Care Quality Commission

Oxford University Hospitals NHS Trust

Nuffield Orthopaedic Centre

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

Overall rating for this hospital	Good
Medical care	Good
Surgery	Good
Outpatients	Good

Summary of findings

Contents

Summary of findings

Overall summary

The Nuffield Orthopaedic Centre, Oxford, is the smallest hospital in the Oxford University Hospitals NHS Trust, with 160 beds, and serves a population of around 655,000 people. It provides specialist acute medical and surgical services in orthopaedics, rheumatology and rehabilitation to the people of Oxfordshire. The hospital also undertakes specialist services such as the treatment of bone infection and bone tumours, limb reconstruction and the rehabilitation of those with limb amputation or complex neurological disabilities. The Nuffield Orthopaedic Centre site includes the Oxford Centre for Enablement and the Botnar Research Centre.

The hospital is registered to provide services under the regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

To carry out this review of acute services, we spoke to patients and those who cared or spoke for them. Patients and carers were able to talk with us or write to us before, during, and after our visit. We listened to all these people and read what they said. We analysed information we held about the hospital and information from stakeholders and commissioners of services. People came to our two listening events in Oxford and Banbury to share their experiences. To complete the review we visited the hospital over three days, with specialists and experts. We spoke to more patients, carers, and staff from all areas of the hospital on our visits.

The services provided by the Nuffield Orthopaedic Centre were good. There were some areas for improvement within services. These related to the documentation about patients' care needs in care records to ensure that staff had suitable information. Considering the impact of this across the services, the hospital did not meet the regulations relating to records. There was also room for improvement in the effective dissemination of learning from incidents which occurred in other areas of the hospital or the Trust, to ensure that these did not occur again. Local feedback of learning and actions to be taken following incidents was carried out within the hospital.

The staff within the hospital felt proud to work there, although there was a feeling of being distanced from the trust. Some staff reported positive changes since the hospital became part of the trust. However, there was significant discontent with some senior clinicians at the hospital who reported poor engagement from the senior management of the trust.

Patients' views and experiences were a key driver for how services were provided. Patients said they felt safe and well cared for. Staff worked in multidisciplinary teams to co-ordinate care around a patient.

The hospital worked towards achieving national targets in relation to waiting times, cancelled operations, and delayed discharges. There was acknowledgement that there was limited access to suitable placements in the community and that this had an impact on the access to services.

Staffing

The hospital monitored and planned staffing to meet patients' needs. We observed that there were sufficient staffing levels. However, some staff reported that they did not always have time to spend with patients to allow them to express their concerns about care and treatment. Bank and agency staff were used to supplement the staffing of wards where vacancies existed. Staff generally found that bank and agency staff were well skilled and able to undertake the work required of them. Planning of staffing to meet patients' needs had been used to increase the number of staff on wards. Divisional reports showed that the staff vacancy rate ranged from 7.8% to 13.25% in different areas of the hospital. There was a focus on recruitment within the trust as a whole, although there were reports of difficulties in recruiting staff due to the high cost of living within Oxford.

Cleanliness and infection control

There were systems and processes in place to ensure good cleanliness and infection control within the hospital. The hospital was clean and staff observed good infection control practices. Staff wore appropriate personal protective equipment when delivering care to patients and suitable hand washing facilities and hand gel were readily available.

Summary of findings

The number of methicillin resistant Staphylococcus Aureus (MSRA) bacteraemia infections and Clostridium difficile infections attributable to the hospital was with the acceptable range for a hospital of this size. The number of patients with a catheter who contracted a urinary tract infection was similar to the average for England in the last 12 months.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Good

We found that services at the hospital were safe and the hospital had a good safety record. Staff had a good understanding of how to report incidents. Where incidents occurred, appropriate investigations followed and learning was identified. Although staff were aware of incidents and learning, there was evidence that the learning from incidents was not always disseminated effectively to ensure that actions were taken to prevent reoccurrence. In some cases action plans had not been completed within set timescales following incidents.

Monitoring of safety was apparent in the hospital. Information about safety was available on wards for staff, patients, and visitors. This included the last instance of patient falls or pressure ulcers were visible in ward areas. There were systems in place to ensure safety within operating theatres.

While we saw that people received good care and treatment, there were areas for improvement in the completion of patient records, which had the potential to put people at risk. Records did not always provide sufficient information to staff to ensure that people received the care that they needed. This was on both medical and surgical wards.

There were sufficient staffing levels which were planned to meet patients' needs. Staff recorded staffing levels against patient needs for each shift. We saw that this had been used to increase the staffing levels on medical wards where some staff reported they did not always have sufficient staff. The hospital experienced difficulties in recruiting and retaining staff due to the cost of living within the area.

Are services effective?

Good

Outcomes for patients were good. Patient reported outcome measures (PROMs) for hip and knee replacement surgery showed no evidence of risk and good reported outcomes for patients. The trust standardised in-hospital mortality rates for the musculoskeletal group was much better than expected, when compared with other trusts. National guidelines and best practice were applied and monitored. Staff worked in multidisciplinary teams to co-ordinate care around a patient.

Are services caring?

Good

During our inspection we observed people receiving compassionate care. Patients were treated with dignity and respect. Privacy was maintained in all areas, curtains were drawn around patient beds when care was provided. Patients confirmed this.

Patients said they were involved in making decisions about their care and treatment. However, there was little documentation in records to show this.

Summary of findings

Information was available to patients and their families in suitable formats to meet their needs. There were facilities available to provide interpretation services for patients whose first language was not English. Examples were given of when these services had been used within the hospital.

Are services responsive to people's needs?

Good

The service was responsive to people's needs. However, there were some areas for improvement regarding the documentation in records of patients' individual needs, including whether they had been identified or assessed as being vulnerable or living with dementia or a learning disability.

Patients said when they needed help staff responded to call bells quickly.

The hospital worked towards achieving national targets in relation to waiting times, cancelled operations, and delayed discharges. There was acknowledgement that there was limited access to suitable placements in the community and that this had an impact on the access to services. This also had an impact on people leaving hospital. However, staff told us that routine discharges from the hospital were managed efficiently and effectively. Patients received appropriate information about discharge from hospital.

Patients were aware of complaints procedures and felt confident that their concerns would be taken seriously. The hospital routinely captured feedback using the friends and family test. There was evidence of this being monitored and discussed within the hospital.

Are services well-led?

Good

There was a clear trust vision and a set of values. Many staff did not know what the vision and values were but portrayed similar values and a passion to provide excellent patient care. Staff said they were proud of the work they did. However, they felt distanced from the running of the wider organisation. This was particularly clear in the Oxford Centre for Enablement (OCE) where the matron was based on another hospital site within the trust.

