7 (respiratory) we observed equipment was labelled to indicate it had been cleaned and was ready for use. Clinical waste was stored safely and sharps bins not over filled.
- Cleaning audit scores were displayed on the wards and indicated high (above 95%) compliance. However, during the inspection we identified some areas on ward 8 which were not clean.
- We observed staff also adhered to the trust policy for 'bare below the elbows' to minimise the risk of spreading infections.
- Hand hygiene audits between April 2016 to July 2016 was 98% and above for all wards we visited except for ward 9 in May 2016 when they achieved 92% and for ward 7 in July 2016 where they had not participated in the audit.
- The trust scored in line with the national average for cleanliness in the most recent patient-led assessments of the care environment (PLACE), in April 2016, scoring 97% against a national average of 98%.
- Wards had single rooms where they could isolate patients to control infection risks, however there was constant pressure for these as they were also used for caring for patients with specific needs, for example patients receiving end of life care.
- Between April 2015 to March 2016, 38 patients acquired Clostridium difficile (C.difficile is a bacterium which can lead to infection) against a target of 32 cases. Twenty of the 38 cases were in the division of integrated medicine and specifically four in respiratory wards. Following root cause analysis two of the cases identified a delay in sending stool specimens and delay in commencing a stool chart. Three cases were in the integrated elderly care division, no lessons were identified. The major identified risk factor was the use of antibiotics.
- The trust required that all patients were screened for meticillin resistant staphylococcus aureus (MRSA is a bacterium which can lead to infection) prior to or on admission. Between April to July 2016, there had been no cases of MRSA reported in in the division of elderly care or integrated medicine.

Environment and equipment

- We observed the wards we visited had controlled entry and exit to facilitate staff and patient security.
- All the equipment we observed on the ward was in working order and staff said they had sufficient equipment available to provide patient care. Systems were in place to request repairs and staff said repairs were dealt with efficiently. We saw records held by the maintenance department which identified the equipment on the wards we visited and that they were all 'in service' which included the electrical safety test.
- On ward 7 staff reported a lack of equipment, in particular monitors and probes. Staff borrowed from other wards to manage the situation.
- The wards had emergency trolleys equipped with defibrillator and equipment required in the event of a cardiac arrest. One resuscitation trolley located on ward 8 was shared between wards 8 and 9. We checked the contents and records for the trolley. We found the suction machine had not been plugged in and informed the nurse in charge. Staff told us daily trolley checks were undertaken to ensure equipment was safe and suitable for use. We reviewed the records

for wards 4 and 8 and found daily checks had been undertaken with the occasional one omitted. This was raised with nurse in charge who said it was probably as staff may have been too busy.

- On ward 4 equipment was stored in hoist bays, we observed this presented a degree of obstruction to staff in accessing equipment at the back of the bay.
- A therapy gym was located on ward 8. This enabled staff to provide patients therapy within the ward area and have access to appropriate equipment. However, staff informed us the gym had been used in the past to accommodate patients if needed as part of the trust escalation plan to meet capacity.
- Stoke Mandeville Hospital scored slightly below the national average for condition appearance and maintenance in the most recent patient-led assessments of the care environment (PLACE), in April 2016, scoring 90% against a national average of 93%.

Medicines

- The trust had medicines management policies and standard operating procedures in place to ensure the safe handling of medicines in accordance with national guidance. However, we found standards were not maintained. For example, medicine reconciliation targets were not met. The trust achieved 56% in April 2016, 51% inJuly 2016 and 59% in August 2016 against the trust target of 60% to be complete within 24 hours. The totalnumber of medicines reconciliationshad a target of 80% which has not been met for April May, July and August21016. This increased the risk that patients received the incorrect medicines. We saw two out of 12 prescription charts were not seen and endorsed by a pharmacist. This meant that medicine errors were less likely to be identified on patient admission and issues with compliance were potentially missed.
- At times there were delays in discharge medicines (TTO) turnaround times although the satellite pharmacies on the surgical floor and in emergency medicine were helping to alleviate unnecessary delays. On ward 7 staff told us they aimed to order TTOs the day before discharge to allow additional time for the medicine to arrive on the ward.
- In discussion with the trust chief pharmacist it was clear they were aware of the issues which related to medicines optimisation in the trust, in particular the lack of clinical pharmacy service to care of the elderly wards. The trust was in the process of recruiting pharmacist and technician staff to fill the 6.39 whole time equivalent clinical pharmacist and 3.31 whole time equivalent technician vacancies. The chief pharmacist said the service managed the risk by prioritising the needs of high risk acute patients and those with complex medicine needs. In June and July the vacancy rate was 18% and 19% respectively resolving to 7% in August.
- We observed how medicines were stored on the wards we visited. Although medicines were stored in locked cupboards, some medicines such as sodium chloride and water for injections, which should be securely stored. The treatment rooms on the care of the elderly wards (8 and 9) were open. Patients with dementia on these wards were seen walking around the ward and could enter the treatment rooms which compromised patients and others safety.
- We observed controlled drugs (CD) were stored safely in appropriate cupboards and we reviewed records which showed daily stock checks had been completed. CD audits were conducted by pharmacy staff which assessed safe storage and record keeping. We reviewed controlled drugs storage and records and found records were not always complete. For example, the received section in the order book was not signed, some orders only specified 'box' or 'bottle' as the quantity and some stock levels were recorded as 'boxes' without specifying the quantity in the box. Patient own controlled drugs and expired CDs were not always stored separately to stock CDs which was not in line with good practice guidelines. We found three week expired CD (oxynorm 5mg per 5ml liquid) in the cupboard which had not been collected by pharmacy for disposal.
- We saw out of date copies (September 14 to March 15 editions) of the British National Formulary (BNF) on the medical wards, although pharmacy staff told us staff had access to the online BNF resource via the trust intranet.
- Our review of 12 prescription charts showed low incidence of omitted doses on inpatient prescription charts. Although allergies were documented, these

were not signed and dated on 11 charts as per chart instructions, prescriber identifiers were not routinely completed, duration and indication for antibiotics was not completed on four out of six charts.

- On ward 8 the medicine fridge temperatures were in range and records were seen for the past 6 months. On ward 9 the fridge temperature records showed gaps in the record. For example, in August 2016, the temperature had only been recorded for six days and five of the maximum temperatures were out of range. There was no indication of any action taken in response. This did not provide assurance that the refrigerated medicines were safe to use.
- On ward 8 staff did not always follow best practice and trust policy for the storage of medicines. For example, we saw bags which contained patients own medicines and TTOs were stored in the medicine trolley because some patient lockers were broken. We found liquid medicines were not always annotated with date of opening. For example, lactulose, haloperidol 10mg per 5ml and senna syrup. There were loose mixed strips of tablets and an injection ampoule stored together in the medicine trolley. Three amiodarone injection 30mg per ml pre-filled syringe were out of date and this was brought to the attention of ward staff and they arranged replacement of the expired stock.
- The medicine policy and standard operating procedures were not always followed. The trust auditing of storage, fridge temperature monitoring and CDs highlighted some of the concerns we had also identified. However, during the inspection we did not see that the medicines optimisation auditing processes had driven improvements for patient safety.

Records

- Patient records were held in paper and electronic format. During the inspection visit we observed some poor practice which compromised security of confidential information. On ward 8 we saw a computer was left on with patient test results visible. On ward 9 we saw a patient's discharge summary clearly visible to staff and visitors (during visiting time). The unsupervised nurse station contained records of patients' personal details which included their medical history.
- Notes were stored in a records trolley but the open trolley was left unattended, this meant there was a risk that unauthorised people could access patient records. A bag of open confidential waste was located behind the nurse station which contained handover sheets.
- Our review of records showed notes were clearly written, and generally well organised. They included information about patients' medical history and social situation, as well risk assessments, care plans and observations. They also included entries from different disciplines, including therapists, palliative care team and dieticians where appropriate. The entries we saw were signed and dated and legible.

Safeguarding

- Staff we spoke with were familiar with the trust safeguarding procedures and were aware of the actions to take to keep people safe from abuse. Staff gave us examples of when they had intervened if they suspected abuse.
- Staff had access to the senior ward staff and hospital safeguarding lead if they had concerns. Staff recorded safeguarding concerns on the trust incident reporting system.
- Our review of patient records showed that safeguarding issues were identified and recorded.
- All staff were required to undertake safeguarding vulnerable adults and children training annually.
- Training records showed in the division of integrated elderly care, 85% staff had completed adult safeguarding training and 89% had completed child safeguarding level 1 training in the previous 12 months against a trust target of 90%. However, only 66% had completed safeguarding children level 2 training. In the division of integrated medicine, 75% had completed adult safeguarding and 82% safeguarding children level 1 and 80% level 2.
- We witnessed one incident of a staff member who demonstrated poor moving and handling practice. We notified senior staff on duty and they took immediate action in response and investigated the incident.

Mandatory training

- The trust mandatory and statutory training covered a range of topics which included fire safety, adult basic

life support, safeguarding, patient moving and handling, information governance, infection control, dementia awareness and equality and diversity. Certain staff groups had additional core training requirements or training to a different level, such as intravenous training and medicines management training for registered nurses,

- The majority of training was accessible to staff by e-learning. Staff were allocated time during their working day to complete mandatory training. The trust target for completion of mandatory training was 90%. In August 2016 overall 90% of staff in the division of elderly and community care were up to date with mandatory training and 82% in integrated medicine. In integrated medicine the lowest achievement was in fire safety awareness (58%) and infection prevention and control and safeguarding adults (both 75%). In integrated elderly care the lowest achievement was in fire safety awareness of 62%.
- Staff were sent an email reminder when their training was due and ward managers were also sent information about their staff compliance with mandatory training.

Assessing and responding to patient risk

- Staff completed risk assessments for patients in relation to malnutrition, mobility and falls risk, skin integrity and pressure ulcers. Staff recorded these assessments in the patients' records. Information was summarised in the ward handover sheets for staff.
- Staff carried out risk assessments for venous thromboembolism (VTE) in newly admitted patients in accordance with NICE guidance. Data showed between April and June 2016, 95% of patients had been risk assessed.
- Staff used the National Early Warning System (NEWS) to monitor patients and identify deterioration in their health. Quarterly NEWS audits were undertaken. We reviewed the results of the last three audits. Staff understood the actions they should take should a patient's score increase above an agreed level. Records showed that staff had taken the appropriate actions. The most recent audit for July 2016 showed 98% and above compliance on the respiratory wards and care of the elderly wards. The results also showed an improvement in completion of the NEWS tool over the last six months.
- The trust assessed all patients over the age of 75 for dementia. This enabled the staff to respond to and manage risks associated with living with dementia. Performance data was reported on the divisional scorecard: the trust achievement for screening patients for dementia known as 'dementia case finding' was 87.7% which was below the trust target of 90%, dementia diagnostic assessment was 100% and dementia referrals for follow up were 71.1% against a target of 90%.
- We observed handovers and these showed staff responded to patient risks, for example by requesting specialists in a timely way and by obtaining specific equipment and aids.
- On the two elderly care wards, 8 and 9, staff placed patients at a high risk of falling in beds where they could be observed most closely from the nursing station. Where necessary, staff arranged for one to one support for patients, for example if they had a high risk of falling or if they needed close supervision due to an authorisation of deprivation of liberty safeguard in place. The nurse in charge requested additional staff to provide the enhanced needs for such patients.
- Training data showed 90% of staff in the division of elderly care had received training in the trust mandatory training module titled 'summoning emergency help' and 80% staff in integrated medicine, compared to the trust target of 90%. Data showed staff had received basic life support training, 88% in the division of elderly care and 84% in the medical speciality wards.

Nursing staffing

- The trust used the safer nursing care tool, which adjusted staffing levels depending on the acuity of patients. For example, patients with major physical/social or mental health needs were 'specialed' and designated as one to one care. Daily staffing was reported on the ward's safety board under the headings as planned, actual and safe.
- Ward skill mix was approximately a 60:40 ratio between qualified or registered nurses and

unqualified or health care assistants. Wards 4, 6 and 8 worked on a rota of long days; 12 hour shifts. Ward 9 worked on a mixed rota with three shifts: early, late and night and some staff working 12 hours.

- We reviewed the ward staffing level data for two weeks up to the day of the inspection. The data for the respiratory wards generally showed staffing was in line with requirements. Ward 7 was staffed in line with planned levels for all shifts except one. On ward 4 there had been three shifts which were below the planned staffing level due to four registered nurses on duty instead of five. On one shift there had been three registered nurses instead of five. Staff on ward 4 told us although the ward was usually staffed, often staff were moved to other medical wards to cover shortages on those wards.
- On the elderly care wards, ward 8 had three shifts below expected staffing levels where there had been one registered nurse less than planned. During the same period, ward 9 had eight shifts over six days when there was one registered nurse less than planned. On the late shift, the day before the inspection (5 September 2016) there had been two registered nurses less than planned. This meant there were two registered nurses to care for 21 patients, although healthcare assistants were also on duty at the same time.
- Staff told us the impact of working on or below minimum staffing levels meant sometimes antibiotics were delayed and paperwork was not always completed for example, pressure ulcer risk assessments. However, staff we spoke with said they did not often have to stay over their shift.
- Staff said below minimum staffing levels were not reported as an incident unless it was 'not safe' and this would be determined by the nurse in charge.
- Patients observed staff were stretched but also said when they used the call bell staff attended within a reasonable time frame.
- We saw planned and actual nurse and healthcare staffing levels were displayed on the wards we visited, which was updated daily. On the day of inspection the staffing levels displayed on wards 8 and 9 indicated they were as planned. The nurse in charge said additional healthcare assistant staff would normally be requested to provide one to one care for patients with high needs. However, we found planned staffing levels on the ward did not always reflect the actual staffing levels required to account for the enhanced needs of certain patients.
- At one point during the visit we observed two patients who were confused. One patient (with enhanced needs) was seen lying on the floor in front of the nurses' station. Three members of staff assisted the patient, which left two members of staff for the remainder of the 20 patients on ward 8. At the time there was also more than one patient who required enhanced care.
- Ward managers told us they filled outstanding shifts with their own ward staff first, then offered bank shifts and as a last resort requested agency staff.
- There was an escalation policy in place, which staff were aware of and would implement. Staff would be moved to the area with the greatest needs to work towards ensuring safe levels. On the care of the elderly wards staff would be shared across the wards.

Medical staffing

- Data showed the trust had a lower proportion of consultants and registrars than the national average (29% compared with 37% and 31% compared with 36%, respectively). There was a higher proportion of middle grade and junior doctors, 11% and 29% compared with 6% and 21%.
- Six consultants covered care of the elderly wards: four registrars and 11 junior doctors. We saw an improvement in the feedback from junior doctors since the previous inspection. The doctors we spoke with described a working environment where they were satisfied with the senior support and cover arrangements.
- On the elderly care wards a daily consultant ward round and daily focus meeting took place.
- Respiratory medicine was a consultant led service. Respiratory consultant cover was two consultants with a team of one registrar and three junior doctors (registrar and foundation year 1 and foundation year 2).

Medical care (including older people's care)

Major incident awareness and training

- Staff were aware of the procedures for managing winter pressures and major incidents. The trust had contingency plans for power or water failure.
- Staff told us the major incident plan had been tested to assess how long it would take staff to attend if needed.
- Annual fire training and fire officer attended the ward to assess and provide staff teaching on for example the information displayed on the fire panel.
- The trust had business continuity plans for use in situations such as seasonal fluctuations in demand, a power failure or adverse weather conditions. There were corporate business continuity strategies in place, which showed how senior management should manage an emergency at each site, depending on the level of impact.
- There was a trust 'Incident response policy' for staff to follow should a significant event occur at the hospital or in the local area. Staff knew where to find this policy on the intranet and senior staff understood their responsibilities if a major incident occurred.

Are medical care services effective?

Requires improvement

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

We rated effective as 'requires improvement' because:

- Training on the mental capacity act and the deprivation of liberty safeguards was available for all staff. The up take of training in the elderly care wards was below the trust target.On ward 8 we found DoLS paperwork had not been fully completed with dates and signatures. This meant there was a risk patients were deprived of the liberty without the correct authorisation in place.
- The results of a number of national audits showed medical services performed worse than the national average. For example, the results of the myocardial ischaemia national audit project (MINAP) national audit 2013/14, National Institute for Cardiovascular Outcomes Research (NICOR) heart failure audit and National Diabetes Inpatient Audit (NaDIA) and national inpatient falls audit showed performance worse than the England average.

However

- Medical services followed pathways and protocols based on national guidance, such as the National Institute for Clinical Excellence (NICE) guidelines. Patients' care was planned and took account of current evidence-based standards.
- Staff undertook a range of clinical audits to benchmark practices and identify areas for improvement. Where results were below expected levels, staff investigated causes and implemented improvement plans.
- Patients were satisfied with the food provided and it met their specific needs. Staff monitored the quantities of food and fluid patients took, if necessary, to help them with their nutrition and hydration.
- Staff worked in multidisciplinary teams and specialist teams were accessible to provide support to staff and patients.
- Staff were qualified and had the skills they needed to carry out their roles effectively. They participated in annual appraisals and there was good access to professional development.

Evidence-based care and treatment

- Medical services had pathways and protocols for a range of conditions, based on national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were in place, for example, for heart failure, stroke, diabetes, respiratory conditions, falls prevention, pressure ulcer prevention and sepsis. The trust monitored implementation of the policies to ensure they complied with NICE guidance.
- We reviewed the trust clinical audit programme. The division of integrated elderly and community care had participated in four audits in 2015, including the national audit of inpatient falls. The falls audit plan 2015 identified a number of areas for improvement which the trust had acted upon.

Medical care (including older people's care)

- The division of integrated medicine had participated in twelve national audits including chronic obstructive pulmonary disease and diabetes. Staff we spoke with on the respiratory wards were familiar with the outcomes of the audits and actions that had been taken in response. For example, measures were in place following the chronic obstructive pulmonary audit (COPD) audit to provide additional support for patients to reduce admissions and facilitate early discharge. The audit also found the trust needed to make improvements in the smoking cessation advice provided to patients. Actions were taken to identify patients on admission and ensure advice was provided. A re-audit had shown improvements had been made.
- The trust's sepsis group had developed a sepsis screening and treatment pathway based on the National Clinical Guideline No. 6. Sepsis Management. Doctors and nurses used this tool to assess the risk of sepsis in patients and to give clear guidance on what actions to take and when.
- The trust used a scale recognised by NICE to assess the risk of pressure ulcer development. This enabled staff to categorise the risk of skin breakdown and prompted them to take the right action. The trust used skin bundles for both preventative care and treatment of pressure ulcers.
- Staff assessed patients at risk of malnutrition or dehydration using the malnutrition screening tool developed by the British Association for Parenteral and Enteral Nutrition.
- Patients at risk of venous thromboembolism (VTE) received VTE prophylaxis in line with NICE guidance. The trust monitored this to check compliance.

Pain relief

- Patients we spoke with and our observations indicated pain relief was provided on time. Patients were provided regular pain relief and when needed. The records we reviewed showed staff monitored and recorded patients' pain levels on a score of 1-3 and used the electronic assessment system.
- Staff we spoke with on the respiratory ward confirmed they had undertaken pain management training, they were also supported by the trust pain team and were aware of what action to take if patients reported unresolved or escalating pain.