Some staff reported positive changes since the hospital became part of the trust. However, there was significant discontent with some senior clinicians at the hospital who reported poor engagement from the senior management of the trust. They reported decisions being taken at a trust level without the engagement of the consultant body. There were also reports of poor morale. In other areas there were reports that clinicians felt able to call for senior help when required. Nursing staff said they felt supported by their line managers.

Patients' views and experiences were a key driver for how services were provided. Patients said they felt safe and well cared for. Patients reported being involved in booking appointments. There was an established patient involvement group, which met to discuss what improvements could be made to the site for the benefit of patients.

Summary of findings

There was a clear governance structure with reporting lines from departments through directorates and divisions, ultimately to the trust board. However, there was a lack of clarify by staff around lines of accountability, cross divisional and cross hospital working.

Summary of findings

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

Medical care (including older people's care)

Good

There was a good understanding and awareness by staff of the need to report incidents and the process in which to do so. Where incidents occurred we saw they were reported through the directorate and divisional structure. Feedback about incidents and the resulting learning and actions occurred within local areas. However, the formal process in place to ensure learning from incidents was not effective because staff were not aware of that which occurred in other areas of the hospital or the trust.

Staff were caring. We saw staff dealing with patients in a kind, compassionate and caring way. Patients generally spoke highly of the care they received Staff worked effectively and collaboratively to provide a multidisciplinary service to patients, particularly those with complex needs. There were areas for improvement in the completion of patient records, which had the potential to put people at risk. Records did not always provide sufficient information to staff to ensure that people received the care that they needed.

The hospital was responsive to the needs of the local population.

The hospital was well led at a local level. There remained some disconnect with the wider trust and between the OCE and the rest of the NOC. Senior staff were aware of this. This is an area of improvement for the trust.

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Surgery

Good

The hospital had a good safety record, with only one serious incident reported in the last 12 months. There was evidence that this incident, which resulted in the death of a patient, had been thoroughly investigated and learning had been identified. Although, the trust had formal processes in place to disseminate learning from incidents, this was not effective because staff were not clear about the learning from this incident.

All of the patients we spoke with were effusive in their praise for the staff at the hospital, with comments including: "nothing is too much trouble" and "this is the best hospital I have been in". Staff were caring, dedicated, and proud to work at the hospital. It was considered a good place to work by many staff, who felt well supported by senior clinicians and local management. Staffing shortages for nurses and healthcare assistants presented an ongoing challenge and there was regular use of temporary staff. Staff expressed frustration about patients' discharge being delayed because of a lack of suitable alternative hospital beds or support in the community. This sometimes led to 'bed blockages' and cancelled operations. Despite these challenges, staff believed that they provided a good quality of patient care and discharge arrangements were proactively and effectively planned.

There was significant discontent among the consultant body, who were concerned about the culture and the management style of senior management. There was unhappiness about a lack of engagement with clinicians and a belief that decisions were being taken without consultation with clinicians, for financial reasons, and which were detrimental to patient care. Some senior staff felt they could not speak out or did not feel that they were listened to.

Summary of findings

Outpatients

Good 

Patients received safe and effective care delivered by sufficient numbers of staff with relevant training. The triage team ensured that patients were assessed and each appointment was booked to ensure a smooth transition to investigations and treatment within the hospital.

We spoke with eight patients and most were complimentary about the service. Patients were well informed, had their appointments booked in a timely manner and did not wait long to be seen. All patients' records were computerised and accessible. The environment was clean and spacious and the department was well led.

Summary of findings

What people who use the hospital say

There was no specific nationally available data for the Nuffield Orthopaedic Centre. However, the hospital trust was rated about the same as other trusts in the 2012 Adult Inpatient Survey. It performed above the national average in the inpatient and the A&E department Friends and Family test. The trust was ranked better than other trusts in five out of 69 questions in the 2012/13 Cancer Patient Experience Survey, and only worse than other trusts in two of the questions.

Areas for improvement

Action the hospital MUST take to improve

- Patient records were not fully completed or detailed with all the patient's individual needs, placing them at risk, including whether they had been identified or assessed as being vulnerable or living with dementia or a learning disability and in relation to complex wound care management.

Action the hospital SHOULD take to improve

- The process for sharing learning following incidents was not effective. Staff were not aware of the learning from incidents in other parts of the hospital or trust.
- Despite issues being identified (following a serious incident) in the care and management of diabetic patients, actions as a result of this, in the NOC had yet to be fully implemented.
- The trust should continue with their active recruitment, as despite recent improvements in staffing levels in OCE, staff felt they required more staff to provide the care some of their patients needed.
- The trust should ensure that in line with the electronic patient records policy, all agency staff have appropriate access to the electronic patient record system to avoid any potential risk to delivery of patient care.
- The trust should work to improve engagement with staff (particularly the consultant body) within the hospital in order that they are consulted about changes within the hospital and to ensure that they feel their views are listened to.

Good practice

Our inspection team highlighted the following areas of good practice:

- On medical wards staff worked well between teams. There was effective multidisciplinary approach in both the Bone Infection unit, where 90% of patients were under the care of more than one specialist consultant, and the OCE.
- There was excellent engagement with the patient and relatives in forming goals and expected lengths of stay (which were often months) within OCE.
- Access to psychological support for patients who remained in hospital for a considerable period.
- Despite less than optimal working space, the rheumatology day unit was run efficiently, and patients were very happy with the service they received.
- New management of the OCE had a clear vision for the future direction of the service.
- There was good evidence of the use of the Mental Capacity Act 2005, and the use of best interest decisions within the OCE. Staff had a good understanding, and were knowledgeable in relation to their remit when considering DoLS.
- Staff were felt to work above and beyond what was expected of them to meet the patients' needs.
- The outpatients triage team prioritised patients in the referral pathways to direct them for assessment and treatment prior to a face to face consultation within three weeks.
- All outpatient records were on the electronic patient record system (EPR) so there were no hand written notes.

Nuffield Orthopaedic Centre

Detailed Findings

Services we looked at
Medical care (including older people's care); Surgery; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Chris Gordon, Consultant Physician, Medicine and Elderly Care, Hampshire Hospitals Foundation Trust; Programme Director NHS Leadership Academy

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission.

The team of 51 (12 of whom inspected this location) included CQC inspectors, managers and analysts, consultants and doctors specialising in emergency medicine, obstetrics and gynaecology, oncology, diabetes care, cardiology and paediatrics . It also included junior doctors, a matron, nurses specialising in care for the elderly, end of life care, children's care, theatre management, cancer, and haematology and two midwives together with patient and public representatives and experts by experience. Our team included senior NHS managers, including two medical directors, a deputy chief executive, and a clinical director in surgery and critical care.

Background to Nuffield Orthopaedic Centre

The Nuffield Orthopaedic Centre, Oxford, is the provider of specialist orthopaedic rheumatology and rehabilitation for Oxfordshire. The centre was a separate NHS trust until the merger to form Oxford University Hospitals NHS Trust in 2011. It is part of a large-sized teaching hospital providing acute, specialist and community healthcare to the people of Oxfordshire. The hospital serves a population of around 655,000 people. There are around 160 beds at the hospital and the trust sees around 186,000 patients as inpatients each year, the majority at the John Radcliffe Hospital. The trust arranges around 878,000 outpatient appointments each year.

The Oxford University Hospitals NHS Trust has teaching-hospital status as part of Oxford University. The trust employs around 11,000 staff, most who work at the John Radcliffe Hospital.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Oxford University Hospitals Trust was considered a medium-risk trust and an aspirant foundation trust.

Detailed Findings

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?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 25 and 26 February 2014.

During our visit staff were invited to attend drop-in sessions in the hospital. These included nurses below the role of matron, allied health professionals, junior doctors, student nurses, consultants, and administration staff. We talked with patients and staff from all areas including the wards, theatres, outpatients departments and the A&E department. We observed how people were being cared for, and talked with carers and/or family members. We reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the location.

An unannounced visit was carried out on 2 March 2014 during the afternoon and evening and 3 March 2014 during the day.

Good

Medical care (including older people's care)

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

Information about the service

The Nuffield Orthopaedic Centre (NOC) provides a small range of medical care services alongside the elective surgery orthopaedic services. These included the Bone Infection Unit (BIU), Oxford Centre for Enablement (OCE) and rheumatology services within the Rheumatology Day Unit (RDU). Both the BIU and the RDU are housed within the main hospital building, while the OCE is a building within the grounds, a short walk from the main building. Patients attend the RDU for the delivery of intravenous drug therapies as a day case. Admissions to the BIU and OCE can vary with some patients remaining there for several months.

We spent time in all three areas. We talked to 10 patients, two relatives and 14 staff including nurses, doctors, consultants, therapists, specialist nurses, and support staff. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance data and information about the trust. We received additional information from our listening events, focus groups, and interviews. We used this information to both inform and direct the focus of our inspection.

Summary of findings

There was a good understanding and awareness by staff of the need to report incidents and the process in which to do so. Where incidents occurred we saw they were reported through the directorate and divisional structure. Feedback about incidents and the resulting learning and actions occurred within local areas. However, the formal process in place to ensure learning from incidents was not effective because staff were not aware of that which occurred in other areas of the hospital or the trust.

Staff were caring. We saw staff dealing with patients in a kind, compassionate and caring way. Patients generally spoke highly of the care they received Staff worked effectively and collaboratively to provide a multidisciplinary service to patients, particularly those with complex needs. There were areas for improvement in the completion of patient records, which had the potential to put people at risk. Records did not always provide sufficient information to staff to ensure that people received the care that they needed.

The hospital was well led at a local level. There remained some disconnect with the wider trust and between the OCE and the rest of the NOC. Senior staff were aware of this. This is an area of improvement for the trust.

Good

Medical care (including older people's care)

Are medical care services safe?

Good

Safety and performance

There was a good understanding and awareness by staff of the need to report incidents, all of which were received by the ward sister and matron. All staff we spoke with, including occupational therapists, pain nurse specialists, junior and senior nursing staff and health support workers told us they knew how to report an incident, although not all had been required to do so. Where serious incidents occurred, we saw these were reported within the directorate and division.

On admission, patients were assessed to identify their risk of falling, of developing pressure damage and for their nutritional state. Information was available to staff, patients and visitors (in the form of "safety crosses") on the walls in inpatient areas. This provided a visual record of the number of days since the last incidence of patient falls or pressure ulcers for patients, relatives, and staff to see. It was noted that this had not been updated for five days in one area, due the ward manager being away. Nursing staff were aware of the "safety thermometer" which was used to measure the risk of falls, pressure ulcers, and urinary tract infections among inpatients. We saw these results also posted on the boards along with incident data trust wide, within the directorate and by speciality.

The trust monitored safety indicators through quality dashboards which were also monitored both at divisional and directorate level. The medical wards consistently met the trust target to assess at least 96% of inpatients for the risk of venous thrombolytic embolisms (VTE). Nurses told us this was completed by the doctors on admission and was recorded on the electronic patient record (EPR) system.

Nursing staff told us there were times when they were short of staff. At times, cover was not always found, particularly within the specialist areas. Where agency or bank nurses were used, staff told us they generally found them to be well skilled and able to undertake the work required of them. We spoke with a senior nurse who was responsible for staffing within the hospital. While staffing levels had been identified for all wards within the main building, no reference to staffing levels was made for the OCE. Staff on this ward told us they were often left short staffed if one member of staff was off sick. The divisional quality reports show the vacancy rate in the OCE as 13.25% in January 2014 and 7.8% in the BIU in January 2014 (having dropped from 13.2% in November 2013). Where patients required one to one nursing due to the nature of their condition, this could be requested and this cover was usually found. Where two patients required this level of support and supervision at the same time, this was harder to obtain. Staff we spoke with told us that they were not unsafe, but "just wanted more time to hear people's concerns". While we were there we saw one patient in receipt of one-to-one nursing care to keep them safe and prevent them from falling.

Patients were assessed to identify their risk of falling, of developing pressure damage and for their nutritional state on admission. We saw in four out of 12 records reviewed, these had not been completed. The tool used to assess the risk of falls within the OCE was designed for acute admissions, rather than for patients requiring rehabilitation. It was not clear as to what actions to take as a result of the assessment for these patients.

Learning and improvement

Within the NOC blood sugar monitoring forms used, had been changed and were currently being piloted as a result of a serious incident. We saw staff using them to record blood sugars. They told us they found the forms easy to interpret and follow.

We saw signs and instructions for staff, patients, and visitors about hand washing to prevent the risk of cross infection. Some rooms had additional signage requiring people to adhere to additional infection control measures before entering. Staff used hand gel, gloves, and aprons before entering the rooms, although on one occasion, staff exited the room and did not remove their gloves, only their apron. Where staff did not wash their hands, we saw them being challenged by other staff to do so.

Learning from incidents was evident within the hospital, for example, we saw that as a result of work to reduce the risk of falls, the trust "Fall Safe" program was being extended to all wards. Staff told us they were aware of this program and that it was in use on the BIU.