Nutrition and hydration

- Patients we spoke with said their water jug was replenished at least daily and there was sufficient food choices on the menu to suit their requirements.We observed drinking water was available for patients.
- Stoke Mandeville hospital scored above the national average for food assessment in the April 2016, hospital's 'patient-led assessment of the care environment' (PLACE), scoring 91% against a national average of 88%.
- Patients who were assessed as needing assistance with meals were provided with meals on red trays. This served as a visual reminder to staff. We observed these were in use on the wards we visited and staff assisted patients at meal times. Wards displayed posters which informed patients and relatives about the importance of protected meal times.
- Records showed staff completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments. The MUST was used to identify patients at risk of malnutrition. Staff contacted a dietician for additional advice if needed. Patients were weighed weekly to monitor weight. Food charts were maintained for patients who were risk assessed for malnutrition.
- Staff assessed and recorded patients' nutrition and hydration status using a recognised tool. They completed food and fluid charts when assessments showed there was a need and noted patients' intake each day. Dietitians were also involved in patients' care. They provided dietary advice for patients with poor appetites or for those with diabetes and those identified as at risk according to the screening tool.
- Staff also monitored the quantity of fluids taken by patients who required intravenous infusions, to ensure they received the right amounts.
- Speech and language therapists assessed patients' ability to swallow safely and left clear guidance for ward staff on how to prepare their food and drink to the right consistency.

Medical care (including older people's care)

Patient outcomes

- The trust participated in a number of national audits. These included the falls and fragility fractures audit programme, the lung cancer audit and the national chronic obstructive pulmonary disease audit programme. In 2015/16 the divisions of medicine and elderly care participated in 14 national audits. We reviewed the reports and action plans for some of the audits undertaken.
- Results of the National Diabetes Inpatient Audit (NaDIA) in September 2015 showed the trust performed worse than the England average percentage for 11 out of 17 measures. The trust performed worse than the England average for staff knowledge on diabetes care, foot risk assessments, meals and visits by the specialist diabetes team. The trust performed better than the England average on six of the 17 measures including patients able to take control of their diabetes care, patients admitted with foot disease, medicine, prescription and management errors.
- The trust's performance in the national inpatient falls audit 2015 was below the national average. The trust had developed an action plan to address the poor performance by, for example, the introduction of a multifactorial risk assessment tool. The action plan was monitored by the trust falls steering group.
- The trust participated in the national lung cancer audit 2014. The results showed the trust performance was in line with the national performance level.
- Results of the myocardial ischaemia national audit project (MINAP) national audit 2013/14 showed the hospital's outcomes were worse than the England average. Forty two (42.9%) patients with non-ST-elevation infarction (nSTEMI) were seen by a cardiologist or a member of the cardiology team. This was lower than the national average of 94.3%. The audit showed 42.9% of patients were admitted to a designated cardiac ward (against a national average of 55.6%). The hospital performed worse than the national average for the proportion of nSTEMI patients referred for an angiogram, 66.7% against 77.9% nationally.
- The hospital participated in the National Institute for Cardiovascular Outcomes Research (NICOR) heart failure audit for hospital care. Stoke Mandeville hospital performed worse than the England average for three out of four indicators for in hospital care, including input from specialists, and worse than the England average for five out of seven indicators relating to patient discharge including appropriate medicines on discharge and follow up for cardiology referral.
- Readmission data, between February 2015 and January 2016 showed the relative risk of readmission for respiratory medicine was higher than the England average. This was a negative indicator for patient outcomes. The trust had taken action, for example, by initiating a weekly clinic to review urgent cases.
- The service delivery unit scorecards monitored and reported on performance data linked to patient outcomes, such as VTE risk assessments, cases of hospital acquired infections and pressure ulcers.

Competent staff

- Nursing and healthcare assistant staff reported good access to professional development and they said their managers encouraged them to attend training and develop skills. For example, new staff underwent an induction programme during which time they were supernumerary. This allowed them to complete the corporate induction, core training and local induction to ensure they were familiar with the ward they were based on.
- The nurse in charge told us when agency staff were used, they had normally worked on the ward before and underwent a short orientation to the ward at the start of the shift. We observed the nurse in charge (band 6 or 7) provided support and supervision to junior staff when they were on duty.
- Data showed the annual appraisal uptake was 89% for integrated elderly care and for integrated medicine was 90% against a trust target of 90%. Staff confirmed they had an annual appraisal with their manager. Staff we spoke with said they were up to date with their appraisals and had found them useful.
- The ward 7 nurse in charge informed us all new staff attended the preceptorship course and were assigned a mentor and associate mentor. Staff had supervised practice until they had completed medicine and

intravenous medicine competency training. The practice education team were involved in staff development, particularly if an issue was raised around a staff member's practice.

- In the General Medical Council National Training Scheme Survey 2016, the trainee doctors rated their overall satisfaction with training as similar to other trusts. Trainee doctors told us they felt supported and enjoyed working at the trust. This was an improvement on the previous inspection.
- Junior doctors we spoke with reported good access to their registrar and consultant for support. They said the consultants provided regular feedback to junior doctors on their practice and progress.
- Junior doctors said they were satisfied with access to teaching sessions. For example, once a week teaching on respiratory and elderly care, grand rounds and x-ray teaching sessions. The respiratory consultant led ward rounds four days a week; the registrar led the ward round as a learning opportunity and consultant provided support and troubleshooting.

Multidisciplinary working

- The ward 7 manager reported effective collaborative working. For example, if a diabetic patient was admitted to the respiratory ward, staff sought advice from the staff on the diabetes ward to assist if needed.
- Staff referred patients to specialist teams, for example palliative care team, pain team and speech and language therapists if needed.
- Staff told us multidisciplinary team (MDT) working across the division was well developed with staff from different disciplines supported each other to coordinate patient care and treatment. Patient records showed that care planning for patients with complex needs included assessments by different professionals.
- We observed a daily focus meeting on ward 8. This was a one hour multidisciplinary meeting which included medical, nursing and allied health professional staff. Participants demonstrated a thorough knowledge of patients' needs and care plans, which resulted in agreed ongoing progress to facilitate patients discharge.
- We spoke with one of the respiratory consultants who said they regularly discussed patients with all members of the multidisciplinary team and were available during ward rounds if needed.
- We observed staff on ward 7 held 'board rounds', where nursing, medical, therapy staff and social worker discussed each patient on the ward and planned further care or discharge arrangements as appropriate.
- Ward 7 staff described a good relationship with the pharmacy department and they valued the contribution of their dedicated ward pharmacist for support.

Seven-day services

- The trust was working towards compliance with all four of the key priority clinical standards of the NHS services, seven days a week framework, which ensured high quality care for patients every day of the week. The trust had participated in the NHS national sustainable improvement survey in April 2016. The results showed the trust were fully compliant for two standards (Access to diagnostics and consultant directed interventions) and partially compliant for two (Time to first consultant review and on-going intervention).This resulted in an action plan in response to the findings from the survey. The action plan included review of consultant job plans and ensuring staff provided information to patients and families of the diagnosis and treatment plan, within 48 hours of admission.
- The out of hours cover for medicine for older people was 9.30pm to 10.30am and was staffed by one consultant, one registrar and two junior doctors. In addition to this two medical registrars were on call until 11pm, one covered A&E and one for ward referrals.
- Out of hours cover for integrated medicine was provided by two junior doctors and a registrar with the support of on call consultant from home. One consultant we spoke with said the on call arrangements worked well. After 11pm there was one foundation year 1 (FY1) and one foundation year (FY2) doctor on duty. There was also one medical registrar on site and one consultant on call to cover the medical wards and A&E referrals.

- There was a pharmacist available on site 9-5 for inpatient items seven days a week. There was an on-call pharmacist available 24/7 for emergencies outside these times.
- The diagnostic imaging department provided an on-call service outside of normal working hours and at weekends so patients had access to key diagnostic tests such as x-ray and computerised tomography (CT) scans.
- The physiotherapy and occupational therapy teams provided cover Monday to Friday 8am to 4pm and out of hours cover was provided by an on call physiotherapist.

Access to information

- The nurse in charge updated handover information at the end of their shift. The handover sheet contained summary medical and care information on individual patients as well as other necessary information such as if the patient was do not attempt cardiopulmonary resuscitation or deprivation of liberty authorisation was in place.
- A discharge letter was sent to the patients' GP for information. The information contained details on the patient's diagnoses, medicines, treatment and plans for follow up. We saw an example of this.
- Nursing staff told us when they transferred patients between wards or teams, staff received a handover of the patient's medical condition and on-going care information was shared. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff asked patients for their consent before providing care or treatment. The inpatient assessment form prompted staff to carry out mental capacity assessments if they felt patients might not have the capacity to make decisions or provide informed consent. On ward 8 nursing staff said the psychiatric in reach liaison service carried out the assessments for .
- Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). They had access to advice and had completed training on MCA and DoLS. Data showed staff had received MCA training, 85% in the division of elderly care and 92% in the medical speciality wards. Uptake of training on deprivation of liberty safeguards was 90% in medicine and below the target of 80% in elderly care wards at 77%.
- We reviewed a range of patient records on different wards and they included evidence of informed consent. Where appropriate, staff had completed MCAs and DoLS referrals. Ward sisters highlighted those patients with a DoLS in the ward safety brief and the handover forms made reference any DoLS due to expire or which required renewal.
- On ward 8 we reviewed three DoLS forms. We found they had not been fully completed with dates and signatures. We raised this with senior staff at the trust who reported that the trust had been in communication with the local authority regarding the processing of DoLS forms and the local authority recognised there was a backlog of forms. The issue had been identified as a risk on the service risk register. Senior nursing staff said the trust maintained a spreadsheet of DoLS which was reviewed weekly by the trust safeguarding board and staff were kept informed of how the wider issues were being addressed at senior level.

Are medical care services caring?

Good

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

We rated caring as good because:

- Patients and their relatives were positive about the caring attitude of staff, their kindness and their compassion. They said staff treated them with dignity and respect

- Patient surveys showed that staff were caring and protected people's privacy and dignity. The hospital's 'patient-led assessment of the care environment' (PLACE), April 2016, audit score for privacy and dignity was 73%, below the national average of 84%.
- The monthly NHS friends and family test (FFT) results showed between January and June 2016, 83% to 100% of patients recommended medical services at the hospital.
- Patients we spoke with said they felt involved in their treatment, understood their treatment plans and were able to make their own decisions. They also said staff helped them emotionally with their care.

Compassionate care

- We spoke with 10 patients. Nine patients were very pleased with the care they received and described the staff as "attentive". Although they also commented the staff were "over stretched."
- We observed caring interactions between staff and patients, for example, staff attended promptly and were gentle and compassionate to an unwell patient on ward 8.
- We observed staff behaved in a way to respect patients' privacy and dignity for example by closing doors and drawing privacy curtains before they provided personal care.
- Ward 7 staff said the biggest impact on patient care was not always being able to give palliative patients a side room for privacy and dignity, as the room may be needed for isolation purposes.
- The hospital's 'patient-led assessment of the care environment' (PLACE) audit in April 2016 showed Stoke Mandeville hospital scored below the national average for assessment of privacy and dignity at 73% against a national average of 84%.

- Friends and Family Test (FFT) results for the trust showed the hospital had a lower response rate (15%) than the national average (26%) for the period June 2015 to May 2016. The response rates for wards 4 and 9 were significantly higher at 39% and 36% respectively. Between January 2016 and June 2016 patients on ward 4 consistently recommended the service except for in May when there was a dip to 93%. Ward 8 achieved 100% except for February (97%) and April (83%).

Understanding and involvement of patients and those close to them

- On ward 4 nursing staff said they spent time with patients after the ward round and specifically asked patients if they understood what the doctor had told them, in order to provide further information or explanations if needed.
- One patient we spoke with on ward 8 said when the consultant had seen them they involved the patient's spouse in the discussion and "Gave all the information and explained the risks."
- We observed a consultant ward round where staff explained procedures and medicines and responded to patients' questions.

Emotional support

- We observed staff discussed patient care in a sensitive way. At handover meetings, it was evident that staff considered patients' wellbeing, included their emotional needs, when discussing their care and treatment. This included helping patients prepare for their discharge from hospital.
- Staff said there was a policy of open visiting hours for all patients. Relatives could stay with patients if they required palliative care, had additional needs or were very anxious / distressed. The nurse in charge took account of individual circumstances and supported patients and relatives appropriately. Staff demonstrated a patient focussed approach to ensure patients' emotional needs were met.

Are medical care services responsive?

Good

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

We rated responsive as good because:

- The medical services leadership team planned services to meet the needs of the local population, in coordination with other health and social care services. This recognised the local geography, population and neighbouring services.

Medical care (including older people's care)

- There were services to improve the access and flow of patients through the hospital, to promote shorter lengths of stay. The trust is an integrated trust which provides acute and community services. This facilitated the development of improved pathways of care, for example the respiratory pathway and the creation of the division of integrated elderly and community care.
- Ward staff and the discharge team started to consider and plan patient discharges from the date of admission. The trust worked with partners to improve the coordination of patient discharges and transfers to remove barriers to delays where possible.
- Staff tried to resolve patients' concerns before they became complaints. They took complaints seriously and made changes in response to patient feedback. Complaints were managed in a timely way.
- Staff understood how to provide support to vulnerable people, including those living with a dementia or a learning disability or difficulty.

However,

- Trust data showed a significantly higher percentage (44.2%) of patients waiting for a residential home placement, contributed to the delayed transfers of care, compared with the national average of 10.2%. The trust was working with local authority to improve the situation.

Service planning and delivery to meet the needs of local people

- Divisional lead nurses reported the trust was working on repatriation of patients from other trusts to bring patients care closer to home and to provide care in the patient's home if appropriate.
- Senior staff worked with the commissioners of local services such as GPs, the local authority, other providers and patient groups to plan and co-ordinate services to meet the needs of local people.
- The Buckinghamshire integrated respiratory service (BIRS) linked patients in the community with ward patients to provide support.
- The trust had created the division of integrated elderly and community care to improve the delivery of services for older people and move care closer to home.

Access and flow

- The general and acute medicine bed occupancy between April 2016 and June 2016 was above 85% potentially affect the quality of care given to patients and patient flow through the hospital.
- The trust monitored patient access and flow through the hospital using an electronic tool. This enabled site managers to determine where issues may arise and capacity be impacted. We reviewed the July 2016 monthly capacity governance report which reported patient moves during their inpatient stay. The report showed 93% patients stayed on the same ward after admission to the hospital, 104 patients were moved once and seven patients twice. The number of medical outliers (medical patients admitted on a surgical ward) peaked at 16 in July and the target of less than four was only met on two days of the month. This was attributed to the increased emergency department activity during the month.
- Trust data since April 2016 showed the planned length of stay for patients on wards 8 and 9 was less than 15 days. This had been achieved for ward 8 in July 2016 at 10.5 days and ward 9 achieved 12.9 and 11.9 days in April and June respectively.
- Between May 2015 and April 2016, data showed a significantly higher percentage (44.2%) of patients who were waiting for a residential home placement contributed to the delayed transfers of care, compared with the national average (10.2%).The trust was working with the local authority to improve the situation. For example, the increased provision of packages of care in the patients' own homes.
- On the wards we visited we saw daily multidisciplinary meetings were held which focussed on meeting patients' needs with an aim to achieve safe discharge from hospital. Staff started to plan patient's estimated discharge date from admission.
- The respiratory consultant told us a weekly clinic was held for patients in need of urgent care or to support patients who had recently been discharged.

Medical care (including older people's care)

- The trust had designated 'escalation beds' which were only used in exceptional circumstances, with sufficient staffing and authorised by senior trust staff.

Meeting people's individual needs

- On all the wards we visited we saw staff had taken time to support patients. For example, on ward 7 a parent of a patient with a learning disability was enabled to stay overnight to support the patient with communicating their needs to staff. We were told the learning disability team had also attended to provide advice to the patient, family and staff.
- Staff said they had access to the learning disability specialist nurse for advice and support.
- On the elderly care wards staff said approximately half the patients were living with dementia.There was a dementia activities coordinator in post to support patients on wards 8 and 9.
- Trust data showed over 90% staff had received training in dementia awareness, which was repeated every three years.
- Ward 7 had have recently purchased three reclining chairs for patients and this was particularly important for respiratory patients as sometimes they struggle to sit upright.
- Staff said they had access to interpreters for patients who could not easily communicate in English. However, in practice staff often relied on family members or other staff to translate. The trust had access to telephone, face to face and sign language interpreters. As well as written information in large print, Braille and audio translations.
- Stoke Mandeville hospital scored below the national average in the most recent patient-led assessments of the care environment (PLACE). In April 2016 the trust achieved 55% and 66% for dementia and disability assessments against national averages of 75% and 79% respectively. The trust had made recommendations to improve the situation which focussed on dementia and the appointment of PLACE divisional champions to monitor progress.

Learning from complaints and concerns

- Between September 2015 and September 2016, there were 10 complaints reported for the respiratory service out of 178 for the division. Most of which were related to delays and cancellation of appointments. There were twenty one complaints from wards 8 and 9 out of a total of 32 for the division of community and integrated elderly care. Issues varied but most were regarding discharge, transfer, referral and nursing care. We saw reports which identified the actions taken in response to complaints. The trust also provided a report which highlighted the top three reasons for complaints and what actions had been taken to address them. For example, staff training which focussed on the importance of attitude in interactions with patients.
- Staff said they tried to resolve patients' queries and concerns before they became a cause for complaint. For example, the nurse in charge of ward 7 explained there had been an issue with patients and families expectations of side rooms. In response posters were displayed to inform patients that side rooms were prioritised for infectious patients.
- The respiratory consultant said they received feedback from patient advice and liaison service (PALS) regarding individual patient concerns.
- Complaints were discussed in the directorate clinical governance meetings. This was confirmed by our review of the notes of the respiratory governance meetings and elderly care governance meetings.
- Staff we spoke with were familiar with actions that had been taken in response to recent complaints. For example, due to a high number of outpatient appointment cancellations, extra time had been allowed for consultants to run clinics during periods of high demand.
- This information was displayed in the format: 'You said… We did' comments such as 'Patients said they would like to watch Olympics', 'We did. Used a computer to show the Olympics.'

Are medical care services well-led?

Good

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

Medical care (including older people's care)

We rated well led as good because:

- Medical services had developed strategies with clear objectives to develop staff and services in collaboration with other stakeholders in health and social care.
- There was a governance framework for the services, although the leadership team recognised this needed improvement. Staff reported on service quality, safety and performance each month, and used this information to improve services.
- Services participated in audit programmes and the clinical governance team had oversight of audit, performance, risks, quality and finance. This enabled them to provide challenge and support decision making in developing services.
- Staff said the leadership team were supportive and there was good visibility from the executive team. They said they would feel confident to raise concerns if they felt a need.
- Staff felt the trust was good at recognising staff contributions. Many of the wards displayed recognition awards for teams and individual staff.

However,

- Senior staff in the medical division were aware of the risks in the service, for example, medicines management risks. However, improvements had not been followed through.

Leadership of service

- Each division was chaired by a consultant and the leadership included an operational director and divisional chief nurse. The SDUs were led by a clinical lead, however the division of integrated elderly care had some vacant SDU lead posts.
- During our inspection we spoke with ward managers, matrons and directorate leads in respiratory and older peoples care. They all demonstrated a clear understanding of their services. Staff reported good access to matrons and directorate level staff.
- Staff we spoke with said they felt managers listened to their concerns but were not always able to solve the problems such as staffing.
- On the wards we visited we saw comments from the matron checklist or matron round aimed at staff, for example, on ward 9 the matron made comments, such as for to staff to ensure they monitored and recorded all aspects of patients' care.
- In the division of medicine they aimed to build a stronger leadership team and had created a new matron post, but there were still vacancies in the clinical leadership teams.
- Medical staff told us they were well supported by senior colleagues.