Staff told us they received feedback following incidents that occurred in their work area. Feedback was disseminated through the ward sister following more

serious incidents, if there were salient learning points for their work area. We saw this had occurred following a serious incident within the main building of the Nuffield Orthopaedic Centre in the past; however, there appeared to be little spread of learning across to the OCE. Staff there told us they were aware of rumours following a serious incident. The formal process in place to ensure learning from incidents was not effective because staff were not aware of that which occurred in other areas of the hospital or the trust.

Systems, processes and practices

Patients on the two wards and the RDU told us that they felt safe. At the time of the inspection, no medical patients were on any of the surgical wards at the NOC. Bed management meetings took place daily and in the absence of a matron, a senior nurse was in charge and carried a pager for staff to contact for information and support. During our unannounced visit we saw senior staff visiting wards to check staffing levels and patient acuity.

When patients attended the RDU at times the administration of their medication was slowed due to their clinical condition in order to meet their needs This usually only happened on the first administration of a particular drug regime. Patients were warned of this possibility and arrangements were in place to allow the treatment to continue overnight with the patient being admitted to a neighbouring ward. Staff we spoke with had a good understanding of safeguarding procedures. Knowledge of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards was detailed within the OCE. Staff told us how these processes were used to protect vulnerable people.

Monitoring safety and responding to risk

Staff told us they were encouraged to report concerns about safety via the trust incident reporting system but they often did not received feedback. Some staff felt they were kept up to date, whereas others felt less so. Senior nurses obtained feedback via the matron who attended divisional and trust wide groups. The senior nurse was then required to feed back to their team. Where this was a small team, we saw this worked well face to face. In other areas, ward meetings were held and minutes made available to the staff. However, there was little opportunity for bank staff and those employed on a zero hours contract to obtain feedback.

We spent time on wards observing care provided to patients. While we saw some excellent care, some records were not completed fully or accurately and this posed a risk to those patients. This was particularly evident in risk assessments and care plans for the management of wounds. We saw one patient was receiving VAC therapy – a therapeutic technique using a vacuum dressing to promote healing in acute or chronic wounds. Their records did not contain a care plan to inform staff how to care for them during their treatment. Notes did not contain a care plan where a patient had diabetes, and risk assessments were not routinely reviewed to establish any changes in condition or treatment. We saw one risk assessment that had not been reviewed for twelve days. This placed the person at risk of incorrect or inadequate care.

Staff had a handover of information each shift and they had a handover sheet for each shift. This was more accurate and informative than the notes and care plans. We saw staff of various disciplines updating this throughout the day. Staff from the bank and agency staff started at different times, and did not always receive the formal handover. One temporary staff member told us staff always told her what was happening when they arrived on duty. However, the reliance on verbal information and a handover sheet posed a risk that staff would not be aware of patient changes and so appropriate care may not be given.

Anticipation and planning

Staff in all areas told us that access to equipment was not a problem and that requests for specific items were acted on promptly. Where additional pressure relieving mattresses were required, staff told us these could be obtained within three hours.

Staff recorded staffing levels against patient needs on each shift. This information had been used to increase the staffing within the OCE. Staff told us that this had led to an immediate increase in the number of trained nurses on duty, although there remained a vacancy factor that they were attempting to address through recruitment.

Good

Medical care (including older people's care)

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

Good

Using evidence-based guidance

Adherence with national best practice guidance regarding relevant care and treatment was monitored. Where areas were identified that practice did not align with recommendations, action plans were developed to address the shortfall.

Within specialities, outcomes were monitored through local review as well as participation in national data collections. For example, the OCE reported their outcomes to the UK specialist Rehabilitation Outcomes Collaborative (UKROC) and used global measures of disability. In addition, the rheumatology service participated in national audits. Local audits were undertaken to measure the effectiveness of the services.

At the OCE we saw staff were innovative and creative in their support of patients. Staff were passionate that their patients received care, treatment, and support in line with current best practice.

People were supported to regain their independence. Support was given to people to eat and drink, but they were also supported and encouraged to regain these skills.

Performance, monitoring and improvement of outcomes

Patients could remain in both the BIU and the OCE for a significant period, with admissions varying from days to many months. Within the OCE we saw multidisciplinary team meetings occurred following admission to discuss and monitor therapy goals and expected date of discharge. This involved the patient and relatives as well as the full multidisciplinary team.

To promote and maintain wellbeing, psychological support could be obtained for patients who remained a long time. Bespoke meals could also be obtained because the usual meal pattern of a two-week rotation could become repetitive.

Staff asked patients for consent prior to undertaking care. This was recorded within the care records. Patients told us they gave consent to care and felt care was carried out in their best interest. Signed consent forms were completed prior to surgery. These contained details of the risks involved.

Mortality and Morbidity meetings were held as well a case review for readmissions and unusual cases. This allowed outcomes to be monitored.

Staff, equipment and facilities

Staff spoke positively of good team working. Specialist equipment was available on the wards and staff told us that where additional equipment was required, it could be obtained quickly which promoted a positive outcome for patients. People were able to be cared for in single rooms where their infections required. Side rooms were also in use where a patient was particularly unwell and nearing end of life.

Despite the limited space within the RDU, patients were happy with the care and attention they received. One person told us that despite the lack of space, they never felt cramped. We observed the area to be quiet and calm, despite there being little space between patients for staff to carry out their duties.

Patient dependencies were reviewed following the organisational changes which occurred in November 2013, during which seven divisions were reduced to five. As a result, more nursing staff posts were required and agreed by the board.

The ward areas were well equipped and equipment was available. Within the OCE, there was a large seating and dining area for staff, patients and relatives to use, and all meals were taken in a communal area. Visiting from families was encouraged and visiting hours had been extended to run from 10am to 10pm. There was a good-sized family room, which had a number of children's toys for them to play with. Meal times were protected with no clinical activities taking place at these times although families where encouraged to bring in home-cooked food if patients wanted. They were enabled to sit and eat with their relative if they so wished. There was a purpose-built gym used by the physiotherapists and several activity rooms, including woodwork and craft-making for patients as part of their rehabilitation. There were other rooms available for group sessions. To the side of the ward there was a "living unit", which was a purpose-built flat for patients and relatives. We were told that this allowed a

Good

Medical care (including older people's care)

family to practice having their relative at home if they were worried whether they could cope. This had the advantage of having the clinical team on-call nearby if they needed anything. It also provided a small amount of accommodation should a family want to stay overnight at the unit for a special occasion.

Multidisciplinary working and support

Some patients had multiple health needs which required the input of several teams. For example, patients on the BIU were often under the care of surgical as well as medical teams. There was a team of doctors based on the ward, and other specialities attended as required to ensure all clinical needs were met. Within the OCE there were a team of medical staff available during the week. In the evenings and at weekends, support was provided by the medical team who were on call for the main NOC building. Staff on OCE told us they bleeped staff if required. While sometimes the response was slow, there was a "fast bleep" system to alert the doctor if medical assistance was required urgently.

Staff told us that they had access to learning and development and ward based compliance with statutory mandatory training was in excess of 90% compliance. It was recognised, however, that funding for attendance at national conferences and learning events was difficult. Where additional skills were required, and additional training could be provided "'in house", this was arranged. For example, VAC therapy training for staff on BIU and following issues identified because of a deaf patient, deaf awareness training.

There was a new electronic system for monitoring mandatory training. This meant automatic emails were sent out whenever their training was due. However, senior staff where only able to see the updates for their immediate team members rather than the whole ward. Previously, on the OCE, there was a chart in the staff room with everyone's RAG (red/amber/green) status for training, but that this had been taken down with the new system.

Are medical care services caring?

Good

Compassion, dignity and empathy

We saw staff speaking to patients with kindness and compassion. Curtains were pulled around patients and were held together with red "engaged" pegs, when care was delivered. Call bells were to hand and we heard them answered without much delay.

On arrival at the RDU patients were seen in a side room for confidential discussions and consultations before receiving their drug therapy in the main area of the unit. Patients told us they were treated with dignity, respect, and compassion by all staff. They said staff went above and beyond what was expected of them to meet their needs, even at times when they appeared short staffed. Staff interacted well with patients in the OCE and noted that one staff member had come into work on her day off to provide an escort for a patient to return home.

Involvement in care and decision making

Within the OCE, patients and relatives were involved in decision making and goal setting. Staff asked patients for consent prior to undertaking care. This was recorded within the care records. Patients told us they gave consent to care and felt care was carried out in their best interest. Signed consent forms were completed prior to surgery. These contained details of the risks involved.

Trust and communication

Patients told us that staff asked for their consent to treatment and kept them updated about what was happening to them.

For patients whose first language was not English a telephone interpretation service was available. We were told that interpreters would be brought in to translate during consultant rounds. This had recently occurred on the BIU for a patient who was profoundly deaf and used sign language to communicate. In addition, staff used yellow cards" to support patients with learning difficulties express themselves, particularly in relation to pain, though not all staff knew where these were kept, stating instead they would use non-verbal cues such as screaming, shouting and facial gestures.

Good

Medical care (including older people's care)

Emotional support

Patients told us that medical and nursing staff were supportive even when they were busy. Staff expressed frustrations that they were not always able to spend the time with people to allow them to express their concerns.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Within the RDU, patients were sat closely together and movement was limited. A side room was used if patients needed some privacy. However, the patients on this unit felt that the good standard of care provided outweighed the poor environment.

On the OCE ward patients had a two-week assessment period during which rehabilitation goals were defined. Patients (where possible) and relatives were encouraged to complete a short questionnaire so that their wishes could be taken into consideration. There was then a multidisciplinary team meeting with the staff (medical, nursing, and allied health professionals) and including the patient (and relative) to discuss the outcome of the assessment. Staff told us that this was to ensure that the patient and relative where involved in the decision making process. However, not all relatives we spoke to thought this was the case. They said the meeting felt very one sided, and that they were merely informed of the plan rather than be integral to shaping it. No written information is provided after the discussion and there were no therapy goals displayed in patient's rooms. Patients each had a personalised timetable which outlined what activities they would be undertaking each day in order to help them towards their agreed goals.

Vulnerable patients and capacity

Patients were not routinely screened for dementia on admission unless they were over 75 years of age or staying in hospital for more than 72 hours, as per national guidance. Within the notes we reviewed, we did not see any dementia screening had been undertaken because the patients did not conform to the criteria. Patients on OCE were often confused and required additional nursing support to keep them safe. When requested, this would be provided, though cover became increasingly difficult if this level of supervision was needed for more than one patient.

We saw that when needed a best interest meeting was held to support the choices of patients with confusion. This ensured that decisions were made within the legal framework of the Mental Capacity Act 2005.

Access to services

Occupancy levels across the trust were at a level of 92%. Because of the specialist nature of the services, patients remained on the wards. Both areas were full at the time of our inspection.

The OCE acknowledged that there was a long waiting list for admission to the ward. The nature of the patients that were cared for at the centre for enablement meant patient turnover was low and patients may remain an inpatient for several months. Patients were referred primarily from the John Radcliffe site, but they also receive out of county referrals.

Leaving hospital

Patients received appropriate information about discharge, including leaflets and specific information relating to them, and discharges were planned. Within the OCE, discharge goals were set early on in the patients stay and were subject to regular reviews. Because patients stayed in both inpatient areas for some time, staff did not identify issues with regard to planning and preparation for discharge to us.

Learning from experiences, concerns and complaints

All inpatients were given the friends and family test on discharge and results were monitored at directorate and divisional meetings. Patient complaints and concerns were also reviewed and reported at ward meetings.

Good

Medical care (including older people's care)

Are medical care services well-led?

Good

Vision, strategy and risks

Most staff we spoke with told us they were proud to work where they did. However, they felt distanced from the running of the wider organisation, although they reported positive changes since the NOC became part of the Oxford University Hospital Trust.

There had recently been a change to the directorate structure within the trust. The OCE was previously within the musculoskeletal and rehabilitation division rather than the medicine, rehabilitation and cardiac division. The divisional restructure had resulted in the OCE now being more aligned to the John Radcliffe site and as such from October 2013 a new matron was in place. The matron was based at the John Radcliffe site, but came across to the OCE once a week. It was acknowledged that this was a new role and that certain changes were in their early stages. The matron had already started to make changes with the way patient acuity was measured which had resulted in increased staffing numbers for the ward.

The matron had a clear vision of what they wanted the OCE to look like in two years' time. They acknowledged the need for greater integration with the John Radcliffe site and that lessons where not always being transferred or shared between other hospitals in the organisation. This was also the case between the NOC and OCE. There was the potential that the OCE could become isolated from both the John Radcliffe site and NOC as a result of the changes, but the matron was aware of this and was keen to ensure that this did not happen.

The OCE staff reported that there was not good visibility from the executive team. They told us that the chief nurse had undertaken an executive team walkabout recently, but that they had not seen the other executive directors. There was a sign by the entrance to the ward stating that the medical director had been involved in the most recent walkabout in November 2013, but staff did not recall this. The trust told us that this area had been subject to a peer review visit as part of the trust wide programme.

Governance arrangements

We saw the monitoring arrangements and feedback about ward performance. Directorates each held clinical governance meetings where incidents, complaints, and concerns were monitored as well as quality and outcome measures and compliance with national guidelines. Ward staff meetings were held during which staff received feedback and could discuss results. Directorate clinical governance reports fed into both the divisional and then trust governance processes. This meant performance was monitored, and risks could be escalated to both the division and the trust.