Vision and strategy for this service

- The trust vision was to provide safe and compassionate care, every time. We saw this on all trust documents and displayed throughout the hospital. There was a strategy in place to support the achievement of this vision, as part of the trust's five-year plan (2015-2020).
- The trust's chief executive chaired the Healthy Bucks Leaders Group and work on the local health and care system sustainability and transformation plans (STP's).
- Their divisional strategy included specific divisional and specialty objectives. These related to service and staff developments and reflected national and local priorities. A key strand through all these was to improve collaborative working with other health and social care providers to deliver integrated services.

Governance, risk management and quality measurement

- The trust operated a divisional structure with clear governance framework from ward to board. Service delivery units (SDU) were located in each of the five divisions depending on their speciality. For example, care of the elderly wards were in the SDU of medicine for older people and rehabilitation which was in the division of integrated elderly and community care. The SDU of respiratory medicine was in the division of integrated medicine.
- We reviewed the notes of the clinical governance committee meetings for the division and SDU meetings. The divisional clinical governance meetings discussed the contents of the divisional board report, which covered quality and safety information including incidents, mortality reviews, audits,

complaints and patient feedback. The respiratory SDU clinical governance notes showed brief points of discussion, which covered the same topics as in the divisional clinical governance meetings.

- The divisional leads had a good understanding of service performance and barriers to improvement. A range of projects were in place to promote improvement, for example to improve discharge arrangements and treatment pathways. The divisional governance committee captured key actions for named leads to report on within a stated timeframe. They also received the department's mortality and morbidity meeting minutes and escalated any learning.
- Each service delivery unit (SDU) had monthly clinical governance meetings but the May and June clinical governance meetings for respiratory were cancelled. The notes of the monthly clinical governance meetings for the respiratory SDU showed attendance by medical and nursing staff. Incidents and learning was discussed.
- The medical division had separate risk registers for each directorate and escalated red risks to the trust's risk register. For example, medicine risks included falls, pressure ulcers (1 grade 3 in last 16 months), and behaviours that may challenge. The respiratory SDU risk register included patients not attending outpatient appointment, delays in reporting scans and not enough TB nurses. The risk register for elderly care included in the top two risks: the lack of assurance regarding the deprivation liberty safeguards process and the lack of pharmacy service to the elderly care wards. Actions were highlighted to mitigate the risks.
- The medicine division's audit programme included national and local audits. The divisional clinical governance reports reported on results from audits and details of further actions required to improve outcomes for patients. Audit action plans were detailed, showing leads for each action point and deadlines for completion. However, for example in the case of medicines audits, recommendations had not been acted on or followed up which we saw led to poor compliance with the trust's medicines policy and standard operating procedures.
- A monthly divisional quality and safety report was presented at the divisional board meetings, this included review of incidents and all deaths in the division with outcomes of investigations and coroners findings.
- There was a sepsis lead for the trust. Recent trust wide audits on sepsis management had identified actions that staff needed to take to improve the promptness of treatment. Further audits were planned to monitor compliance.
- Monthly matrons meeting took place. We reviewed the notes of the last ward sisters meeting for medicine for older people (MFOP) which showed how communication was cascaded from the directorate to the wards and actions monitored. For example, the July 2016 minutes recorded discussion regarding the planned changes to staff supervision. Another discussion item referred to the training staff had received regarding the use of warming blankets and the matron was trying to acquire these for the wards,
- We reviewed notes of ward meetings, for example for ward 9 (August 2016) showed issues were discussed in enough detail for staff who were not present to be aware of the actions and expectations. For example, a reminder to staff to complete the 'intentional rounding' documentation (nurses carry out checks on patients to assess and manage their fundamental care needs).
- Notes of the respiratory sisters meeting in July 2016 discussed the issue of open visiting and staff concerns of the potential compromise of patient privacy and dignity. For example, during consultant ward rounds. The agreement was made to monitor the situation and to ask relatives to leave the bay when rounds were taking place.

Culture within the service

- Nursing staff we spoke with on the care of the elderly wards and respiratory wards told us they worked well as a team and "pulled together" to prioritise patient care.
- One of the respiratory consultants told us the culture around reporting incidents had changed dramatically

and there was now more transparency in reporting. Staff confirmed they had no hesitation in reporting incidents. Staff said there was an open culture where they were prepared to ask questions.

- Staff were most proud of the quality of care they provided, their caring approach and the quality of the clinicians.
- Sickness absence across the medicine for older people wards was 6% as of June 2016 and had been above target of 3.5% since April 2016. Managers considered some of the higher sickness absence in the elderly wards may be due to the pressure staff felt when dealing with challenging patients.

Public engagement

- The trust encouraged patients and their relatives to give feedback on their care using the NHS Friends and Family Test (FFT). The medicine division performance dashboard included monthly data on the percentage of inpatients who had completed the survey and the percentage who would recommend the service. On the wards we visited we saw FFT scores, for example on ward 8, the board displayed 'June 47.1% response and score of 93.8%.'
- Wards also displayed feedback from patients, including any comments for improvement and the action they had taken in response.
- Matron reported she held a weekly matron surgery for patients/ relatives to have open access to raise issues.
- The ward 7 manager said the respiratory division had regular meetings and patient representatives attended. For example, a patient receiving pulmonary rehabilitation had highlighted that respiratory patients find it difficult to lie in bed and the ward had purchased three reclining chairs from charity funds.
- The national inpatient survey results (2015), for Buckinghamshire Healthcare NHS Trust showed patients rated their care about the same as patients at other hospitals. Overall the trust's cores had improved on the previous year.

Staff engagement

- Staff we spoke with said there was 'good staff cohesion and retention'. We saw on ward 9 for example, students applied for posts. Staff said "Everyone was here because they wanted to be." Although staff also acknowledged the work could be challenging especially due to the number of patients with complex needs.
- The staff friends and family test result for June 2016 showed was based on a response rate of 40% and showed 76% would recommend the trust for care or treatment, and 58% would recommend the trust as a place to work. Over three quarters of staff said they would feel secure raising concerns about unsafe clinical practice and 65% said they were confident the organisation would address their concerns.
- We saw ward 7 had a monthly newsletter. For example, the August 2016 issue was a brightly coloured one page bulletin which highlighted key updates and reminders for staff.
- The matron for integrated elderly care had recently launched a new divisional bimonthly newsletter. We saw the first edition, September 2016, which highlighted issues of interest including training and pilot projects across the division and recognised staff achievements and awards as well. It also included a staff quarterly temperature check which showed staff's main area where they wanted to see improvement was staffing levels and what the division had been doing to improve the situation.
- Monthly ward sisters meetings and ward meetings took place.
- For the majority of the questions in the NHS Staff Survey 2015 staff gave similar responses to staff in other trusts. However, they rated two questions below the national average: 'Fairness and effectiveness of procedures for reporting errors, near misses and incidents', and 'percentage of staff working extra hours.' Although both were below the national average the results for Buckinghamshire Healthcare NHS Trust were an improvement on the previous year.

Innovation, improvement and sustainability

- The division had learnt from national work, for example, the trust had implemented a 'stay in the bay' initiative since April 2016. The aim of the project was to reduce the number of falls by 25% over a three month period.

Medical care (including older people's care)

- The trust was in the process of developing a FRAIL service to vulnerable older patients (over 80 years and complex medical conditions), to provide early specialist multidisciplinary assessment and care planning.
- The respiratory ward was considering a proposal to adapt one of the rooms into a satellite pharmacy to improve the TTO dispensing service.

Surgery

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

Information about the service

Buckinghamshire Healthcare NHS Trust provides day case, elective and emergency surgical care at Stoke Mandeville Hospital. From March 2015 to February 2016, there were 18,993 admissions for surgery; 48% of the surgical activity was day case, 5% elective surgery and 47% emergency surgery. Over the same period, general surgery, plastic surgery and ophthalmology made up 73% of all surgical treatments performed, with 12% trauma and orthopaedic and 15% covered by other specialities.

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

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

During our inspection, we inspected all the theatre suites, four surgical wards (covering trauma and orthopaedic, general surgery, plastic surgery and gynaecology), the surgical assessment unit (SAU) and day surgery unit. We spoke with 10 patients, 2 relatives and 28 members of staff, including theatre and nursing staff, porters, housekeeping staff, allied health professionals, medical staff and the divisional leads. We also reviewed five patient records, observed care on the ward, in the operating theatres and in the recovery area. We analysed data provided by the hospital before, during and after the inspection.

Surgery

Summary of findings

We rated this service as requires improvement because:

- The pharmacy service did not have planned staffing levels and could not deliver an effective service, including to surgical patients. The service did prioritise patients with the greatest need but some key performance indicators were not achieved.
- Staff on the wards did not always dispose of out of date medicines promptly. They did not always follow the trust's controlled drugs policy when documenting receipt of controlled drugs. We found medicines that had not been stored at the correct temperature and gaps in temperature log books.
- We found incomplete records for the anaesthetic machine logbooks in the operating departments and for the resuscitation equipment on the wards. It was not clear if staff completed the daily safety checks and the equipment was safe to use.
- Theatre staff did not always comply with the trust's uniform policy to minimise the risk of infection.
- Staff did not have a good understanding of the principles of Mental Capacity Act and associated Deprivation of Liberty Safeguards and their responsibilities in relation to these areas, to support people whose circumstances made them vulnerable and who could not always give consent.
- Patients' record keeping was not to a consistent standard. Although patients told us they made informed decisions about their surgery, medical staff did not always document the conversation fully.
- The division had not achieved the 18-week referral to treatment time indicator for 90% of patients admitted for an operation over the last five months.
- Three trust policies and standard operating procedures were out of date for review. .
- Not all departmental and managers' meetings had minutes recorded. Therefore, the formal and permanent record of decisions that teams reached and actions staff agreed to take were missing.

However:

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

Surgery

- Staff told us the leadership across the service was good and the senior team were visible and accessible. Staff had an annual appraisal and could access additional training to develop in their role.

Are surgery services safe?

Requires improvement

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

We rated this service as requires improvement for safe because:

- Staff were not following trust policy and best practice guidance when controlled drugs orders were received by ward staff or they completed the daily stock check of controlled drugs. Also, staffing shortages in the pharmacy department resulted in reduced support to departments and we found evidence of some unsafe practices in relation to medicines management, including out-of-date medicines or medicines belonging to discharged patients not segregated from current medicines. Not all medicines were stored securely or at the correct temperature, to ensure they were safe for use. Staff had not kept all temperature logbooks up-to-date.
- In the operating departments, the anaesthetic logbooks were not complete, to provide assurance staff had completed the daily safety checks and equipment was fit for purpose, prior to patients having surgery. On some of the wards, staff had not completed the daily checks on the resuscitation equipment in line with the trust policy, to ensure it was ready for use in an emergency.
- We found equipment and surgical supplies were not always stored securely to prevent them being removed or tampered with.
- Theatre staff did not always collect a new set of scrubs to change into when returning to the operating department from another area in the hospital, in line with the trust's uniform policy and as good infection control practice.
- We found staff had not completed patients' records in full, including the signing of prescription charts.
- Not all staff were up-to-date with their level 2 safeguarding children and vulnerable adults training.

However:

- The trust had made significant improvements to the culture when staff reported incidents. Staff felt confident and able to report incidents. The trust recognised the

importance of learning from incidents to improve the care provided to patients. Staff demonstrated a good understanding of duty of candour and gave examples where they had used this to support patients.

- All clinical areas were visibly clean and staff had access to sufficient equipment to provide safe care and treatment. Staff in general adhered to infection prevention and control practice on the wards and in theatres. Patient's safety and daily staffing information was prominently displayed for patients, staff and visitors to read, as part of the trust's open and honest approach.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns. Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate.
- Overall, staffing levels met the planned levels for theatre, nursing and medical staffing. The trust achieved this using bank and agency staff for some shifts, particularly in the operating departments. Managers followed the trust escalation procedures when they identified staffing shortages for their department.

Incidents

- Staff knew how to and felt confident to report any incidents which occurred. They used an electronic reporting system and told us they normally received feedback. The divisional leads monitored on a monthly basis the total number of incidents reported, looked for trends and reviewed the time for managers to sign off that they had investigated incidents allocated to them.
- All staff we spoke with told us there had been a significant change in the culture around reporting of incidents compared to our previous inspection in 2014, this was particularly evident in the operating theatre departments. Staff told us incidents were seen as an opportunity to learn and improve practice. The trust recognised the importance of everyone being open and honest. A staff member told us 'the environment and culture felt better'.
- Nursing staff on the wards told us managers shared learning from incidents at daily meetings, through their ward communication book and discussed incidents at team meetings. We reviewed three sets of team minutes and found none of them contained notes about recent incidents. In the operating department, fortnightly quality and safety meetings were held, with a delayed start to the operating lists to enable all staff to attend. The meetings covered learning from incidents, notes were taken and shared with staff unable to attend. The senior team hard worked hard to make positive changes to the reporting culture within the department. The anaesthetic team had introduced a pre-prescribed saline flush as a change to practice following an incident.
- From July 2015 to June 2016, staff in the division of surgery and critical care reported 1091 clinical incidents, the majority were graded no or low harm (1044). Fourteen of the incidents were considered serious incidents. Four of the serious incidents related to treatment delays and there were no particular themes for the remaining 10. Three of the serious incidents were never events, two had occurred in ophthalmology theatres and one in the day surgery theatre. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The trust had competed a root cause analysis for each never event, debrief held with staff and learning shared locally and across other sites run by the trust, with an agreed action plan in place. The root causes were human error, staff not adhering to trust policy and poor communication. The departments planned to audit compliance in six months time.
- The operating theatre departments introduced excellence reporting in July 2016. Staff were encouraged to report excellent practice, to enable positive learning to be shared between teams and improve the quality of care provided to patients, rather than only learning from mistakes. Staff who reported were recognised by the central governance team.
- Medical staff included mortality and morbidity, to discuss unexpected deaths or adverse incidents affecting patients and learning from these events as part of their speciality clinical governance meetings and audit days. Minutes were shared with staff unable to attend. Learning from significant events was shared across specialties and with the divisional managers where relevant.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support. Staff gave examples of where they had recently applied duty of candour and learning because of an incident.

Safety thermometer

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

Cleanliness, infection control and hygiene

- All clinical areas we visited in theatres and on the ward were clean and tidy. We observed staff following good infection control practices, to minimise the risk and spread of infection to patients such as cleaning their hands before and after patient contact and ensuring they were 'bare below elbows'. Staff also had access to personal protective equipment (PPE) such as gloves and aprons, which we observed them using appropriately. There were hand sanitiser points around the hospital for visitors to use, to reduce the spread of infection to patients.
- There was an infection prevention and control (IPC) lead for the trust and most departments had a staff member who was the lead for IPC. They promoted good IPC practice and helped to complete IPC audits. We saw wards included the outcome from hand hygiene audits on their public information boards and the number of days since they had any cases of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile. The trust IPC team produced monthly division reports which included results for each ward and department. The team audited a different IPC area each month, in addition to hand hygiene audits, such as use of PPE and safe use of sharps.
- Results from the most recent hand hygiene audit in August 2016, showed overall 98% compliance for the division, the target for compliance was 95%. Results were also recorded for each surgical ward and theatres. The division kept a log to show the action taken when staff members were observed not to comply with an element of the hand hygiene observational audit. This enabled the division to monitor and take further action where staff repeatedly did not comply with the trust policy. Staff were required to complete annual IPC training.
- From April 2015 to March 2016, across the division of surgery and critical care, there were no cases of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) and two cases of hospital acquired Methicillin-sensitive Staphylococcus Aureus (MSSA). There were 11 cases of Clostridium difficile and no cases hospital acquired E.Coli. The division monitored the incidence of hospital acquired MRSA and Clostridium difficile as part of the division scorecard, assessing compliance with the agreed local target of 1 case per month of Clostridium difficile and no cases of MRSA. For July 2016, there had been one case of Clostridium difficile and one case of MRSA.
- The trust hospital policy 'Methicillin resistant staphylococcus aureus' (2007), required all patients (elective and emergency) to be screened prior to or on admission other than for specific surgery cases as identified by the Department of Health. Elective patients

with a positive result received treatment prior to the hospital admitting them for surgery. Emergency admitted patients considered at higher risk of having MRSA were cared for in side rooms, to minimise the spread of infection to other patients, until staff knew the swab results.

- The trust submitted data surgical site infection data, for patients having orthopaedic surgery to the Centre for Infection. From April 2015 to March 2016, the incidence of surgical site infections for patients having repair of fracture neck of femur was 0.7%, this was below (better than), the national average of 1.5%. No lapses in care had been identified during the trust investigation into the infections. There had been no infections for patients having hip or knee surgery.
- The decontamination and sterilisation of surgical instruments, took place on-site, meaning equipment was always available for routine surgical procedures.
- Each ward had a schedule of cleaning and checking for items such as bedpan washers, mattresses and furniture. All records we checked were complete. Housekeepers worked hard to keep patient and staff areas clean and tidy. Staff valued having a housekeeper allocated to each ward.
- In the day room on Ward 1, two patient chairs had a split in the fabric meaning staff could not clean them wiped properly. Although, there was a sign advising people not to sit on them, they had not been removed out of the area, to prevent them being used.
- On ward 2, the cleaning cupboard door was closed but not locked, although staff had locked the cleaning products away. However, this did not meet the (COSHH) requirements, which requires all doors to be kept locked. There was a sign on the door reminding staff to keep the door locked.
- We observed some poor IPC practice by staff in the operating department in the day surgery unit theatre and ophthalmology theatre. Staff kept their bags in the anaesthetic room and operating theatres, due to their lockers being in a different theatre suite. This was a potential infection control risk. Theatre staff were seen to return to the operating department in scrubs and not collect a new set to change in to prior to returning to the operating theatre, creating infection control risks. This was also not in keeping with the trust 'Uniform and dress code policy' (2015). We also found intravenous fluids stored on the floor in the storage rooms and the store room in the day surgery unit was untidy with a number of items on the floor, preventing staff from cleaning the floors properly in these areas.

Environment and equipment

- Staff told us there was sufficient equipment for them to care for patients and we saw staff maintained stock levels well for both reusable and single use items. Equipment in general was stored appropriately, with clear labelling in storage rooms. However, staff had not completed daily checks on all the anaesthetic machines in the operating theatres and daily checks of the resuscitation trolley on some wards.
- Staff were not adhering to The Association of Anaesthetists of Great Britain and Ireland safety guidelines: Safe Management of Anaesthetic Related Equipment (2009) as the logbook with each anaesthetic machine had not been completed daily prior to the sessions starting to confirm the equipment was in working order and safe for use. In theatre 2 of main theatres, the last recorded check was 21 March 2016. There were also gaps in the logbooks for the other theatres in this area. This was a potential significant risk to patients if the equipment failed during an operation.
- In main theatres, the storeroom door was open, although there was a sign on it reminding staff to keep the door closed. The combination code was on a label next to the door, meaning anyone visiting the department could access the cupboard, with the potential risk of items being removed or tampered with. In addition, the area in Mandeville Wing for storing the lenses used for ophthalmology surgery was not secure. Again, there was potential for contents to be tampered with, as the lenses and associated paperwork were not locked away.
- On wards 1 and 2, four doors in total were labelled as 'fire door- keep locked', we found them all to be unlocked and three to be open. There was no release mechanism on the doors so the automatically closed. On ward 2, staff told us a different department had previously used the ward and they did not feel they needed to lock the doors. They had not completed any risk assessments to support this practice.