Leadership and culture

Medical and nursing staff were dedicated and committed to providing good patient care, and to improving care. Staff said they felt supported by their line managers. Doctors were supervised and felt able to call for senior help when required.

Patient experiences, staff involvement and engagement

Patients we spoke with told us they felt safe and well cared for. The RDU was described as very efficient and well run, despite the constraints on it by the size of the unit. Patients' spoke of never having appointments cancelled. They said appointments were made with their involvement, so they always knew when they were next due to attend before they left.

An established patient involvement group met three times a year to discuss what improvements could be made to the site for the benefit of patients.

Learning, improvement, innovation and sustainability

Electronic patient records (EPR) were in the process of being rolled out. Staff appeared comfortable with using them. There was a policy in place for the use of temporary smartcards by agency staff to access the EPR. However, agency staff did not have access to the EPR system and therefore would still write on paper form. This had the potential for things to be missed and for the notes to be disjointed.

Good

Surgery

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

Information about the service

Surgical services at the Nuffield Orthopaedic Centre formed part of the trust's musculoskeletal clinical directorate, which was a sub-division of the neurosciences, orthopaedics, trauma and specialist surgery division. The hospital specialised in spinal, elbow, foot and ankle, hand and wrist, hip and knee surgery long bone/pelvic infection and reconstruction. Operations were planned (elective). There were three inpatient orthopaedic wards, eight theatres and a day case unit.

Summary of findings

The hospital had a good safety record, with only one serious incident reported in the 12 months prior to our inspection. There was evidence that this incident, which resulted in the death of a patient, had been thoroughly investigated and learning had been identified. The formal process in place to ensure learning from incidents was not effective because staff were not aware of that which occurred in other areas of the hospital or the trust.

All of the patients we spoke with were effusive in their praise for the staff at the hospital, with comments including: "nothing is too much trouble" and "this is the best hospital I have been in." Staff were caring, dedicated, and proud to work at the hospital. It was considered a good place to work by many staff, who felt well supported by senior clinicians and local management. Staffing shortages for nurses and healthcare assistants presented an ongoing challenge and there was regular use of temporary staff. Staff expressed frustration about patients' discharge being delayed because of a lack of suitable hospital beds or support in the community. This sometimes led to bed blockages and cancelled operations. Despite these challenges, staff believed that they provided a good quality of patient care and discharge arrangements were proactively and effectively planned.

There was significant discontent among the consultant body, who were concerned about the culture and the management style of senior managers. They were also concerned that they were given inadequate time for teaching, research and personal development. There

Good

Surgery

was unhappiness about a lack of engagement with clinicians and a belief that decisions were being taken without consultation with clinicians for financial reasons, which were detrimental to patient care. Some senior staff felt they could not speak out or did not feel that they were listened to.

Are surgery services safe?

Good

Safety and performance

The Nuffield Orthopaedic Centre had a good safety record, with no never events and only one serious incident reported between December 2012 and November 2013. A serious incident occurred in March 2013, which resulted in the death of a diabetic patient following surgery. An investigation, including a root cause analysis, had been carried out promptly and an action plan had been developed to ensure that staff were educated and systems improved to minimise the risk of a similar occurrence.

In the 2013 Patient Led Assessments of the Care Environment (PLACE), the Nuffield Orthopaedic Centre scored over 90% for two of the areas assessed; cleanliness and facilities. The quality report for the musculoskeletal and rehabilitation services division showed that between August 2012 and October 2013, 111 out of 115 patients received "harm free care". This showed that there was a low incidence of harmful events such as pressure ulcers and urinary tract infections, falls and blood clots.

Learning and improvement

Theatre staff were well informed about safety matters and could describe how and when to report untoward incidents. They told us that incidents were investigated thoroughly and learning was disseminated.

There was some evidence of learning from incidents. The investigation report following the serious incident in March 2013 showed that learning had been identified but it was not clear how far this learning had been disseminated and what progress had been made in implementing all identified remedial actions nearly 12 months on.

A specialist diabetic nurse had been appointed to support staff; this staff member was currently in training. A new blood glucose monitoring chart was in evidence on E ward, where the incident had taken place. The ward sister told us this had been implemented hospital-wide but not trust-wide because this "would take a little longer". They told us this documentation formed part of a more comprehensive protocol for the care of diabetic patients but this had not yet been ratified. The investigation report into the incident had identified a contributory factor being

that there were only draft guidelines for the management of diabetic patients at the Nuffield Orthopaedic Centre and there were no trust-wide guidelines. We found that this was still the case. The action plan stated the intention was to "Set up a task and finish group to review the draft NOC guidelines for peri-operative management of diabetic patients for urgent ratification and roll out". The implementation date for this action was recorded as June 2013 and the status was recorded as "in progress". The trust told us that the action plan following this incident had been subsumed into a wider trust-wide programme of action and learning. Consequently, some of the actions in the original plan were not completed as they had been superseded.

Systems, processes and practices

There were systems and processes in place to keep people safe. We observed a theatre team participating in a team brief/planning meeting prior to their operating list starting. They introduced themselves, discussed the planned theatre list and equipment. We witnessed them engaging well with the WHO checklist process. This is a safety checklist developed by the World Health Organisation, which requires all of the theatre team to engage and accept joint responsibility for ensuring that safety checks are undertaken at each defined stage of the surgical procedure, thereby minimising the risk of the most common and avoidable errors. Compliance with the WHO checklist was audited on a monthly basis. Performance in the musculoskeletal and rehabilitation division between August 2012 and October 2013 ranged between 93% and 100%.

There were procedures in place for close monitoring of patients immediately following surgery, with observation charts being completed hourly for four hours and reducing incrementally thereafter. A "track and trigger" process was used to monitor patients' important signs, such as their breathing rate and to alert staff if a patient's condition was deteriorating, and required medical advice or intervention.

Premises were suitably designed, laid out, and well equipped to ensure patients' safety. Wards were well laid out, with provision for close observation of acutely unwell patients and for barrier nursing of infectious patients. Wards were clean and there were appropriate arrangements for cleaning and for the segregation and disposal of waste. There were adequate hand washing facilities and patients told us they saw staff regularly washing their hands. Staff observed the "bare below the elbow" uniform policy and wore suitable protective clothing, such as gloves and aprons, which were in plentiful supply. There was a resuscitation trolley on each ward. We checked one trolley, which was fully equipped and consumable items were all in date. There were records to show that the equipment had been checked daily.

Bays and single rooms were spacious and allowed for safe moving and handling of patients. The wards were well equipped with lifting equipment and there was ample storage space so that corridors were free from clutter and trip hazards. There were appropriate anti-slip floor finishes and hand rails to prevent falls. There were call bells in bathrooms and toilets so that people could call for help.

Medicines were appropriately stored and disposed of and there were regular audits by the hospital pharmacist to ensure that safe systems were maintained.

Monitoring safety and responding to risk

There was a clinical governance system to monitor quality and safety. This operated at team level, reporting upwards to directorate, divisional and trust level. Each directorate and division maintained a risk register and produced a monthly quality report. Risk registers were also discussed and reviewed monthly.

Anticipation and planning

On surgical wards planning was done well to reduce any potential risks to patients. Staff assessed patients promptly on admission in order to identify risks. If patients required a higher level of observation, for example, then workload was discussed at handovers and organised to facilitate the required level of support.

In theatres pre-list briefings took place where the whole team discussed the planned cases and discussed issues such as equipment, timings, and individual roles.

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

Good

Using evidence-based guidance

There was an enhanced recovery programme in place for hip and knee surgery. This was a new evidence-based approach designed to help people recover people more

quickly after surgery. The Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences was a partner in a joint initiative called the Priority Setting Partnership (PSP) on hip and knee replacement. The aim of the PSP was to gather information from patients and clinicians to inform future research and treatment.

Performance, monitoring and improvement of outcomes

Information on patient reported outcome measures (PROMs) was gathered from patients who had hip or knee replacement surgery. Patients were asked about the effectiveness of their operation and the response data showed no evidence of risk and good outcomes for patients. The trust achieved compliance with the nine standards of care measured within the National Hip Fracture Database.

The number of unscheduled returns to theatre within 48 hours between August 2012 and October 2013 averaged at 0.8 per month, ranging from nil to three per month. The number of surgical site infections ranged from nil to 13 per month, with the average being 2.3 per month.

Staff told us that sometimes operations were cancelled because beds were not available. Extended length of stay for some patients was "a constant challenge" because of a shortage of rehabilitation beds or other support in the community. A senior nurse told us that the orthopaedic wards were staffed and resourced to function as short stay wards and there were concerns that patients who remained in hospital for longer may not always get the attention they needed. They said "we have a high turnover of patients; there is a potential for 'long stayers' to get left behind". They told us that some patients stayed in hospital for up to a month. They said that these patients' did receive on-going rehabilitation and were seen by physiotherapists and occupational therapists, although therapists' priorities had to be supporting patients in the acute phase of their recovery. They said that there were no additional resources to support longer-term patients.

Staff, equipment and facilities

Staff told us that patients' operations were sometimes cancelled due to lack of capacity. This was due to a lack of beds. Patient flow was a significant challenge. A major contributory factor was the lack of availability of appropriate beds or support packages in the community for people who required a period of rehabilitation. This meant that such patients occupied beds on acute wards, preventing further planned admissions.

Optimal staffing levels on the orthopaedic wards were not consistently achieved. The hospital experienced difficulty recruiting and retaining staff. These difficulties were largely attributed to the cost living in the area and parking costs. There was high reliance on temporary (bank and agency staff). Although staff told us that generally the calibre of temporary staff was high, they felt that use of temporary staff inevitably impacted on the quality and continuity of patient care. Staff, including a student nurse, told us they felt well supported and received a good level of training for their role.

Multidisciplinary working and support

Staff told us that there was excellent multidisciplinary working between doctors, nurses, physiotherapists and occupational therapists, all of whom attended bed meetings, although a senior nurse reported little support from physicians for surgical patients with co-existing medical conditions. Handovers between shifts were held as a team and then individual patients were discussed on a one-to-one basis. This level of communication helped to ensure continuity of care. A staff member told us "You get to know your patients better this way and it is safer."

Are surgery services caring?

Good

Compassion, dignity and empathy

Patients on orthopaedic wards were treated with compassion. They were effusive in their praise for staff and the way they had been treated and cared for. Comments included; "I have received excellent care from the doctors and the nurses. They [nurses] are constantly checking to make sure you are okay." One patient, who had travelled a long distance for their treatment and come a little unprepared, told us how grateful they were that staff had arranged replacement batteries for their hearing aid and had found a charger for their mobile phone.

Patients told us they had plenty to eat and drink and the quality and choice of food was good. There was a ward

pantry where staff could prepare drinks and snacks for patients in between meal times. There was a fridge where patients could store their own food and drinks if they had special preferences.

Patients' privacy and dignity were respected. All of the patients we spoke with told us they were treated with courtesy and respect. We noted that curtains were drawn around patients' beds when personal care was provided. Ward accommodation, including toilets and bathrooms, was segregated so that men and women were afforded privacy and dignity. There were some side rooms with en-suite facilities. These were used at the nurses' discretion for people who had particular needs.

Six out of 11 patient reviews posted on the NHS Choices website between March and September 2013 gave the hospital five stars. Themes included excellent care, patient focused care, supportive staff, and good communication.

In the Patient Led Assessment of the Care Environment (PLACE) in 2013, the Nuffield Orthopaedic Centre scored 85.3% for privacy, dignity and wellbeing, and 76.7% for food. There were no breaches of the target to provide single-sex accommodation during 2013.

Involvement in care and decision making

Patients told us they felt involved in decisions about their care and treatment. They told us that nursing staff made efforts to get to know them and understand their needs and preferences. However, we saw little information recorded in care plans to show this.

Trust and communication

Patients told us they were well informed about their medical condition and their treatment. The risks and likely outcomes of surgery had been explained to them and they had been asked for their consent. There was a range of patient literature available, both on the wards and on the trust's website. There were posters displayed with commonly asked questions and answers about surgical procedures. These included "What does my knee replacement look like?" and "Will my implant set off a metal detector?"

There was a "who's who?" notice at the entrance to the wards so that staff could be identified. There were also posters showing the how different staff roles could be identified by the colour of their uniforms. Information was displayed showing how the ward performed in terms of the incidence of pressure ulcers, infections, and falls. There was also information showing how many staff should be on duty.

Patients were encouraged to provide feedback about their experience on the ward. The hospital, in common with all of the trust's locations, used the friends and family test to capture patient feedback. Questionnaires were given to patients on discharge and responses were displayed on ward notice boards. There was also a white board where patients and carers could record their comments.

Emotional support

Patients and relatives told us they received the support they needed to cope emotionally with their treatment and hospital stay. There was a chaplaincy service and multi faith prayer room in the hospital.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patients told us that all of the staff were responsive to their needs. Those people who had used their call bells when they needed help said, staff always responded quickly.

The hospital worked towards achieving national targets in relation to waiting times, cancelled operations, and delayed discharges. The NHS constitution sets out that patients should not wait more than 18 weeks for treatment from the time they are referred. Overall data for the trust showed no cause for concern in relation to this target.