- We reviewed the records for daily and weekly checks of the resuscitation trolleys in the operating departments and on the wards for the week of our inspection and found these were complete, other than for ward 16a/b, which shared a trolley. There were six days in August, when staff had not checked the trolley to ensure it was ready to use in an emergency.
- We checked about 10 items of single use equipment and found all were in date. In addition, we checked five pieces of clinical equipment and all were in date for servicing.
- Staff told us if equipment broke and needed replacing or they needed additional equipment they could obtain this through the central equipment library.
- Theatre staff raised concerns the sterile wraps for theatre instrument kits were sometimes damaged and prevented surgeons using the kit until it was sterilised again. They had reported this as an incident and investigations found kits were being stored on top of each other, with wraps damaged when staff moved the kits. Managers had contacted the manufacturer of the wraps to see if a heavier weight wrap was available.
- Staff told us and we saw there was suitable equipment available for bariatric patients. Staff completed training on using this equipment as part of their manual handling training. Staff completed manual handling training every two years. As of August 2016, division compliance was 88%, against the trust target of 90%. We observed staff in the operating theatre moving patients appropriately to minimise the risk of injury to the patient and staff.
- Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately. Clinical waste bins were clearly labelled and we observed staff kept the rooms used to store clinical waste clean and tidy to minimise infection risk.
- The infrastructure of some of the operating suites was old and the trust recognised there were risks about some aspects such as the electrics. The theatre matron and maintenance team completed monthly safety walkabouts. There was also a lack of storage for equipment, which had to be stored in corridors, making it more likely to be damaged. In the anaesthetic store rooms, some items were overstocked. Staff told us they tended to look at the level of stock, rather than monitoring the use to determine when they needed to order more supplies.

Medicines

- We had significant concerns about the effectiveness of medicines' management systems in the operating departments and on the wards.
- There were 13 whole time equivalent vacancies for the pharmacy service across the trust. This was having a significant impact on the service that pharmacy staff could provide to the wards, operating departments and for patients.
- Staff shortages resulted in the pharmacy team not completing all medicines' reconciliation checks within 24 hours of a patient being admitted to the hospital. This standard is part of National Institute for Health and Care Excellence Guidance (NICE) guideline 5- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. The trust target was for pharmacy staff to start 60% within 24 hours and 80% to be completed, the department achieved 49% and 62% respectively in August 2016. There was an increased risk of patients receiving the incorrect or delays to their normal medicines due to incomplete checks. The department had risk assessed and was trying to ensure the needs of acute patients with complex medical needs were addressed first.
- We found out-of-date British National Formulary (BNF) pharmaceutical reference books on the wards. This was unsafe practice as the advice and recommendations may no longer apply. There was access for staff to the on-line guide via the trust intranet, which contained current information but staff sometimes referred to the book instead.
- In main theatres, staff had not completed the logbooks to confirm they had checked the temperatures of the fridges in the anaesthetic rooms. This was to ensure medicines were stored at the correct temperature, in-line with trust policy. For theatre 1 and 4, the last date in the logbook was May 2016 and for theatre 5, March 2016; there was no assurance staff recognised the

importance of these checks. Medicines stored at the wrong temperature and not according to the manufacturer's specifications could reduce the efficacy of medicines administered to patients.

- On ward 16a/b, staff had not recorded the fridge temperature for eight days during August 2016. On three days, they had recorded the temperature as less than 2°C but had not documented what action they had taken, if any. The fridge contained medicines for patients no longer on the ward and the medicines were not separate from useable stock, to prevent them being inadvertently used. Expired liquid antibiotic had leaked in the fridge and staff had not cleaned this away. We found approximately 20 insulin pens and vials stored in the fridge, some which for patients no longer on the ward. The process for checking of medicines and stock rotation was not effective or being adhered to by staff.
- Additionally on ward 16a/b, staff did not always complete the daily stock checks and sign the received section in the controlled drugs order book, this was not in line with the trust's policy. Staff did not follow the procedure for discarding of controlled drugs. We found controlled drugs belonging to a patient who was discharged from the ward in July 2016, had not been returned to pharmacy.
- Staff were reporting medicine incidents and minutes from the pharmacy governance meetings showed staff discussed outcomes and learning shared. Pharmacy staff also recorded dispensing errors and omitted doses. The divisional leads monitored the number of medicine errors as part of the monthly quality and safety report and whether harm had occurred to the patient. Nursing staff told us they discussed incidents and learning from medicine errors at team meetings but there was no record of this in the three sets of minutes we reviewed.
- Permanent nursing staff told us they completed online training and completed a medicine's competency framework before they could administer medicines unsupervised. Agency staff had to supply evidence of completed training to their employment agency prior to being able to complete shifts at the trust, there were no additional checks completed by the trust to confirm staff were competent to administer medicines.
- Staff kept medicine trolleys locked and secure when not in use. They also stored patients' medicines securely in patient lockers, where these were in use. The nurse had the key to restrict access to the medicines. Cupboards containing medicines were kept locked and the door to the treatment room on ward 16a/b had key pad entry as additional security. We found no out-of-date medicines in the medicine cupboards we checked.
- In general, the eight prescription charts we reviewed were complete. Medical staff recorded allergy information but did not always sign and date this information as stated on the chart. Also, they did not always sign each entry such as for venous thromboembolism (VTE) assessments. The duration and reason for antibiotics was not always completed. The hospital provided pre-printed day surgery prescription charts which listed possible medicines a patient might need; medical staff signed and dated against those relevant for that patient.
- Patients told us nursing staff usually gave them their medicines on time. Staff had given them clear instructions and advice about any medicines they needed to use at home, prior to discharge from the ward. However, nursing staff on the day surgery unit raised concerns there were sometimes delays of up to four hours for patients receiving their medicines that delayed their discharge from the ward. Also due to the pharmacy closing at 5pm, there had been occasions when patients had to return to collect their medicines the next day.
- Medical staff followed the trust's microbiology protocols for the administration of antibiotics.

Records

- Patients' care records were in paper and electronic format. Paper records were stored on the wards in lockable trolleys. Staff did not raise any concerns about the availability of patients' records. The standard of record keeping was inconsistent, as records we reviewed were not all completed in full.
- On all the wards we visited, the records trolley was either kept locked at all times or when unlocked kept by the nurses station or in the treatment room to prevent unauthorised access to patients' records.
- The care records contained pre-operative assessments, risk assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and

medical staff notes and discharge checklists and assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists where relevant.

- We reviewed the care and surgery records for five patients who had undergone surgery. Whilst the notes were legible, none of the records were complete. Errors included no care plan or goals or documentation of how the patient had been involved in this and no record of discharge planning. The sign out for the World Health Organisation (WHO) surgical safety checklist had not been recorded for one patient and the time out on the checklist for another.
- Ward managers told us they completed patients' record audits and discussed the findings at team meetings. Some wards displayed the results from the most recent audit. In general surgery, doctors completed an audit of the quality of the operation notes (July 2015), comparing findings to the audit from April 2015 and compliance with guidelines from the Royal College of Surgeons. They found improved compliance for 14 of the 20 areas reviewed but the majority remained below 100%, including recording the time (20%), responsible consultant (20%), blood loss (30%) and DVT prophylaxis (13%). They planned to re-audit and consider a more specific operation note pro-forma.

Safeguarding

- Safeguarding was part of the statutory training for all staff, the level of training required determined by their clinical role. Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and how to seek support if they needed to.
- Staff in the ward described two occasions when they had needed to raise a safeguarding concern and the process the department had followed.
- Flowcharts of the safeguarding process were on display on the wards and in operating department, including all the relevant local telephone numbers. Staff could access the trust safeguarding policy on the intranet for reference. Not all the staff we spoke with could name the safeguarding leads but knew where to find their contact details if the needed them.
- As of August 2016, 78% of staff in the division of surgery and critical care had completed safeguarding adults (level 1) training and 81% had completed safeguarding children (level 1) training, against the trust target of 90%. For those staff required to complete level 2 adults training compliance was 70% and for level 2 children training 72%. Departments were compliance were low had taken action and the trust told us staff had a due date for completion of the required training.
- All staff had to complete PREVENT (Protecting people at risk of radicalisation) training every three years. The PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who are at greater risk of radicalisation. The Department of Health required trusts to have 90% of staff compliant with this training by 2018, the trust was on track to meet this target.

Mandatory training

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

Assessing and responding to patient risk

- Staff assessed patients for key risks on admissions and continued to monitor these before and after their

surgery. These included risks about mobility, medical history, skin damage and venous thromboembolism (VTE). There were systems and processes in place to support staff to complete these assessments.

- All elective surgery patients had a pre-operative assessment to identify and plan the management of any concerns around their health and wellbeing, including the need for additional tests. Nursing staff also completed assessments to identify those patients at risk of falls, malnutrition and developing a pressure ulcer. Where relevant staff transferred this information to the theatre list to ensure the correct grade of medical staff was present in the operating theatre; this was particularly important for patients with a greater risk of anaesthetic complications. Theatre staff raised concerns some patients did not have all their pre-operative tests completed, such as bloods and X-rays prior to surgery and this caused delays in theatres. They felt this was related to the staffing shortages for the pre-assessment clinics.
- The trust told us the endeavoured to screen all emergency admissions over the age of 75 for dementia as part of the Commissioning for Quality and Innovation (CQUIN) payment. They had plans in place to include the screening tool as part of the surgical care pathway to improve compliance.
- National Institute for Health and Care Excellence (NICE) quality standard 3- Venous thromboembolism in adults: reducing the risk in hospital recommends all patients on admission, receive an assessment of their venous thromboembolism (VTE) risk so appropriate treatment can be given to patients, such as prophylactic medicines. The division achieved the trust target of 95% compliance for April to June 2016. There was no data for January to March 2016, which the trust had recognised as a risk and taken action. One of the five patient records were reviewed did not contain a VTE assessment.
- Staff used the National Early Warning System (NEWS) to monitor patients and identify deterioration in their health. This is a series of observations that produce an overall score. An increase in the score showed a deterioration in a patient's condition. Results from the most recent quarterly surgery and critical care division audit (July 2016) on completion of the chart showed 97% compliance overall but with slightly reduced compliance of 88% on ward 12b, against the trust target of 95%. The division action plan included ensuring all staff had completed the mandatory training module and senior staff completing random observational spot checks.
- If a patient's condition deteriorated, staff followed the trust 'NEWS escalation process' guidelines (2014), which stated the steps staff must take depending on the score recorded. If a patient did not recover as expected after day case surgery, medical staff arranged a transfer to a surgical inpatient ward. On the day surgery unit we saw a poster reminding staff to follow the situation, background, assessment and recommendation (SBAR) technique when monitoring patients who were showing signs of deterioration.
- The majority of staff we spoke told us they had completed sepsis training, could describe the symptoms and the action they needed to take. We saw sepsis information and treatment pathways on display on the wards. Staff used a screening and action tool and trust guidelines were in place for treatment of patients with suspected sepsis. The trust monitored the percentage of patients who had received treatment in line with the NICE guideline 51- Sepsis: recognition, diagnosis and early management.
- Staff completed adult basic life support, immediate or advanced life support training depending on their role. As of September 2016, 93% of staff had completed the adult basic life support training. Staff working in theatres were required to complete immediate life support training.
- Theatre staff followed the World Health Organisation Five Steps to Safer Surgery checklist. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning and end of each theatre list and the WHO surgical safety checklist, which included sign in, time out and sign out. We observed three operations and for all each stage was completed, with good engagement from all staff. For one procedure, the sign in checklist was completed but there was no written documentation completed at the time, either in the patient's notes or on the electronic record. Staff completed these both later on.

- Theatre staff told us and we observed that additional time was taken up completing the WHO surgical safety checklist in the patient's record and on the electronic record. The trust had not yet transferred to complete electronic patient's records. Staff were concerned of making errors when they uploaded the information. This trust used this data for audit purposes. Results from the most recent patient records review and observational audit for May 2016 showed compliance of 95% or above for all the different stages of the WHO Five Steps to Safer Surgery. An action plan was in place to address areas of non-compliance, with a repeat audit planned for November 2016.
- There were adapted version of the WHO surgical safety checklist in use in ophthalmology and urology, in keeping with best practice guidance.

Nursing and theatre staffing

- Staff working on the surgical wards and in the operating department told us and we saw from rotas that in general shifts were staffed appropriately based on the number of patients and the needs of these patients. An electronic staffing tool was used that highlighted were shifts did not meet the minimum staffing for the ward, so managers could address this.
- Ward and theatre managers described the escalation process if the staffing levels for their area dropped below the minimum safe staffing. They told us senior staff were responsive and where possible reallocated staff to another ward or tried to recruit bank and agency staff at short notice. The electronic rostering system highlighted when shifts were below the minimum level, with managers recording any mitigating actions they had taken. The trust also held daily bed occupancy meetings to monitor staffing levels due to changes to the needs or number of patients.
- All wards we visited, displayed their planned and actual registered nurses and health care assistants for the day, for patients and visitors to refer to. Patients told us although staff were busy, the care they received felt safe, however, two patient described how ward 16b was busy and chaotic. The trust also reported their actual nurse staffing hours against planned nurse staffing hours on their website, however, they had not updated this information since March 2016.
- We reviewed the rotas for wards 1, 2, 16a and 16b; for the week prior to our unannounced inspection. Where the hospital had not been able to fill shifts using permanent, bank or agency staff to meet the planned minimum level, the shifts went out to agency again. The hospital had used 31% agency staff to fill the shifts on the surgical floor which included wards 16a and 16b and 20% agency staff for vacant shifts on wards 1 and 2, during August 2016. The division considered these departments as 'hotspot' areas and monitored staffing closely. Staff told us ward 16b was often short of staff, with nursing staff being moved from other surgical wards. This resulted in them having less time to complete observations particularly at night.
- On one ward, we saw an extra health care assistant added to the ward numbers, so a patient living with dementia could receive one to one care.
- We reviewed the staffing rotas for the operating theatres for the week of our unannounced inspection and all theatres were staffed in line with the trust standard operating procedure 'Safe staffing in theatres' (2015). This SOP followed the staffing guidance from the Association for Perioperative Practice (AfPP).
- There remained a high use of bank and agency nursing staff and operating department practitioners in the operating department due to staff vacancies, with 46% of nursing shifts filled by agency staff in August 2016. The division considered this department a 'hotspot' area and monitored staffing closely. There was a 21% nurse vacancy rate at the time of our inspection, with some staff recently recruited and due to start in the next four months.
- The theatre matron allocated shifts 10 weeks in advance but had to review the rotas at six, four and two weeks after they had attended the theatre scheduling meetings, to accommodate changes to planned theatre sessions.
- Consultants raised concerns about the shortage of pre-assessment nurses and the backlog of surgical patients needing a pre-assessment. The trust estimated there to be a backlog of 600 patients and already had taken some action to reduce this, including offering linked outpatient and pre-assessment appointments and more anaesthetist led pre-assessment clinics for patients with complex conditions.

Surgery

Surgical staffing

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

Major incident awareness and training

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

Are surgery services effective?

Good

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

We rated this service as good for effective because:

- Staff planned and delivered people's care and treatment in line with current evidence based guidance, standards and best practice. There was good monitoring of compliance with these standards at departmental and division level.
- Across the surgery service, departments monitored patient outcome data at a local level and submitted data to national audits to enable benchmarking to similar services. Results from these audits showed patient outcomes were in keeping with the national average. Staff used outcome data to identify ways to improve patient care and treatment.
- Patients told us they had made an informed decision to give consent for surgery. They could access pain-relieving medicine as needed during their stay in hospital.

- The hospital had systems in place to ensure they provided care for inpatients seven days a week, including access to on-call theatre and diagnostic imaging staff in an emergency. Planned operations were performed mainly during the week.
- Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs. Staff in general could access the information they needed to provide care for patients once they were admitted to hospital.
- The trust supported staff to become competent in their roles and provided specific training programmes. Staff told us they had received a recent appraisal and felt able to progress in the career, although some theatre staff felt there were limited opportunities for development.

However:

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

Evidence-based care and treatment

- Staff working across the surgery service told us and the trust provided evidence to show how they used national guidance (for example, from the National Institute for Health and Care Excellence (NICE)) and from relevant professional bodies for the care and treatment they provided for patients.
- Services had written local policies to reflect this guidance and some departmental meetings covered changes to national guidance and the need for policy amendments. The division had a robust audit programme in place, with submission to a number of national benchmarking audits, so service delivery leads could monitor the quality of their service. Also, audits were completed to monitor compliance with NICE guidance. The trust sent a monthly email to key lead staff to make them aware of NICE guidance released each month.
- The trauma and orthopaedic service published an audit in May 2016, auditing compliance with NICE Clinical guidelines (CG3)- Pre-operative tests for elective surgery. Results showed some patients were having additional investigations prior to surgery compared with the guidance. There was an impact on patient's time, costs and stress for patients. The service planned to liaise with the anaesthetic team to confirm which tests were required and produce additional guidance for staff.
- The division had reviewed and reported in August 2016 about compliance with key sepsis screening and treatment targets in line with NICE guidance. They had identified areas of reduced compliance and action plans put in place to ensure patients received treatment within the recommended treatment time.
- Theatre staff followed NICE guidance Quality Standard 49- Surgical site infection. This included steps to follow to minimise the risk of infection during surgery. The team has also re-audited compliance with NICE Clinical Guidelines (CG65)- Hypothermia- prevention and management in adults having surgery. The results found improved compliance with monitoring and maintaining of core body temperature but would continue to improve staff knowledge and understanding of the importance of maintaining normal body temperature at all stages of the surgery process. The department would keep a record of any patients who did experience hypothermia and the reasons for this.
- The trust monitored for any new or updated technology appraisals from NICE. These are recommendations from NICE on the use of new and existing medicines and treatments within the NHS. The action log included whether staff needed to update local clinical guidelines in response to the update. The trust held joint monthly meetings with the local clinical commissioning groups (CCG) to discuss these guidelines and other areas of concerns relating to safe, cost effective prescribing in the local area.
- To improve patient outcomes for patients having elective orthopaedics surgery, staff followed evidence based enhanced recovery pathways. Staff prepared patients for surgery and provided a structured post-operative recovery plan, including pain relief and early mobilisation. This involved physiotherapists and occupational therapists where appropriate, to help patients with recovery and discharge arrangements.

Surgery

Pain relief

- Nursing staff assessed patients' level of pain using a numerical scale and recorded this on the patients' New Early Warning Score (NEWS) chart. Records we reviewed showed staff had acted appropriately to the score recorded, with pain reliving medicine given to patients.
- A staff member told us they used specific tools such as the faces visual pain scale pictures, either for patients unable to verbalise their level of pain, due to the effects of the anaesthetic or for patients with communication difficulties.
- We observed a handover between the anaesthetist to the recovery team, this included information around ongoing pain management for the patient, to ensure they remained comfortable.
- Patients and staff could access specialist advice from the pain management team. The team supported patients with acute and chronic pain and provided a daily weekday service to the wards and an on-call system out of hours.
- Patients told us they received adequate pain relief and staff responded quickly when they were in pain. One patient told us 'staff made sure I was pain free'.

Nutrition and hydration

- Nursing staff advised patients abut fasting times prior to surgery at pre-assessment. They also completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments during their pre-assessment and staff repeated this when they admitted the patient to hospital. The MUST was used to identify patients at risk of malnutrition. Staff could contact a dietician for additional advice if needed.
- Patients' specific dietary needs were also recorded at pre-assessment, so the catering team could be informed and provide suitable food for the patient during their stay.
- Staff monitored patients for post-operative nausea and vomiting. Staff gave anti-sickness medicine to patients as needed, which medical staff had written up prior to surgery.
- Patients had access to drinks by their bedside. Nursing staff checked that patients had regular drinks and where relevant monitored and recorded their fluid balance levels.

Patient outcomes

- Surgical specialities collected service specific data on patient outcomes and submitted this to a number of national audits to enable them to compare and benchmark patient outcomes against those achieved nationally. There was also a robust divisional audit programme in place for local monitoring of patient outcomes. Staff presented the results at speciality clinical governance meetings, to enable discussion and changes to practise.
- The trust participated in the National bowel cancer audit (2015), with results showing the trust was within the expected range when compared to other hospitals.
- For the National oesophago-gastric cancer audit (2015), the trust performed above (better than) the national average for two indicators and within the expected range for the remaining two indicators.
- Results from the Vascular audit (2015) showed variable performance; one indicator was above the expected range, two were within and two below.
- For the National hip fracture audit (2015), the hospital were within the expected range for all but one indicator, the case ascertainment, which was worse than the national average.
- Results from the National emergency laparotomy organisational audit (2014), showed the hospital provided the correct facilities to perform emergency laparotomy for 16 of the 28 measures reported on. For the National emergency laparotomy organisational audit (2015), the hospital treated more than 50% of patients in line with seven out of 10 of the recommended standards.
- Patient Reported Outcomes Measures (PROMs) are a national tool used to measure health gain in patients following hip replacement, knee replacement, varicose vein and groin hernia surgery in England. The measures are reflective of patients' responses to questionnaires before and after surgery. Data for April 2014 to March 2015, showed the trust had similar PROMs to the England average for groin, hip and knee surgery, with better PROMS for patient having varicose vein surgery, compared to the England average.
- The overall standardised relative risk of readmission at the hospital was slightly above the England average for elective and non-elective admissions other than for plastic surgery and elective general surgery. This figure considers the actual number of readmissions against the expected number.
- The average length of stay for elective patients at Stoke Mandeville Hospital was 2.6 days, better than national average of 3.3 days (March 2015 to February 2016). The

length of stay for elective trauma and orthopaedic, ophthalmology and plastic surgery patients was similar to the national average. On average, non-elective patients stayed at the hospital for 3.7 days, significantly better than the national average of 5.1 days, however, trauma and orthopaedic patients stayed significantly longer, 10 days compared with the national average of 8.7 days. However, the average length of stay for general surgery and plastic surgery emergency patients was better than the national average.

- At the time of out inspection, the surgery service had not achieved Anaesthesia Clinical Services Accreditation (ACSA) but planned to work towards this as part of the theatre improvement programme.

Competent staff

- Staff told us they had received a recent annual appraisal and the majority felt supported to complete additional training to enable them to develop in their role.
- Data provide by the trust showed as of August 2016, compliance with appraisals for medical staff in the division of surgery and critical care was 81% and for non-medical staff 90%, against the trust target of 90%.
- Most staff commented positively about the access to training opportunities for continuing professional development. Some healthcare assistants told us the trust had financially supported them to complete a National Vocational Qualification (NVQ) as part of the 'Itchy feet' programme to encourage staff to stay and develop their role. However, nursing staff in theatres felt there was limited career development for staff of grade Band 5 or below. They also told us they felt there was greater difficulty in accessing courses compared to their colleagues working on the surgical wards.
- Staff did not receive formal clinical supervision, however, staff told us their managers did observe them when working and issues around performance were discussed with them. We saw evidence in meeting minutes showing the trust had taken action when staff performance was not as expected or in line with trust's policy.
- Theatre staff attended monthly training meetings, which covered mandatory training, equipment updates and audit outcomes. From July 2016, theatre staff from Wycombe hospital provided cover for some of the emergency lists to allow staff from this hospital to attend the sessions. Staff had and continued to raise concerns that the amount of emergency operations performed at the hospital made it harder for them to attend training sessions as they were sometimes needed at short notice to cover a list. At Wycombe hospital most surgery was elective and lists could be cancelled in advance.
- Staff on the day surgery unit sometimes had to care for medical patients. They did not always feel competent to do this and felt they did not receive sufficient support from staff working on the medical wards.
- We saw completed records showing permanent staff undertook competency tests, relevant to their area of work, to ensure they had the necessary skills to carry out their role. Staff who worked as 'link nurses' such as for pressure ulcers or dementia, told us they did feel they always had sufficient additional knowledge to be able to confidently support their colleagues.
- Students completed placements on some of the surgical wards. Staff who were mentors told us they completed an annual update to their training, which was a requirement of the universities sending students on placement. There were separate information boards for students, advising them of relevant trust policies, useful contacts and the learning opportunities and expectations for the ward they were working on.
- In the General Medical Council National Training Scheme Survey 2016, the trainee doctors rated their overall satisfaction with training as similar to other trusts. Trainee doctors told us they felt supported and enjoyed working at the trust.
- Patients could review and compare the clinical outcomes for surgeons working at the trust via a link from the trust website to the My NHS website.

Multidisciplinary working

- Throughout the inspection, our observations of practice, review of records and discussions with staff confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment.
- There was clear communication between staff from different teams, such as theatre staff to ward staff and between the ward staff and physiotherapists. We observed safe and effective handovers of care, between the ward, theatre and recovery staff. There was good communication between all members of the theatre team when they mad a change to the order of patients on the operating list.

- Daily ward round took place seven days a week on the surgical inpatient wards. Medical and nursing staff were involved in these, together with staff from other specialities as needed. The trauma and orthopaedics wards had a dedicated physiotherapist and occupational therapist providing specialist care and treatment for these patients as part of their enhanced recovery programme.
- Nursing, theatre staff and junior medical staff told us it was easy to contact a consultant if they needed advice. The consultant had overall responsibility for a patient's care.
- If a patient needed to be transferred to another hospital, medical staff were responsible for liaising with the hospital and arranging for the transfer, after discussion with the patient's consultant.
- Staff were aware of who to contact if they needed to arrange an urgent review for a patient with sepsis. The trust monitored compliance with all aspects of the sepsis pathway.
- When the hospital discharged a patient, they sent a letter to the patient's GP.
- Nursing staff on the ward told us there were sometimes delays to patients being discharged as their to take out (TTOs) medicines were not always ready and they had to chase this with the pharmacy department. Dispensing audits showed the pharmacy department had not met the trust key performance indicators (KPIs) of 95% of TTOs dispensed within 90 minutes, for April to August 2016, which supports the comments from staff. Compliance ranged from 69% to 81%.

Seven-day services

- The trust was working towards being compliant with all four of the key priority clinical standards of the NHS services, seven days a week framework, which ensured high quality care for patients every day of the week. The trust had participated in the NHS national sustainable improvement survey in April 2016 and devised an action plan in response to the findings from the survey, where they were fully compliant for two standards (Access to diagnostics and consultant directed interventions) and partially compliant for two (Time to first consultant review and on-going intervention). The action plan included review of consultant job plans and ensuring staff provided information to patients and families of the diagnosis and treatment plan, within 48 hours of admission.
- All specialities had a consultant on-site seven days a week, normally 8am-6pm during the week and varying daytime hours at weekends. Services held daily ward rounds for all patients and had daily handover meetings to discuss new admissions or complex patients. There were rotas in place to provide medical cover to the wards out of hours and at weekends. A specialist registrar was always on duty to support more junior medical staff.
- A 'hospital at night' team was used to co-ordinate care provided by medical staff as they changed shifts, discuss any patients of concern and make staff aware of bed capacity issues.
- We saw the on-call rotas for the operating department, theatre staff and anaesthetic staff were available if there were any unplanned returns to theatre or emergency admissions. There were two emergency teams on-site and an additional team on-call, which could attend, if there was the need to run three emergency theatres.
- The pharmacy department ran an on-call rota so staff could access clinical pharmacy advice seven days a week, at any time.
- The radiology department provided an on-call service outside of normal working hours and at weekends so patients had access to key diagnostic tests such as X-ray and computerised tomography (CT) scans.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends. However, nursing staff on the day surgery ward told us the physiotherapists had sometimes gone home, if patients returned late from theatre. They gave patients an information leaflet and the physiotherapist called them the next day.

Access to information

- Nursing, theatre and medical staff raised some concerns around access to patient records; however, they told us these were normally available when they admitted a patient for surgery. Bank and agency staff had access to all patients' records to enable them to care for patients effectively.
- Staff raised concerns that patients arrived on the wards from A&E or their GP had referred them and they did not bring any paperwork with them. Staff had to spend time chasing this information and the reason for admission.
- Theatre and ward staff commented there were errors on the operating lists, which resulted in issues such as patients arriving at the wrong time affecting the flow of

patients between the ward and operating departments. This disrupted bed management plans on the wards. Staff had reported these incidents and the division recognised this as a key risk. The administration and theatre teams were reviewing the standard operating procedure for in-patient bookings.

- A member of staff told us there were sometimes delays in medical staff reporting on the findings of X-rays or scans. This caused delays in patients starting their treatment post-surgery and had the potential to impact on their rehabilitation and planned discharge date.
- Nursing staff told us when transferring patients between wards or teams, staff received a handover of the patient's medical condition and on-going care information was shared. We observed informative and effective handovers between theatre and recovery staff. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.
- A discharge letter was sent to the patients' GP, staff placed a copy of this in the patients' file for reference. The letter contained information on the operation performed and any support or medicines needed post-surgery so the patients' GP was aware.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the importance of seeking consent for procedures but could not describe with confidence the use of mental capacity assessments, where there was a risk a patient did not have the capacity to consent, in accordance with the Mental Capacity Act (2005). Staff understanding of the use of deprivation of liberty safeguards was limited which may impact on patients' care.
- Staff completed Mental Capacity Act training on induction but were not required to renew this. In addition, all staff completed Deprivation of Liberty Safeguards awareness training every three years. As of September 2016, 88% of staff had completed Mental Capacity Act training and 79% of staff had Deprivation of Liberty Safeguards training, against the trust target of 90%.
- Senior staff told us ward staff did not always monitor Deprivation of Liberty Safeguards applications that staff had made for patients on their ward. This could result in staff unlawfully depriving patients of their liberty without the appropriate safeguards in place. Senior staff were working with the county council to improve access to the Deprivation of Liberty Safeguards application system. Also, the trust planned to introduce from October 2016, a new patient care record, which included an assessment of capacity for all patients. They recognised the need for additional training to ensure staff felt confident to complete the assessment and take action to safeguard patients.
- However, on one ward, a member of staff did describe how they had used the Deprivation of Liberty Safeguards process for a patient where they had concerns and who needed one to one support.
- Patients told us they had been able to make an informed decision about surgery, before signing the consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The five consent forms we checked confirmed this.
- If a patient was admitted for emergency surgery and did not have the capacity to give consent, then medical staff made a decision to proceed with surgery, if it was in the patient's best interest.
- The results from the last trust informed consent audit, (November 2015), showed variable compliance for the areas reviewed in the patient care record and consent forms. The trust recognised the significance of the concerns, actions included a new 'consent' committee, making staff aware of the expected standards for consent forms, and the trust planned to re-audit in November 2016.

Are surgery services caring?

Good

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

We rated this service as good for caring because:

- Patients and their relatives spoke highly about the caring attitude of staff, their kindness and compassion. Staff treated patients with respect and dignity, and in general maintained patient privacy and confidentiality.
- Staff respected patients' personal, cultural, social and religious needs. Staff involved patients and those close

to them, with decisions about their care and treatment. Patients told us they felt involved in their care, understood their care plan and were able to make informed decisions about their care and treatment.

- Staff gave patients appropriate support and information to cope emotionally with their care and treatment.

However:

- Patient names were displayed in areas accessible to other patients and visitors.

Compassionate care

- The majority of patients we spoke with were pleased with the quality of care and treatment they had received. Patients told us that staff had made them feel comfortable and relaxed prior to surgery. Patient comments included "the staff could not do enough for you" and "the hospital and staff are excellent". Staff on the surgical wards told us they sometimes felt frustrated as low staffing numbers prevented them from spending sufficient time speaking with patients.
- Staff providing care to patients introduced themselves and explained their role and how they would be involved in the patients' care.
- The surgical wards, day surgery and assessment unit collected results of the Friends and Family Test (FFT) and displayed these for patients and relatives to view. The FFT asks patients how likely they would be to recommend the hospital to their friends and family based on their experience. The FFT results for the surgical service for July 2016, showed some variation against the 95% national average. For example, on ward 2, 91% of patients would recommend the hospital to their friends and family, compared with 70% of patients admitted to Ward 16A. The response rate for the surgical wards at the hospital ranged from 4% to 57%, against the national average of 25%.
- We observed staff providing compassionate care to patients. Staff spoke with patients, in a kind and respectful manner. We saw staff treated patients as individuals, staff understood and considered patients' personal, cultural, social and religious needs.
- We saw staff closing the curtain around patients' beds during ward rounds to offer some privacy for discussions and screens were used in the recovery area and discharge area to maintain dignity.
- In the eye surgery day unit, the hospital had created space for an additional waiting area to enable family or carers to stay with the patient to offer support.
- On the wards, staff used whiteboards to display patient information, including patient names. There were no screens on the whiteboard to cover patient identifiable information, other than on ward 16b. On ward 1, patient names were in full, with symbols placed by their name to show their care needs. The hospital did not gain written consent from the patient to display this information. However, staff on the surgical assessment unit told us patients found it reassuring their name was on the board and they were expected. No patients had asked staff to remove their name.
- Thank you cards were on display on most of the surgical wards. Some of the cards included patient contact details and were visible to all ward visitors. Staff could not confirm if the patient had given consent for the hospital to display the identifiable information.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. In 2016, the hospital's PLACE score for privacy, dignity and well-being was 73.2%. This was lower than the national average of 84.2%. The trust scored similar to other trusts in the 2015 CQC inpatient survey for all key areas relating to care and dignity.
- The discharge and admission areas, in the day surgery units were mixed sex. No patients had complained but we had concerns relating to patient's privacy, particularly for gynaecology patients as there were no curtains provided between the admissions chairs. Staff told us patients could wait in one of the consulting rooms, if the admission area was not suitable. In the discharge room, curtains were used to maintain patients' privacy and dignity.

Understanding and involvement of patients and those close to them

- Staff gave patients the opportunity to ask questions about their care and treatment. We observed staff involving patients, and those close to them, with the decisions about their care and treatment.
- Patients told us all staff had given clear explanations and in sufficient detail to inform them about each stage of their care and treatment, from initial consultation

through to discharge. One patient told us they had been actively involved in all stages of their care and treatment plan and felt the explanations staff gave were very comprehensive. Staff gave patients information leaflets to support the discussions that had taken place.

- Patients described feeling involved in decisions about their care and one patient said they felt "empowered". However, in the surgical assessment unit, two patients commented on the lack of communication from staff, whilst they waited for a decision about the next stage of their care.

Emotional support

- We saw staff providing reassurance and support for patients who were anxious, understanding the emotional impact of surgery.
- Staff supported patients to keep their independence and maintain contact with family and friends. On the eye surgery day unit, there was a phone patients could use to update their relatives or carers once they had their operation.
- Patients spoke positively about the emotional support that staff provided. Patient comments included "staff answered all my questions and put me at ease".
- The trust multi-faith chaplaincy service was on call 24 hours a day to provide spiritual and emotional support for patients and their relatives. The chaplaincy team had links with other local faith leaders if needed.
- Specialist nurses provided emotional and practical support for patients with specific conditions, such as cancer.

Are surgery services responsive?

Requires improvement

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

We rated this service as requires improvement for responsive because:

- The service had a significant backlog of patients requiring pre-operative assessment. The division had not achieved 90% of patients being seen and admitted within 18 weeks of referral.
- Medical outliers were reducing patient flow and restricting bed access.
- Division of surgery and critical care did not achieve the referral to treatment time (RTT) indicator for surgical patients from April to July 2016.

However:

- The trust worked in partnership with local commissioners to plan and deliver services, to meet the needs of local people.
- Patients had timely access to emergency treatment and the trust was taking action to minimise the waiting time for elective surgery.
- Staff took account of the needs of different people, including those with complex needs when planning and delivering services. Staff showed good understanding and made reasonable adjustments to meet patients' individual needs.
- The trust dealt with the majority of complaints within the agreed response time. There was evidence the division leads and frontline staff discussed complaints and used these to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Senior staff worked with the commissioners of local services such as GPs, the local authority, other providers and patient groups to plan and co-ordinate services to meet the needs of local people.
- Stoke Mandeville Hospital was primarily the acute emergency and trauma centre, with inpatient and day surgery facilities. There were 12 theatres across three departments. Theatre utilisation rates for the trust, for April to August 2016, averaged 76%. The division planned to monitor theatres utilisation and report on this monthly, linking with managers to identify ways to improve efficiency and utilisation.
- The trust planned to transfer all eye surgery to Stoke Mandeville Hospital, to maximise efficiency and utilisation of theatres. Staff working in ophthalmology theatres were concerned there was not sufficient capacity to manage all eye surgery at one site.
- The trauma and orthopaedic service had recently split into two wards, one providing acute care for patients and the other rehabilitation. Staff told us the new

system worked well and they felt they provided better care for patients, which met their current needs. Patients told us staff had told them they would transfer to the rehabilitation ward at their pre-assessment appointment.

- The majority of areas within the hospital were accessible for people in a wheelchair, with the exception of the patient consent rooms in the eye day surgery unit. Staff were aware of this and for wheelchair users, the consultant used a portable computer and they saw the patient in a room they could access in their wheelchair. There was limited space in the waiting area in this department for patients in a wheelchair.
- Patients had access to free Wi-Fi. There were plans to build a 'medicinema', which would offer film entertainment for patients, particularly those in hospital for some time. The majority of wards we visited had a day room with a television, however, patients did not have their own television at their bedside. Staff told us that this was due to the high cost of the service and that patients often brought in their own electronic device.
- The layout within the operating departments meant communication boards were visible to patients and visitors. These contained sensitive information that was specific to staff working in these areas. The information was not covered up to prevent the information being read by any visitors to the area.

Access and flow

- The hospital admitted surgical patients through a number of routes, including elective inpatient admission, pre-planned day surgery or from a GP referral. The division monitored the percentage of patients admitted within 18 weeks of referral as part of their monthly surgical quality report. It is expected that 90% of patients are admitted within this timescale. The division overall did not achieve the referral to treatment time (RTT) indicator, for patients on an admitted pathway from April to July 2016, with performance ranging from 58% to 63%.
- Staff carried out a pre-operative assessment for patients undergoing elective surgery. The trust had a significant backlog of patients requiring pre-operative assessment (approximately 600). Staff told us the backlog was due to various reasons including nursing and consultant shortages. A pre-operative assessment work-stream were working to reduce the backlog of patients for pre-assessment. Staff now completed some pre-assessment appointments on the same day as the patients' outpatient appointment so the trust could provide the patient with a date for surgery as soon as possible. The hospital had also introduced filter clinics for orthopaedic patients (in addition to booked pre-operation assessment slots) to improve pre-assessment workflow and facilitate urgent cases. The filter clinics ran between 9am and 6pm during weekdays. The clinics were not suitable for patients with a complex medical history.
- A weekly theatre scheduling meeting was held, with staff attending from all teams involved in managing admissions lists plus staff from theatres to ensure sufficient staff would be available for the planned lists. The teams reviewed the planned lists at six, four and two weeks in advance. We saw lists were amended based on changes to medical staff availability. Spaces in lists were also identified, with administrative staff contacting patients on the waiting list to see if they could attend at short notice.
- The junior doctors' strike although cancelled by the time of inspection had impacted on operation bookings for that week. Theatre lists had been suspended and administrative staff were trying to fill the spaces, this then impacted on the number of staff need in theatres. The hospital had planned appropriately for the strike but there was on impact on theatre utilisation, to prevent delay in patients accessing their surgery.
- Emergency theatres were accessible seven days a week. The trust had a daily trauma operating list. For urgent admissions requiring general or plastic surgery, the trust used a 'consultant of the week' system, where the consultant did not any elective surgery that week, in order to perform emergency treatment. Speciality specific 'hot clinics' were held daily to reduce hospital admissions and support early discharge, by patients being seen within a consultant-led service and a treatment plan agreed.
- Elective surgery operating sessions ran from 8am to 6pm, Monday to Friday.
- In theatres, combined adults and children surgery lists were held. The booking team scheduled children and young people for surgery at the beginning of the day to

reduce the wait for them and to reduce the chance of children and adults being present in the admissions and recovery area at the same time. For eye surgery, the department scheduled children and young people for their operation every other Friday.

- The surgical assessment unit (SAU) had recently started an audit to monitor the time patients spent on the unit waiting for different stages in the assessment process to occur, prior to medical staff making a decision to admit the patient to hospital or discharge them. Results were not available at the time of our inspection. In the SAU waiting area, staff kept the waiting times for the different specialities updated, to keep patients informed on the likely time they would spend on the unit.
- From April to August 2016, the hospital cancelled 169 operations for clinical reasons and 152 operations for non-clinical reasons. As part of the theatre improvement programme, administrative staff called patients three days before admission to remind them of their date for surgery and check patient welfare, with the hope of reducing patient cancellations or patients not attending for surgery. The trust rebooked all cancelled operations within 28 days as per the agreed local target.
- From March to May 2016, bed occupancy on the surgical wards varied from 22% to 100%. It is accepted that at 85% and above, bed occupancy can start to affect the quality of care provided to patients, and the running of the hospital. Wards 1 and 2 had high bed occupancy levels throughout this period (approximately 97%), whereas wards 16a and 16b had low bed occupancy levels (approximately 75% and 66%). Figures were approximate as the data provided by the trust contained some errors.
- Although ward 16a and 16b had low bed occupancy levels, medical outliers were common. Medical outliers are patients who should be cared for on a medical ward but due to bed capacity issues have to be admitted to another ward. For example, in May 2016, staff on ward 16a had on average, five medical outliers to care for each day. Nursing staff reported that they did not feel confident caring for medical outliers and received little support for more complex cases. This may impact on the care and treatment of the medical patients.Senior staff discussed actions to reduce the outliers at the daily operations meeting. Nursing staff ensured patients who were medical outliers had been seen by the medical team.
- Medical outliers in the SAU blocked the flow of patients through the unit. Outliers prevented doctors from admitting surgical patients onto the unit and restricted access to beds. There were beds available on the unit for patients who were too unwell to wait in a chair.
- In an attempt to increase discharge rates and prevent patients staying in hospital longer than necessary, the hospital aimed to discharge 10 patients by 11am each day. From March to May 2016, the hospital did not meet this target once. The main cause of delayed transfer of care residential home availability, accounting for 44.2% of delays.

Meeting people's individual needs

- The majority of staff on the wards demonstrated a good understanding of providing care, support and accommodating patient's individual needs.
- During the patient's pre-assessment, staff recorded information on patients' additional needs. This included information about any translation or interpreter services required, the patient's vision and hearing needs, and any social support needed.
- Patients reported receiving adequate information about their treatment and stay in hospital. Staff gave patients information leaflets about their planned procedure during their pre-assessment appointment or patients could print off patient leaflets from the trust website. Patient information leaflets were in English but contained information on how to request them in another language or format, such as large print. There was also access to an interpreter service.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. The hospital's PLACE score, for the suitability of the environment for people living with dementia, was 54.9% in 2016. This was significantly lower than the national average of 75.3%.
- On admission, the trust should screen all emergency patients aged 75 and above for dementia. From April to June 2016, the trust reported approximately 89% of

patients had been asked the dementia screening question within 72 hours of admission, in line with national targets. However, in for July and August 2016 there had been a significant drop in the number of emergency patients screened for dementia of 79% and 58% respectively. One member of staff on the wards commented that there was 'not enough time to look after dementia patients'.

- In spite of this, we saw evidence the trust was improving their delivery of services to meet the needs of people living with dementia. The trust had a lead dementia nurse who could offer specialist advice to all staff. They had developed a documentation booklet for staff use to improve dementia care. The booklet pilot would begin in October 2016. Eighty eight percent of staff had completed dementia awareness training, nearly achieving the trust target of 90%. Staff used the Abbey scale to measure pain in people living with dementia who could not verbalise their level of pain. On one ward, there was space for a relative or carer to stay to offer support during the patient's stay in hospital.
- People living with dementia have a high risk of experiencing a fall. To mitigate this, there were designated priority beds for patients with complex needs, so staff could observe them from the nursing station. In addition, the trust was considering a separate ward/area for patients who had complex or behaviour that may challenge.
- Staff on the surgical wards and theatres had lead link roles, which meant they normally received extra training on an aspect of patient's care and acted as a resource for other staff. Staff link roles included manual handling, nutrition, diabetes and dementia care.
- The trust had two learning disability liaison nurses who were available to help both people with a learning disability and their carers during their time in hospital. The surgical department would contact the liaison nurses for advice and support when admitting people with a learning disability. The hospital's PLACE score, for the suitability of the environment for people with a learning disability was significantly lower than the national average (66.3% compared to 78.8%). As a result, the Chief Nurse proposed designating a PLACE link in the surgical division to manage outstanding actions identified in the assessments.
- Any patients with a body mass index (BMI) of 30 or above were flagged on the hospital's electronic system, allowing the ward to prepare for the patient's admission. Staff told us equipment was available from central store within four hours.
- In the 2016 PLACE assessments, the hospital scored 91.1% for ward food, slightly above the national average of 88.2%. During our inspection, patients we spoke with praised the quality of the food and were impressed with the choices and quantity available. The service provided alternative menu options when patients had special dietary requirements, for religious or cultural reasons
- Staff recognised people's religious and cultural differences. For example, staff knew the process to follows should a Jehovah's witness require a blood transfusion.

Learning from complaints and concerns

- The hospital had a 'Responding to concerns, complaints and compliments' policy (2012), which provided staff with a clear process to investigate, report and learn from complaints. At the time of our inspection, the trust was conducting a review of the complaints policy, to develop the policy further with staff engagement and feedback.
- Staff recognised that early resolution of patients' concerns prevented the concern from escalating into a formal complaint. When a concern was first raised, it was highlighted to a senior nurse. If the senior nurse was unable to deal with the concern directly, they would direct the patient to the Patient Advice and Liaison Service (PALS) to formalise the complaint.
- From May to August 2016, the trust received 77 formal complaints concerning surgery, of which 59 related to Stoke Mandeville Hospital. The Chief Executive had overall accountability for formal complaints. The Medical Director and Chief Nurse and Director of Patient Care Standards had responsibility for ensuring complaints were processed and responded to in a timely fashion, and discussed across the trust. They also ensured the surgery service took action because of a complaint to improve the quality of care. An investigating officer was assigned complete a full investigation of any formal complaints.
- According to the trust's complaints policy, complainants should receive a to their complaint within 25 working days (In July 2016, the trust contacted 82% of

complainants with a completed written response within 25 days. Although slightly below the trust target of 85%, this result was a significant improvement from the previous month (62%).

- There were procedures for sharing and learning from complaints across the hospital. Complaint themes were discussed at a senior level at the surgical division meetings and highlighted in the monthly quality report. However, we found limited evidence that complaints were discussed at ward or theatre meetings due to these meetings not always being minuted. Staff told us they did though discuss learning from complaints. In July 2016, surgical complaint themes included delays, cancellations and hospital communication with a patient/relative or friend.
- We saw evidence that departments acted upon patient feedback. For example, one ward had reviewed their procedure should patients choose to self-discharge, to ensure the patients were fully aware of the risks. Staff said they were proud of patient's feedback and we saw examples of positive feedback displayed on the wards.
- Information for patients on how to leave feedback or make a compliant was provided throughout the hospital. We saw a feedback boxes in use on the wards. Patients told us they would speak to a member of staff if they had any concerns. All of the patients we spoke with said they had no reason to complain, as their care had been good.

Are surgery services well-led?

Good

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

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

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

However:

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

Leadership of service

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

inspection, there had been a recent change to the director and an interim chief nurse was in post. There were service delivery unit leads in place for each clinical speciality.
- Staff spoke positively about their manager and felt able to raise concerns with them. Staff had confidence in the leaders at all levels within the division and felt they were competent to undertake their role.
- The executive team and divisional leads completed observational visits to the wards and theatres, which staff valued. They felt issues they raised were recognised and where possible the trust had taken action. Some clinically trained senior staff completed shifts on the wards, with feedback provided to the team.
- Consultants valued the positive change in the approach of the senior management teams over the last two years. They felt the focus had moved positively towards improving services and outcomes for patients, looking at efficiency and quality. They felt the management, in particular the deputy divisional director, were responsive to suggestions from clinicians, which resulted in improved efficiency for their individual service.
- Not all ward managers were supernumerary. This resulted in less or insufficient time for them to complete the administrative responsibilities of their role.

Vision and strategy for this service

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

Governance, risk management and quality measurement

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

- There was a sepsis lead for the trust. Recent trust wide audits on sepsis management had identified actions that staff needed to take to improve the promptness of treatment. Further audits were planned to monitor compliance.
- Staff working on the wards told us they attended regular team meetings, which provided an opportunity for them to raise concerns and discuss recent incidents, there were no minutes taken at these meetings. There was no formal record of the meeting (other than ward 16a), as a way to track actions that staff had taken and so staff unable to attend the meeting could see what their team had discussed and agreed. There were also no minutes from the matron and ward sister meetings, which took place on a monthly basis. The trust acknowledged this as a concern, told us there would be a standard agenda for the meetings, and provided the minutes from the first meeting.
- We saw good use of clinical audit programmes across the division to monitor quality and systems, with audit leads identifying actions that staff needed to take. The operating departments held quality and safety meetings every two weeks, which included discussing learning from incidents. They provided minutes for staff unable to attend the meeting.
- Theatre managers and the anaesthetists were developing local safety standards for invasive procedures, in response to the National Safety Standards for Invasive Procedures document. This document supports the delivery of safe care to patients having an operation.
- Staff had access to trust policies and standard operating procedures (SOPs). Most that we read were in date, however, there were some that had gone beyond their review date. The 'Correct site surgery' policy and the 'WHO surgical safety checklist' policy were due for review in 2014. Also, the 'Thromboprohylaxis in adults' was due review in 2015. There was a potential risk to staff and patients due to current best practice not being used and followed. Also, staff were not consistently following the trusts medicines policy and procedures, potentially placing patients at risk. Pharmacy staff had completed audits to monitor compliance but there had not been a sustained improvement in performance.

Culture within the service

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

Public engagement

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

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

Staff engagement

- The trust had a number of schemes in place to recognise and acknowledge the contribution made by staff, to seek their feedback and ideas for service development.
- Staff were encouraged to give positive feedback and express thanks to a staff member or team, for example, if they helped achieve a good outcome for a patient in challenging circumstances. This information was shared at division meetings and included in the monthly division quality report.
- The trust also held an annual staff awards ceremony, with patients and staff able to nominate a team or staff member for an award.
- Information was cascaded to staff through newsletters, emails and staff noticeboards. All departments we visited held team meetings for sharing of information and to provide an opportunity for staff to raise concerns. On ward 16a, learning was shared during the twice daily handovers.
- The division introduced in May 2016, a monthly review of a department by the divisional chief nurse, which included speaking with three staff members to seek their views about leadership, safety, environment, clinical effectiveness and experience where they worked. The divisional chief nurse shared the results with the team to enable them to make changes and so positive feedback could be shared.
- Results from the staff friends and family test showed 81% of staff working in the division would recommend the trust for care and treatment and 62% would recommend the trust as a place to work.
- The division results from the 2015 staff survey showed a better response than the trust average for seven of the 32 key questions and a worse response for the remainder, although for some the difference was not statistically significant. A local action plan had been produced for the operating departments, addressing staff concerns including effective team working, support from line managers and improving staff engagement. The action plan included who was leading on each action, date for completion and how the service would monitor the impact.

Innovation, improvement and sustainability

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

End of life care

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

Information about the service

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

This report details the end of life care in both the Stoke Mandeville Hospital and the Florence Nightingale Hospice.

The consultant-led team include palliative care nurses who worked in the hospital. Between March 2015 and February 2016 there were 1128 in-hospital deaths within the trust.

During our inspection we visited the Florence Nightingale Hospice. We also visited seven wards, where end of life care was provided, the bereavement centre, the chapel and the mortuary. We spoke with nine patients, five relatives and 24 staff, including consultants, doctors, students, staff nurses, health care assistants, ward sisters, members of the palliative care team, end of life care nurse specialists, porters, bereavement, chaplaincy, and mortuary staff.

We observed interactions between staff and patients, and their relatives. We looked at 16 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and 26 medical and nursing care records. Before and after our inspection, we reviewed performance information from and about the hospital.

Summary of findings

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

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

End of life care

- We saw that the care plans were not consistently used for end of life care patients during the inspection. The trust wereaware of the concern and had appointed an end of life care facilitator to improve end of life care education for clinical staff and to ensure the care plans wereused correctly.
- Rapid discharge of those patients expressing a wish to die at home did not always happen in a timely way due to external delays with funding and care packages for complex needs.

However

- There were governance processes, including evidence of investigation of incidents and audits and lessons learnt for staff to improve patient care.
- Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was consistently positive. We saw good examples of staff providing care that maintained respect and dignity for individuals. There was good care for the relatives of dying patients, and staff showed sensitivity to their needs.
- The trust had on going engagement with a people panel to ask for opinions and suggestions in what mattered to them regarding developing plans for end of life care. The panel were consulted regarding the trust wide end of life patient care plans called "Getting it right for me".
- Patients' needs were mostly met through the way end of life care was organised and delivered.
- The people panel were consulted on the trust wide end of life care strategy, which was complete but not published at time of inspection. Staff we spoke with was aware of end of life care priorities and described high quality patient care as the key component of the trust's vision.

Are end of life care services safe?

Requires improvement

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

We rated safe as 'requires improvement' because:

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

However,

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

Incidents

End of life care

- Incidents were reported through the trust's electronic reporting system. All clinical staff we spoke with were familiar with the process for reporting incidents near misses and accidents using the trust's electronic reporting system. Mortuary staff and porters stated they were encouraged to report incidents particularly for end of life care patients.
- There were no never events and no serious incidents reported by the palliative care team between June 2015 and May 2016. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, be implemented by all healthcare providers.
- There were 50 incidents relating to end of life care across the trust. All of these incidents were classed as low risk incidents, such as minor skin injury, trip, slip or a fall or missed medicines resulting in no harm to the patient.
- All incidents were reviewed by a senior staff member such as a team lead or ward manager. Staff told us they felt confident to problem solve incidents themselves without their managers wherever appropriate. One staff member told us an end of life confused patient was trying to get up and mobilise, so obtained an extra staff member to sit with the patient and prevent a possible fall.
- Incidents reviewed during our inspection demonstrated investigations had taken place.Action plans were developed to reduce the risk of a similar incident reoccurring. We were given an example of an incident relating to poor communication by a new member of bank staff in the hospice during a weekend night shift. The hospice had carried out a root cause analysis on this incident as this was a rare occurrence and they wanted to learn from it. The change to practice in the hospice meant all new members of staff were assigned to a permanent hospice staff member during the night shift. Another change to practice was all weekend incidents were reported to the on call nurse whose responsibility included phoning the hospice the following day to check on the well-being of staff members. All clinical staff were informed of the incident and corresponding action plan to prevent further incidents in future through ward meetings and in the clinical governance meeting.
- Staff told us they received feedback on the incidents they had reported. Minutes of monthly team meetings confirmed that the themes of incidents were fed back to staff. Learning from incidents and complaints was also shared across the trust via the route of trust's recently introduced monthly bulletin.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust monitored duty of candour through their online incident reporting system.
- Staff could describe the requirement to be open and transparent with patients following a patient safety incident. All five staff members we spoke with understood specific actions to meet the duty of candour requirements such as a letter detailing the incident and actions taken. All five staff knew how to escalate concerns if they thought duty of candour should be triggered. One senior member of staff discussed a duty of candour incident. This incident was regarding a pressure ulcer developing across a patient's bridge of their nose in the intensive care unit from an oxygen mask. An incident form and full investigation was completed. Staff followed the duty of candour policy and steps taken to reduce this occurrence for other patients were discussed at ward and governance meetings by staff.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing harm to patients and 'harm-free' care. Harm includes new pressure ulcers, and falls. The hospice and wards displayed their results to ensure all staff and visitors were aware of how the hospice and wards had performed. The results in the hospice and on two wards showed that there had been no grade 3 or 4 pressure ulcers or serious falls in over 365 days.
- The trust reported 11 pressure ulcers grade 3 or 4 from 1st Dec 2015 to September 1st 2016.This number was lower than the 30 pressure ulcer incidents in 2014/15. Some pressure ulcers in end of life patients were deemed unavoidable, as reflected in the trust's own guidance. This guidance referenced the national 'skin

changes at life's end' (SCALE) wound research document (2009) that explained why patients in the last days of life would often develop pressure ulcers even with the best possible care.

Cleanliness, infection control and hygiene

- During our two previous inspections in 2014 and 2015 we highlighted there was a potential risk of cross infection in the bereavement office. Deceased individuals' property were being kept in open bags in the office. During this inspection two deceased patients' belongings including soiled clothing were being stored in unlocked cupboards in open plastic carrier bags while awaiting collection from relatives. When we returned on the second day we found three patients property stored in open bags, which poses a potential cross infection control risk. Staff told us that the specialist infection control nurse had visited the bereavement offices to advice on best practice and suitable storage had been ordered but had not yet arrived.
- The trolley for transferring deceased patients to the mortuary was stored inside the mortuary. We saw the trolley had a cover that was old, slightly stained and required washing.The legs and underneath side of the trolley had a build-up of dust and debris.The mortuary staff we spoke with were unclear whose responsibility it was to clean it. We highlighted our concerns to the trust on the first day of our inspection.
- The trust employed a team of infection control staff, which included a microbiologist who assessed and monitored levels of hygiene and infection control within the trust and reported on infection rates on a monthly basis within the hospital. Between April 2015 to March 2016 there had been one patient case of Clostridium difficile. The patient had been nursed in a side room to prevent cross contamination to other patients.
- The Florence Nightingale hospice and hospital wards were visibly clean and well maintained. Staff followed the trust bare below the elbow policy and was seen washing their hands and using hand sanitiser appropriately. Staff from the hospice and on the wards ensured their hand hygiene results were displayed for view by patients and visitors. The results displayed during our inspection showed the hospice had scored 99% and the wards 97% in the audit. Thehospital scored 96.97% for cleanliness in the 2016 patient-led assessments of the care environment(PLACE). This was below the national average of 98.06%. Areas for improvement were displayed and this included staff not wearing rings which contained stones as these cannot be cleaned properly.
- Personal protective equipment was available and staff were seen changing gloves and aprons in between patients to prevent the risk of cross infection. We observed equipment was clearly labelled with green 'I am clean stickers' to show equipment had been cleaned and was ready for use.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps on the wards and the hospice.

Environment and equipment

- Syringe pump equipment met the requirements of the Medicines and Healthcare Regulatory Agency (MHRA). There was one type of syringe pump used in the hospital as per national guidance. This prevented the risk of potential confusion with medicine administration. Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medicine because the syringe drivers used were tamperproof and had the recommended alarm features.
- The hospital had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure it continued to be safe for use. Equipment was clearly labelled with the date when the next service was due
- The mortuary had sufficient bariatric equipment (equipment to support the care of obese people).The facilities were clean and well maintained. There was storage space for 44 spaces within the mortuary building' this included sufficient space for three bariatric patients' bodies to be safely stored.
- Ward staff told us they had good access to equipment needed for pressure area care. Pressure relieving mattresses were delivered from the hospital store and were available the same day when required.
- Patients who received end of life care in their own homes were given priority if equipment such as pressure relieving mattresses were required. This equipment was hired and delivered promptly by an external community

equipment provider. Staff told us that they could access equipment promptly. For example, they were able to access same day/urgent delivery of equipment for patients returning home to receive end of life care.

- Emergency mobile resuscitation trollies were available on the wards and in the hospice. Equipment was secured with tamper-evident tags. We saw staff had documented daily checks and tests which ensured equipment was safe for use.
- The trust scored 89.95% for patient-led assessments of the care environment(PLACE) for condition, appearance and maintenance for the hospital 2016. This was below the national average of 93.37%**.** We saw clinical governance minutes which evidenced maintenance improvement programmes for the hospital.

Medicines

- All medicines were supplied by the hospital pharmacist. The chief pharmacist told us that there was a 6.39 whole time equivalent (WTE) clinical pharmacist vacancy and a 3.31 WTE pharmacy technician and 3.33 WTE support worker vacancy. Clinical staff told us end of life care patients were prioritised in this hospital and medicines were dispensed in a timely manner. The trust had agreed to review staffing in the pharmacy department. However, no date had been set for this.
- Medicines were stored safely at the hospice and in the hospital wards.We reviewed the storage and administration of controlled drugs in the hospital and in the hospice. Medicines were stored appropriately and medicine records were accurately completed. The trust guidance on the administration and destroying of unused controlled drugs was followed.
- Emergency medicines were available for use and were checked regularly. We looked at both the ward and hospice clinic room where medicines were stored and found that the medicines fridge temperature was being recorded daily. Any changes in temperature were responded to appropriately.
- We observed medicine rounds on the hospice site and on wards 5 and 9. Staff carried out appropriate checks to ensure medicines were given to the correct patients. Staff wore bright red disposable tabards to indicate they should not be disturbed when administering medicines.
- Prescription charts were present in the handover and we observed these charts amended or added to in response to feedback from members of staff. These ensured patients were given prompt changes to medicine treatment. All members of staff were listened to and included in the treatment plans for each patient.
- The trust had procedures in place to prescribe anticipatory medicines.These are medicines prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness). We reviewed nine medical and nursing case notes of patients identified as being in the last days of life and saw anticipatory medicines were prescribed appropriately.
- The trust had consolidated to one model of syringe pump device, used to administer continuous medicine. There was a policy and protocol for the use of the device in order to reduce the risk of medicine administration error. Staff told us there were sufficient devices for patient usage in the hospital and hospice. We saw lists of clinical staff names in the wards who had attended training and competency assessment to ensure that they were competent to use these devices. Clinical staff told us they were not allowed to use the device unless signed off as competent.
- The pharmacy department did not provide any compliance aids for assisting patients taking medicines for example timed daily medicine boxes. . If a patient required a timed daily medicine boxes box, the pharmacy department liaised with the GP and community pharmacy. However, staff told us that this sometimes delayed discharge.
- The pharmacy department were linked to the Trust governance structure. Representation on drug and therapeutics committee and reducing harm from medicine incidents governance meeting

Records

- We saw medical and nursing notes were stored unlocked near the nurse's station which was situated in the middle of the ward. However, clinical staff continually accessed the notes, the trolley lid was shut and the trolley was not in public view.

End of life care

- We reviewed 26 sets of nursing and medicalnotes for patients who were receiving end of life care in both the hospice and wards and saw they were up to date, legible, dated, timed and signed.
- The palliative care team in the hospital, and end of life care staff in the hospice wrote in patient records. Decision about care and treatment, and discussions with relatives were clearly documented.
- There was a clear recording process in place for the movement of deceased patients through the mortuary from point of arrival until the funeral directors collected the deceased's body.

Safeguarding

- Staff told us that the trust had a dedicated child safeguarding team and a level 3 trained adult safeguarding nurses who provided training, advice and support to all areas across the trust.
- The trust policy described the processes to safeguard vulnerable adults, children and young people.
- Nursing staff we spoke with had a clear understanding of how to identify report and protect patients from potential harm or abuse.
- Safeguarding training was mandatory. All staff from the palliative care, end of life, and ward nursing teams had undertaken safeguarding adult's and safeguarding children at level 2 training

Mandatory training

- The trust's mandatory training programme included moving and handling, infection control and fire prevention.
- The data provided by the trust showed that compliance with mandatory training did not consistently meet the trust target of 90%. For example, attendance at the yearly medicines management awareness was 68.18%. The yearly practical resuscitation training staff attendance was 44.44% and attendance at the yearly fire safety training was 65.00%.Attendance at deprivation of liberty safeguards, duty of candour, emergency planning and dementia awareness exceeded the trust target.
- The clinical governance meeting minutes highlighted the low attendance on mandatory training but did not detail a robust plan of action to improve attendance.The low mandatory training compliance in some areas meant that staff may have lacked essential knowledge and skills to deliver safe care and treatment. Senior managers told us they were aware of this concern and had actioned a plan of improvement in attendance. The action included supporting managers to ensure staff completed mandatory training modules. Staff were sent an email reminder when their training was due and ward managers were also sent information about their staff compliance with mandatory training.

Assessing and responding to patient risk

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

End of life care

Nursing staffing

- The specialist palliative care nurses included three full time and three part time palliative care clinical nurse specialists working across both hospital sites and based within the hospice. The inpatient wards at Stoke Mandeville Hospital had access to a palliative care nurse specialist 24 hours daily. The wards felt that they provided a good support service.
- The team had appointed an end of life care facilitator in August 2015. Staff told us they had made a substantial impact on the ward in terms of advice on caring for end of life patients and helping with discharging patients who expressed a wish to die at home.
- Staffing was planned using a recognised Department of Health patient acuity and dependency tool which had clear guidance on levels of care and inclusion criteria for clinical staff to follow. The tool had been in place for 8 months and was linked to cost and quality indicators. Senior managers told us they could see areas of risk and mobilise additional staff appropriately to reduce risk areas.Clinical staff told us the tool alerted senior staff to higher risk areas which they responded to by moving nurses from ward to ward as needed.
- Nurse and health care assistant staffing levels were displayed on the hospice and in the hospital wards. These were displayed in three categories; planned, actual and safe. During the course of our inspection, actual and safe staffing met the planned levels of staffing to deliver safe care with the exception of one morning shift which was one healthcare assistant below planned.
- Staffing was sufficient to allow for staff to handover thoroughly between shifts. We observed a medical and nursing handover at the hospice. Each member of staff used a typed handover sheet which was updated daily during handover. Time was taken to discuss each patient and their families thoroughly.

Medical staffing

- The Trust employs 1.8 full-time specialist palliative care consultants; two part-time specialty Drs, and Junior Drs training in Palliative Care.This provides evening and week-end cover with on-call access to a Consultant. The Trust has a total of 572 beds including inpatient beds across hospital sites, community hospitals, intensive care unit , and children's services. The trust did not meet nationally recognised commissioning guidance of one whole time consultant for every 250 hospital beds.Service leads told us that a business case for an additional full time consultant was being considered by the trust at the time of our inspection.
- The consultants for specialist palliative care divided their working week between the hospice and the two hospital sites.The consultants covered 24/7 medical support to the hospital team and for health care professionals across all settings. This enabled a link between the two services and provided "joined up care" between the hospice and hospital.

Major incident awareness and training

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

Are end of life care services effective?

Requires improvement

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

We rated effective as "requires improvement' because:

- Care did not consistently take account of evidence based practice and guidance. End of life care plans were not routinely completed for patients nearing the end of their life.
- Staff had an awareness of the responsibilities regarding the Mental Capacity Act (2005) and Deprivation of

Liberty Safeguards (DoLs). However, we saw that patient's capacity was not always formally assessed when decisions were being made on behalf of patients who were deemed to lack capacity.

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

However,

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

Evidence-based care and treatment

- Advance care planning is a process of discussing and/or formally documenting wishes for future care. It enables health and care professionals to understand how patients want to be cared for if they become too ill to make decisions or speak for them. We found good quality information and guidance available for staff in the advance care plan; 'getting it right for me, patient held record', designed by the palliative care team with patient and family involvement and implemented in January 2016. However, we saw that not all clinical staff used the document so staff and families would not be aware of patient's care preferences for before and after death.
- We reviewed 26 patient records and saw nine patient care records of patients recognised to be in the last days or hours of life. The patient's preferred place of care/ death had been recorded in six records. However, three records were using the personalised care plan and the other three were found in the patients care notes.
- We found that care did not consistently take account of legislation, evidence based guidelines and best practice. Following the national withdrawal of the Liverpool Care Pathway in July 2013 the trust had implemented a two stage care pathway for palliative and end of life patients.
- Stage one was an assessment and treatment care pathway of individual care needs and stage two was implemented when the patient was in their last days of life. We reviewed 14 care records for patients considered to be in the last year or days of life.We saw five care records contained partly completed care plans. Nine care records did not contain care plans at all to support staff to deliver end of life care. Senior nurses acknowledged that the care plans were not being consistently used.
- The trust had employed a full time practice educator to implement the document across the trust and improve documentation of palliative care patients and family's needs. The practice educator told us they conducted regular training events and visited ward staff to highlight the need to ensure the care plans were completed effectively.
- Senior managers acknowledged that end of life conversations needed to happen sooner and there was a challenge to support staff to identify end of life care started in the last year of life. The action plan to improve documentation included additional staff training. We saw that 300 clinical staff had received foundation end of life care training as of October 2015.

End of life care

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

Pain relief

- Patients had appropriate access to pain relief. Anticipatory end of life care medicines were correctly prescribed for symptom and pain relief and patients were provided with pain management support.
- Patients were prescribed appropriate medicine for symptom relief and pain management.
- We reviewed 26 patient notes in the hospice and hospital and saw that a recognised pain assessment tool was rarely used to assess patient's level of pain. The getting it right for me end of life care plan contained information about the assessment of pain and an example of the scoring system which could be used. However, hospice and ward staff did not use a standardised pain assessment tool in practice. We reviewed 14 sets of records and found that no records showed evidence of a pain scoring tool being used. In all 26 sets of records we did see detailed descriptions of patient's subjective and objective reports of pain. Hospice and ward staff did consider and respond to patient's pain and discomfort but without a standardised pain score there was a risk that patients would not get consistent response from staff. There was no baseline for clinical staff to judge whether pain relief was effective for the patient.
- Therapy staff we spoke with said they used the Abbey pain scale assessment tool and two physiotherapists told us that they sometimes used the Wong-Baker facial grimace scale for patients who had difficulty communicating. We saw staff had checked patient's pain levels every two hours in 26 records and pain relief given. However, no pain score was used in any of these records.
- Patients we spoke with on the wards told us that there was "no problem at all" in getting pain relief.Another patient in the hospice said "The nurses are constantly checking day and night how I am and if I need any pain relief, as soon as I ask –it comes!"
- We saw syringe pumps for end of life patients who required a continuous infusion to control their pain in both the hospice and wards.

Nutrition and hydration

- Patients were assessed using the Malnutrition Universal Screening Tool (MUST) which identified nutritional risks.
- We reviewed 26 nursing and medical sets of notes for patients who were receiving end of life care in both the hospice and wards and saw that all of the patients had received an assessment of their nutrition and hydration requirements. However, four patients who were scored as requiring additional support did not have documentation to show referral had been made to a dietician as indicated in the scoring system. Staff told us referrals were usually made by telephone and that there was good access to a specialist assessment from a speech and language therapist (for swallowing difficulties) and a dietitian both employed by the trust.

End of life care

- Two patients we spoke to in the hospice told us the food was very good and there was always plenty of choice. However, on the wards onepatientsaid “the food is not always good” and another patient ona different ward that said “the food is not very tasty”

Patient outcomes

- The service provided data to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, to provide an accurate picture of specialist palliative care service activity. This data highlighted the length of stay for some patients was longer than it needed to be.
- There were trust wide targets such as zero percent of patients being moved to other wards for the 24 hours before their death. Staff said that this target was met in all the wards. The trust had set a target of 85% of end of life patients to be discharged to the preferred place of care within 48 hours of their request.Plans to audit this target in autumn 2016 were documented in the end of life care meeting minutes.
- The trust participated in the National End of Life Care Audit – Dying in Hospital, 2016, the trust was better than the England average for four out of the five indicators.The trust achieved 91% against KPI 3 which measured whether there was documented evidence that patients’ concerns were listened to.This was higher than the national average score for other NHS trusts of 84 %.The trust scored 81% compared to the England average of 83% for KP1, evidence of last episode of care being recognised that the patient would die in the coming hours/days.
- The 2015 Royal College of Physicians National falls audit showed that this trust has lower numbers of inpatient falls resulting in serious harm or death.From 1 January to 31 December 2014 all participating trusts and health boards in England and Wales falls data was 2.76 per 1,000The trust fall data was 0.06.Staff we spoke with on the ward gave examples of preventing patient fallsin end of life care.
- The trust had begun monitoring the preferred place of care figures in April/May 2015, which demonstrated that staff needed to improve documented evidence of patient’s wishes.Not all patients who wished to die at home could be discharged home from the trust in a timely due to a lack of care packages to ensure the patient could be safely discharged home and the trust reported a 44.2% of delayed transfers of care due to awaiting residential home placement or availability. We saw two patients on the wards and one patient in the hospice waiting for care at home. Senior staff told us action plans to improve thisincluded regular meetings with colleagues from adult social careto discuss improvement and recruitment sharing strategies.
- The provision of emergency equipment had improved and mattresses to prevent pressure ulcers could generally be provided the same day. For the quarter 01/07/16 to 30/09/16 inclusive, 116 specialist palliative care patients expressed a preferred place of death of which 95 achieved their preference.

Competent staff

- A practice educator had been employed full time to ensure staff was supported to deliver high quality care for patients. They worked with staff across the trust, community staff, GPs and GP trainees to ensure they were suitably trained to care for people at the end of their life.
- All staff we spoke with told us they had good access to further training and development and felt they had the right skills to deliver care to patients. End of life and palliative care training was delivered at both medical and nursing induction days, including input from the chaplaincy services.
- The inspection team noted the education, learning and development newsletter summer 2016 which highlighted two full day training sessions in end of life care clinical skills for health care assistants.
- Six days palliative care update training sessions for qualified staff in both the community and hospital had been allocated. Staff were given opportunities to attend conferences and other courses and one staff member discussed attending the Royal College of physician’s palliative care spotlight training day. The trust also delivered university accredited modules in cancer care level 6 and 7 and end of life care level 6 and 7.
- We saw that 300 clinical staff had received foundation end of life care training as of October 2015. Records showed 41 staff had completed the Level 7 EOLC Degree Module as of August 2016. We also noted that there were eight end of life care skills in-house training days

available for staff from July 2016 to October 2016. The draft end of life care strategy also prioritised that all clinical staff to be trained in foundational skills in end of life care by the end of 2017

- Porters told us that they received training around sensitively handling the deceased, moving and handling and infection control practices. This training was delivered in-house by the senior porter. The senior mortuary staff member delivered in-house training to mortuary staff which included an orientation to the mortuary, health and safety training, manual handling and training on the administration duties required when registering a body in the mortuary. The porter and mortuary staff told us that they had not received formal trust level end of life care training or infection control training from the infection control nurse.
- Staff told us they had regular annual appraisals. The trust target was 90% .As of August 2016, 100% of end of life care staff within the trust had completed an appraisal.
- The chaplain held listening skills and resilience training at the healthy living hub once a month attended by trust staff.
- The specialist palliative care team all received one to one clinical supervision each month with the palliative care consultant and told us they found these supervision sessions beneficial.
- The clinical leads informed us that there were champions for end of life care on all wards. The champions met formally every two months. We spoke with two end of life champions on the intensive care unit and they were extremely passionate about end of life provision.They had developed their own local initiatives to review patients to ensure that they are on the end of life care pathway and to teach other members of the clinical team.
- The hospital did not classify end of life care training as a mandatory subject as recommended by of the National Care of the Dying Audit 2013/14.

Multidisciplinary working

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

Seven-day services

- The National Care of EOLC the Dying Audit report for Hospitals (NCDAH) 2013/14recommended hospitals should provide face-to-face specialist palliative care service from at least 9am to 5pm, 7 days per week, to

support the care of dying patients and their families, carers or advocates. We saw that specialist palliative care services were available 24/7 for both the hospice and wards..

- The trust ran a pharmacist on-call rota so clinical pharmacy advice could be accessed day or night.
- The therapists based at the hospice worked Monday to Friday. However, they told us there was an informal arrangement with prior agreement to attend out of hours if required. They told us they were called to attend out of hours approximately once every six months.
- Mortuary services were available 8.30am to 9.30pm seven days a week with on-call cover out of hours.Out of hours involved the mortuary staff or the bereavement officer assisting the families with the viewing process.
- Chaplaincy services were available within normal working hours and on Sunday mornings. These hours were divided between two chaplains who also provided an on-call chaplaincy service for anyone who wished to access them. The chaplain told us that the service was stretched due to a lack of staff in the bereavement office buta replacement chaplain position had recently been agreed by the trust.

Access to information

- All staff who worked within the hospice and hospital told us they had sufficient information to enable them to care for patients appropriately. Clinical staff such as the palliative care team could access patient records electronically from whatever care setting they worked within at the trust. This meant if a patient within the hospital required inpatient care at the hospice a referral could be made quickly and simply.
- All staff in the hospital had access to hospital policies and guidance specific to palliative and end of life care via the trust intranet. Staff found this resource valuable and easy to access.
- We saw that when a palliative care patient was discharged home from the hospital or hospice, the GP, the district nurse and care agency were informed via an electronic message.Hospice staff told us that if a palliative care patient died staff would telephone the GP practice so that GP practice would be aware should bereaved family members telephone for further advice or treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust carried out an audit of consent forms in 2015 and found completed consent form for 98% of clinical procedures. 100% of consent forms audited were signed by a clinician. However, in 11% of cases this information was either illegible or difficult to read. We saw an action plan for clinicians to improve and a repeat audit was planned end of November 2016. We reviewed 26 sets of nursing and medical records and saw that consent to care and treatment was obtained in line with relevant legislation and guidance. Where applicable relatives were included in the discussions and these discussions were recorded. We observed staff in both the hospice and wards, explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment.
- Staff had an awareness about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLs). Staff discussed being issued with NHS mental capacity act prompt cards. Staff had received Mental Capacity Act training and various resources were available on the trust intranet, if staff needed more support. However, out of 26 sets of nursing and medical records we found no evidence for 7 patients that formal capacity assessments had been carried out despite documentation by clinical staff that stated the “patient lacked capacity” or that the patient was “confused.

Are end of life care services caring?

Good

We rated caring as ‘good’ because:

- Compassionate and person centred end of life care was provided to patients in the hospice and on the wards by medical and nursing staff and the specialist palliative care team. Medical and nursing staff showed sensitivity when communicating with patients and relatives
- The specialist palliative care team spoke with care and compassion at their handover meetings and considered the dignity of end of life patients. They were sensitive to people’s needs in a holistic way.

End of life care

- Feedback from patients and their relatives was consistently positive about the care they had received. All family members, including pets, were supported to visit or stay at the hospital.
- All staff we spoke with valued and respected the needs of both, the patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered.
- The bereavement and mortuary staff were caring, understanding and responded sympathetically to patients and relative's needs.
- Friends and Family Test data showed 96% of respondents in June 2016 would be extremely likely or likely to recommend the service they were seen by to friends or family. Feedback comments were positive and highlighted the clinical excellence of staff

Compassionate care

- All of the staff in both the hospice and on the wards spoke passionately about providing high quality compassionate individualised care. Staff developed trusting relationships with patients and their relatives. Staff encouraged family members to visit, including children and family pets. Throughout our inspection we heard conversations between all members of staff that cognised the individual needs of patients and their families. For example medicines regimes were adjusted to enable a patient to spend some time at home with their family. Care was adapted for another patient to ensure they were supported to maintain a quiet serene environment as requested by the patient and their family.
- Staff in the hospice consistently told us they felt it was a "real privilege" to work at the hospice. They felt they were able to care for people with dignity and respect and had sufficient time to care for patients and their families. The care and treatment of end of life care patients within all departments was flexible, empathetic and compassionate.
- Staff ensured confidentiality was maintained when attending to individual care needs by closing doors to side rooms or asking patients to move from ward area's to private rooms to talk.
- We observed a handover at the hospice where medical and nursing staff showed an awareness of treating patients and their families in a sensitive and compassionate manner.
- We spoke with three patients in the hospice and four patients on the wards. All of whom were overwhelmingly positive about their care. We observed patients had a high level of trust in the specialist palliative care nurses and were appreciative of the support and care provided. One patient on the ward said "the staff have helped me say to my family that I cannot cope looking after my dog now, it's such a relief to know my son will take care of him, I can sleep easy now!" Another patient in the hospice told us "you feel they know you as a person, you are important, what you are saying is taken into consideration, the doctors and staff remember me and my families name'.
- The trust participated in the National Care of the Dying Audit in March 2016. The results identified the trust was in line with the national average in relation to the provision of care that promoted patient privacy, dignity and respect, up to and including after the death of the patient.
- We saw Friends and Family Test data for 1st March 2016 to 1st June 2016 demonstrated overall patients would be extremely likely or likely to recommend the service to friends or family.

Understanding and involvement of patients and those close to them

- We reviewed 12 sets of nursing and medical records in the hospice. All of the notes contained detailed documentation about caring discussions held with patients and those close to them.
- We observed nursing and medical staff having compassionate and inclusive conversations with relatives. Staff immediately responded to requests for discussions with relatives. We observed all members of staff knew patients relatives by name and greeted them warmly when they arrived at the hospice. Relatives told us that staff communicated to them in sensitive and unhurried way.
- Patients and their relatives told us that they received a high standard of care and were involved in decisions as much as they wanted to be. None of the patients or relatives we spoke with had any concerns with regard to the way they had been spoken with, and all were complimentary about the way they were treated.
- We witnessed several examples of nursing staff explaining to patients and their relatives about care and treatment options and involving them in the care. Time was given to patients and relatives to discuss their

concerns. For example, we saw a staff member explaining to a family why staff needed to continue to turn their family member in bed even though they were unconscious. The explanation included to ease stiff limbs and prevent pressure ulcers developing.

- The trust participated in the National Care of the Dying Audit in March 2016. The results identified the trust as in line with the national average in relation to health professional's discussions with both the patient and their loved ones regarding their recognition that the patient was dying. The survey also identified the trust as in line with the national average for communication regarding the patient's plan of care for the dying phase.
- Patients and family members told us staff discussed with them any issues they had identified as potential risks to their well-being or risks associated with their treatment. An example of this was a staff member discussed different food options family members could bring in as a treat that would prevent possible choking.
- The bereavement officer or the chaplain met with relatives after a death and talked through aspects of next steps and provided information to relatives with a help for the bereaved booklet.

Emotional support

- Patients had access to counselling and psychotherapist services for specialist emotional support if required.
- The hospice provides a 'Bereavement Listener', an opportunity to talk about loss and feelings as people often say things to a bereavement listener that they feel unable to discuss with family and friends. The Bereavement Listener canprovide the reassurance and strategies for copingduring this difficult time.
- Bereaved relatives were contacted by a nurse from the hospice to offer condolences and further emotional support if required.
- The bereavement officer and chaplain saw offering emotional support to relatives as an integral part of their role. We were given examples where staff had met with bereaved relatives and assisted with the funeral arrangements.
- The chaplaincy service provided support for carers, family, friends and trust staff. Nursing staff in both the wards and hospice reported good access to the chaplaincy team. They knew the members of the chaplaincy team by name and said that the chaplains would frequently visit. During our inspection we observed the chaplain offering emotional and comforting support to a patient's relatives. However, at the time of our inspection the chaplain was working in the bereavement team to cover staff absence as well as visiting the wards to see patients. There was a business case for sessional chaplains to see patients as there was no service available on Saturdays.
- We attended a weekly hospital palliative care multidisciplinary meeting. The emotional impact on family and staff caring for a dying patient was considered for all patients.
- All the specialist palliative care nurses were trained to Level 2 in psychological support for patients and carers.
- Trained volunteer bereavement listeners offer support to families and carers following the death of a loved one. Listeners provide time when it is mutually convenient with the bereaved client.

Are end of life care services responsive?

Good

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

We rated responsive as "good " because:

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

However,

End of life care

- There were some delays in discharging patients home to die due to external delays with funding and care packages for complex needs.
- There were insufficient facilities for relatives to stay overnight with patients at the end of their life at the hospital.
- Patients who expressed a wish to die at home did not always get to do so.

Service planning and delivery to meet the needs of local people

- The hospice offered a day hospice for up to 12 patients a day, four days per week. New patients are assessed by the clinical team and offered a 12 week goal orientated therapeutic treatment programme, pain and symptom relief, psychological and spiritual support. This social setting allows patients to learn new skills, reminisce and share personal worries.
- The hospice ran a 12 week programme for patients with chronic lung and heart failure. Patients are taught to understand the holistic nature of their breathing problems and how to develop new coping mechanisms to improve their quality of life.
- Relatives told us they could visit the wards or hospice at any time when their loved ones were approaching the end of life. Staff told us as much as possible they placed patients at end of life in a side room. We saw end of life patients in the hospice and wards in side rooms. Relatives were supported with refreshments during the vigil.
- There was a chapel of rest mortuary viewing area, which was well maintained and dignified. The public entrance to the mortuary viewing area was through the bereavement room.
- The trust had conducted a balanced appraisal of the needs of the population with regards to cancer/non cancer end of life care and this had shaped the trust strategy for improving access for diverse communities such as travellers to end of life and palliative care services.
- Patients who required end of life care were nursed on general medical and surgical wards or were offered a hospice bed if appropriate and available. Nursing staff we spoke with on the wards told us they would give priority to the care of those patients in the last days of life and would try to offer a side room to allow privacy and dignity for the patient and family.
- The needs of family members caring for a dying person were always considered.This included assessment of carer stress and support for arranging respite care. Feedback from relatives highlighted how important this aspect of end of life care was to them.One relative in the hospital confirmed they had open access visiting and were pleased their relative had been moved into the side room. They said they had been at the hospital for three days and staff had been supportive and regular refreshments were offered during their visits. The relative said there was a large chair to use, however, no camp bed was available for them to rest during the night.
- Staff told us that they were flexible with visiting hours if needed to meet the specific needs of individual patients. The hospital offered open visiting hours for relatives/loved ones visiting patients who were nearing the end of their life.

Meeting people's individual needs

- The chaplaincy had an out of hour's list of people and volunteers from different faiths whom they could call on to ensure that a patient's religious and spiritual wishes were met. Two nurses on one ward where not aware of the out of hours list of telephone numbers and this could cause a delay in patients receiving faith visits.
- Patients' spiritual needs were not documented in a unified place within the care record. This meant that staff would not know how to quickly find the documented spiritual needs or corresponding plan of care presenting a risk that the individual's needs in that area were not met.
- Staff we spoke with at the hospice and in the wards told us that when a patient was at the end of their life they tried to allocate a nurse to sit with the patient to read or play music if no family present.
- The chaplaincy told us that when patients or relatives had requested faith leaders from other religious denominations, this would be arranged by the chaplaincy service.

End of life care

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

Access and flow

- The single point of access referral system allowed health professionals to refer to the palliative care team. One GP told us it worked very well. They told us they referred a patient to the hospice and they were admitted to the hospice a few hours later.
- Staff in the bereavement office told us relatives did not consistently receive timely access to death certificates. They told us if a patient died at the weekend, the doctor who certified the death would not be on duty until Tuesday. During our inspection we observed staff attempting to contact doctors to arrange for the certificate to be signed. They told us it was often frustrating but some doctors did not recognise the importance of ensuring the certificates were signed promptly and the impact the extended wait may have on bereaved families.
- Bed occupancy for the trust is higher than the England average and is frequently close to 100% capacity. The

trust has responded to this by employing three discharge planning nurses and one was based at the hospice. Their role was to co-ordinate discharge home if requested by a patient. They worked closely with the occupational therapists, physiotherapists and community nurses to ensure all appropriate equipment and medicines were in place prior to a patient's discharge. They reported they were able to access all specialist equipment promptly.

- Senior staff told us there had been a reduction in the length of stay in hospital for some palliative care patients. Patients had timely access to the specialist palliative care team (SPCT). The trust audited inpatient referral to contact waiting times for the palliative care team for 2016. The audit showed that no patient referred to SPCT as an emergency waited longer than seven hours to be seen. Similarly, patients urgently referred to SPCT were seen within 24 hours.Patient records we reviewed further evidenced data provided by the trust.
- The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was published in 2007, and revised in 2012. The framework set out that patients with a rapidly deteriorating condition should be 'fast tracked' to receive NHS funded care in a place of their choice at the end of their life. From January 2015, the trust began collecting data on the number of end of life patients who were discharged with fast track in place, as well as the numbers of patients who expressed a wish to die out of hospital for which this was not achieved. For the three month period between July and September 2016, 116 specialist palliative care patients expressed a preferred place of care of which 95 achieved their preference. Senior staff discussed they were working in partnership with adult care services to enable more patients to die in the place they requested.

Learning from complaints and concerns

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

Are end of life care services well-led?

Good

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

We rated well led as "good " because:

- Leadership for palliative care was strong. Staff across the trust wanted to provide good care to patients and support relatives whose loved ones were at the end of life. Quality and patient experience were seen as a priority and everyone's responsibility.

End of life care

- The end of life core services had a robust governance structure that went from team level to the trust board. The quality, risks and performance issues within end of life care were monitored through the executive governance framework
- Although the trust did not have a published end of life care strategy, the service leads had identified priorities around improving the end of life care services across the trust. Staff we spoke with was aware of these priorities and described high quality patient care as key components of the trust's vision.
- The trust values were well embedded in practice and staff had begun calling people to account if their behaviour was not representative of the values.
- The Trust was working in partnership with Macmillan to assist with quality of life and preferred place of care planning in the hospital.
- Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- The trust had set up a patient panel to ask for opinions and suggestions in what mattered to them regarding developing plans for end of life care.

However,

- The trust had not audited the views of the bereaved as recommended by the National care of the Dying audit hospitals (NCDAH) 2014/15.

Leadership of service

- Leadership within end of life care was strong with three senior leaders for end of life care. These include the lead nurse, lead consultant and chief nurse. Each lead had clearly defined responsibilities for all staff responsible for delivering care. The trust lead for end of life care was enthusiastic and proactive in driving forward the end of life agenda for the trust and reported good support from the medical director and the trust board members.
- The senior staff for end of life care attended the end of life steering group who then reported to the board. Clinical staff reported that this had improved clarity of who takes overall ownership of end of life care across the hospital.
- Clinical staff described the leadership of the service as "amazing" and one person said "they support and listen to me"
- The specialist palliative care team nurses in the hospice and wards contributed to the overall leadership of palliative and end of life care. All staff in the hospice and wards demonstrated a good awareness of developments within the service.
- The hospice staff said they were given the opportunity to shape their service and discussed a recent proposal for the team to vote whether or not to work long days.
- The trust supported staff to develop their leadership and management skills. For example, staff at band 7 level and above were encouraged to enrol on the trust management course.
- Staff told us their concerns were taken seriously. For example, concerns raised by clinical staff, we saw staff attend a meeting to finalise actions before the launch action cards for therapeutic one to one care of patients, detailing what is expected of the staff member, which included no use of mobile phones to ensure all concentration is on the patient requiring specialised care.
- All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care. The culture was caring and supportive. Staff were actively engaged and there was culture of innovation and learning.

Vision and strategy for this service

- Senior management and clinical staff told us the trust's mission was to provide safe and compassionate care, every time with a focus on providing right care, right place, right time, and first time.
- The executive lead for end of life care was the chief nurse who passionately discussed the trusts commitment to ensuring quality end of life care. We saw minutes of end of life care steering group and forward planning meetings with action plans, named leads and timelines for completion.
- The trusts had set up a patient panel and have worked collaboratively with stakeholders to produce a new end of life care strategy. Senior staff told us that this new strategy should be consulted on in September 2016 and presented to the board in October 2016. The aims of the

strategy were to ensure end of life care was everybody's business, to become more proactive in the identification of end of life patients and to improve communication to support end of life care.

- Staff were engaged with the goal of delivering end of life care. Staff were aware of the trusts developments in end of life care and had a good understanding of how to drive the service forward.
- The trust's strapline "we care" with the acronym as a team we collaborate, to be the best, aspire, respect everyone's value and individuality and enable people to take responsibility was visible on all paperwork. Ward managers displayed trust values on staff notice boards. Staff told us they were passionate about providing safe and compassionate care to patients. Senior staff told us that the values were well embedded in everyday practice and gave the example to encourage staff to take responsibility for safe medicines management..
- Senior leaders were committed to improving end of life care and delivering against the strategy once it had been signed off by the trust board. The trust had worked in partnership with Macmillan to employ a senior nurse for two years. The trust had also employed a dedicated end of life care facilitator.

Governance, risk management and quality measurement

- The end of life care services had a robust governance structure that went from team level to the trust board. The quality, risks and performance issues within end of life care were monitored through the executive governance framework.
- The end of life steering group members met quarterly with the trust's quality assurance group where the outcomes of the quality dashboard and any issues related to end of life care were discussed locally at team meetings. Minutes of clinical governance meetings showed that patient experience data was reviewed and monitored.
- There were audit systems to monitor the quality of the service. The National end of life care audit for March 2016 was completed by the trust and action plans to improve was highlighted in the trust end of life care strategy. The audit of end of life care plans was completed and presented to the board August 2016. Action plans to improve the service included auditing bereaved relatives experience of care and providing bereavement information. The National care of the Dying audit hospitals (NCDAH) 2014/15 recommended all hospitals should undertake local audit of care of the dying, including the assessment and views of bereaved relatives at least annually. However, the trust was aware that they had not audited the views of bereaved relatives
- The trust had a divisional risk register in place, with departmental risk registers completed to link into these. The top divisional risk, recruitment and retention of clinical staff, aligned with concerns raised by staff during the inspection. A lead was responsible for each risk and we saw they were effectively monitoring their risks on the register Clinical leads informed us that any issues or risks related to end of life were escalated to the clinical governance committee and we saw minutes of end of life care meetings which highlighted risks were discussed and managed.
- The palliative care team had regular team meetings at which performance issues, incidents, concerns and complaints were discussed. Where staff was unable to attend team meetings, steps were taken to communicate key messages to them using a communication folder which staff signed to show they had read the contents.
- The palliative care team used a quality dashboard. It showed how the service performed against a range of quality and performance targets. Staff told us that these were discussed at team meetings.
- The trust held monthly mortality review meetings about the care of patients that had died in hospital. Senior nursing staff together with the palliative care consultant reviewed the care and treatment of all patients that died in the hospital. Analysis of patients who died in hospitals was presented to end of life care steering group to identify learning for improvement.
- The trust had a quality committee and a quality and patient safety group which met alternate months, with sub-groups meeting monthly reporting into it, such as the blood transfusion and medical devices committee, dementia, sepsis and falls groups.

End of life care

Culture within the service

- Staff across the trust wanted to provide good care to patients and support relatives whose loved ones were at the end of life. Staff spoke positively and passionately about the care and the service they provided.
- Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns and staff were encouraged to report any identified risks.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The handover meetings and supervision sessions were seen as a time for checking on team wellbeing. There were measures in place to ensure staff affected by the experiences of caring for patients at end of life was supported. This included de-briefing sessions and access to counselling if appropriate.

Public engagement

- The trust had formed a patient/public reference panel to develop the end of life care strategy, patient information leaflets and the end of life care plan. Senior staff spoke passionately about the involvement of patients and families in the development of the future service.
- The trust did not audit views of bereaved relatives and could not therefore make care change improvements to the service based on their views.

Staff engagement

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

Innovation, improvement and sustainability

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

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

The trust must ensure

- Pharmacy staffing is provided to planned levels so that medicines management is safe and clinical pharmacy support is available to departments.
- Staff comply with all aspects of the trust's medicine management policy and associated standard operating procedures.
- The management of controlled drugs is improved and staff comply with the misuse of drugs regulations.
- All medicines are stored within the manufacturer's recommended temperature ranges and that records are maintained to demonstrate that medicines are safe for administration to patients.
- Daily checks of the anaesthetic machines and resuscitation equipment are completed and documented to confirm the equipment is safe for use.
- All patients thought to lack capacity to make decisions about their care and treatments have a formal assessment of their capacity.
- There is a clear process in placewith clear accountability for the cleaning of the mortuary trolley.
- Suitable sealed storage is in place for deceased patients' belongings in the bereavement office.
- The new end of life care plans "Getting it right for me" and the associated "Getting it right for me patient held record" are used by clinical staff for all end of life care patients in the trust.
- Patients who are subject to deprivation of liberty have current and valid authorisation documentation in place.
- The end of life care strategy is completed and published and all clinical staff are aware of this strategy.
- The use a standardised pain assessment tool across the hospital to ensure end of life patients have their pain accurately assessed and responded to.
- A protocol for withdrawing treatment as recommended in the 2015 National Institute of Clinical Excellence guidelines is in place and clinical staff are trained in its use.

Action the hospital SHOULD take to improve

The trust should ensure

- The pharmacy service does not supply out of date British National Formularies.
- Audits completed by the pharmacy service are used to drive improvements and progress should be demonstrated over time.
- All staff working in theatres comply with the trust's uniform policy, in particular changing their scrubs, if they leave and then return to theatre.
- The standard of record keeping is monitored through regular audits and action taken for areas of non-compliance.
- All staff understand the Mental Capacity Act (2005) and are confident to apply this in the clinical setting to safeguard patients.
- Compliance with the trust informed consent audit shows continued improvement, with further action taken to address areas of non-compliance.

Outstanding practice and areas for improvement

- Minutes are recorded for all meetings held within the division of surgery and critical care, with an action log included to provide assurance that concerns are being addressed.
- Medical records are maintained securely on care of the elderly wards.
- Staffing levels are as planned to meet all patients' needs.
- Staff on ward 8 comply with infection control procedures to reduce the risk of infection.
- The high proportion of delayed transfers of care attributed to patients waiting for a residential home placement is reduced.
- Advanced care plans are fully documented in order to comply with patient's wishes.
- Porters, cleaners and mortuary staff receive standardised formal end of life care training.
- The views of bereaved relatives is obtained to make care change to improve to the service
- All staff are aware of the up to date list of telephone numbers for calling different faith ministers to visit the hospital out of hours.
- Information leaflets regarding advance care planning, what happens when someone dies and how to register a death are printed and distributed in all the clinical departments, with a named lead responsible for ensuring they are accessible for patients and families and are up to date.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Requirement notices

- Staff did not check medicine fridge temperatures daily or take action when the fridge temperature was out of range.
- There was no agreed schedule or clear responsibility for the cleaning of the mortuary trolley.
- Belongings of the deceased were not being appropriately sored while awaiting collection

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (1) Care and treatment of service users must only be provided with the consent of the relevant person (3) If the service user is 16 and over and is unable to give such consent because they lack capacity to do so, the regulated person must act in accordance with the Mental Capacity Act 2005 **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

- Out of 26 sets of nursing and medical records we found no evidence for 7 patients that formal capacity assessments had been carried out despite documentation by clinical staff that stated the “patient lacked capacity” or that the patient was “confused”.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...