Department of Health guidelines state that if patients require surgery and their operation is cancelled for non-clinical reasons, their operation should be re-arranged within 28 days. The trust scored similar to expected when compared with other trusts in relation to cancelled operations. Staff told us that operations were sometimes cancelled due to unavailability of beds. Data was not provided specifically relating to the Nuffield Orthopaedic Centre; however, trust-wide data for trauma and orthopaedics showed that the rate of cancelled operations between 1 April 2013 and 31 December 2013 was 0.7%.

Good

Surgery

There were systems in place to assess, monitor, and evaluate people's needs, although the standard of record keeping on wards was varied. We looked at four patients' records. Risk assessments had been completed promptly and daily records, including regular observations were regularly recorded. However, care plans were poorly completed. There were standard templates used for care planning. These were pre-populated, containing a large number of helpful prompts at each stage of the care pathway, for example, preparation for surgery and preparation for discharge. There were core care plans covering areas such as diet and fluids, risk of developing pressure ulcers, wound care, and mobility. In addition, there were care plans for specific needs or conditions, for example, for patients with diabetes or infectious patients. While these were helpful templates, we found that staff had not adapted care plans to reflect patients' individual needs. It was not clear in any of the four care plans we looked at, which of the many prompts were applicable to particular patients because they had not been annotated. Individual indicators were rarely completed. For example, we could not see from care plans what somebody's normal bowel habit was or whether they needed assistance to eat and drink.

We noted in one care plan that a patient had been assessed as being at high risk of developing pressure ulcers. They required regular turning to mitigate this risk but this was not specified in their care plan. The only thing that had been recorded was that an air mattress had been provided. Given that the wards regularly employed temporary staff it was particularly important that people's individual needs and preferences were clearly described. In addition some people may not be able to communicate their needs effectively.

Vulnerable patients and capacity

There was inadequate documented evidence that the needs of vulnerable people were identified or assessed and care planned to meet those needs. We could not be assured, therefore, that they were being supported appropriately.

E ward had been designated as able to accommodate patients with "special needs", including people with a learning disability. The ward sister told us that the nursing staff were "skilled up" to support and care for people with challenging behaviour. Two rooms had been designated carer's rooms so that these patients had access to carers who were familiar to them. A link nurse provided advice to staff. There was a care plan template designed to be used for patients with special needs. There was a booklet called "Information about you" which captured important information about patients, which they may not be able to communicate to staff. This booklet was designed to be hung on the end of the patient's bed so that all staff involved in their care had access to the information.

D ward had been designated a dementia friendly ward and we were told that there were plans to make changes to the environment to make it easier for people with cognitive impairment to orientate themselves. However, we were told that patients with dementia were currently cared for on all wards. A dementia link nurse provided support and advice to staff. We were told that all staff attended mandatory training in dementia. A specific care plan template could be used for patients who were confused or who exhibited challenging behaviour.

We identified one patient on E ward who had been there for approximately three weeks. They were elderly and had a neurological illness and associated dementia. They were accommodated in a single room because they were highly dependent on staff for all aspects of care. We looked at their care plan and associated records. Although there was reference to their medical condition and dementia in the documentation completed on their admission, there was no care plan in respect of these conditions which would guide staff as to how this person should be cared for. The patient had limited communication skills due to their medical condition but there was no guidance as to the most effective way of communicating with them. There was no information captured about this person's personal preferences, which they may not have been able to communicate clearly themselves. We noted that this person experienced period of low mood and had exhibited some aggressive behaviour. There was no plan to describe how staff should manage this and provide appropriate support.

Access to services

Access to services was variable; sometimes operations were cancelled due to unavailability of beds. There was limited access for some people who required a period of rehabilitation, to suitable placements in the community.

Leaving hospital

In common with other trust locations, there were challenges in relation to delayed discharges for patients

who were unable to care for themselves at home following their surgery. Most of the surgical procedures undertaken at the NOC required a short inpatient stay of three to five days. Sometimes discharge was delayed because suitable placements could not be found in community hospitals. There were contracts in place with out of area hospitals which had referred patients to the NOC for specialist surgery. The contracts ensured that the referring hospital arranged for the repatriation of their patients within a stated timescale following surgery.

Department of Health guidelines state "patients should be discharged from hospital when ready and with information and support available to them to ensure they do not need to be re-admitted. Patients should have adequate notice of their discharge and it should not be delayed due to waiting for medicine, to see a doctor or for an ambulance." In the CQC survey of adult inpatients (September 2012 to January 2013) the trust scored similar to expected when compared to other trusts in relation to these targets.

Staff told us that routine discharges were managed efficiently and effectively. There was proactive discharge planning with detailed discharge plans developed on admission. Prompts included checking transport arrangement and medicines were in place, outpatient appointments were arranged and letters had been written to GPs, direct or practice nurses.

Staff told us, despite the fact that occupancy rates were high, they did not come under pressure to discharge patients with inadequate notice or having to transfer them to a discharge lounge in order to vacate a bed. They attributed this to good planning and efficient processes to prevent delays. One such process was that medicines, which patients were prescribed to take home with them, were prescribed early on in their stay and dispensed and stored on the ward. This meant that patients did not have to wait for their medicines to be dispensed on the day of their discharge.

We spoke with two patients who were hoping to be discharged that day. Both told us they were waiting to be seen by a doctor. They were not unhappy about this wait and were confident that all other necessary arrangements had been made.

Learning from experiences, concerns and complaints

Patients told us they would feel comfortable about complaining to staff if something was not right and they were confident that their concerns would be taken seriously. People knew how to complain. Most people told us they would talk to staff and some were aware of the hospital's Patient Advice and Liaison Service (PALS), which was publicised on the wards and on the trust's website.

The wards we visited had received few complaints. We asked staff if there were any themes; they could not think of any.

The hospital routinely captured feedback using the friends and family test. Staff told us that results were regularly discussed at team meetings.

Are surgery services well-led?

Good

Vision, strategy and risks

There was a clear trust vision and a set of values, which were patient focused. Many staff did not know what the vision and values were but portrayed similar values and passion and motivation to provide excellent patient care. There was a strong sense that the Nuffield Orthopaedic Centre had lost its identity when it became part of the Oxford University Hospitals NHS Trust but it remained detached from the larger trust and did not share its vision.

Governance arrangements

There was a clear governance structure with reporting lines from departments through directorates and divisions, ultimately to the trust Board. However, there was a lack of clarity around lines of accountability, cross divisional and cross hospital working. Policies and procedures had not all been standardised following the merger of the Nuffield Orthopaedic Centre and the Oxford University Hospital NHS Trust. This was where they were relevant to the activity in the centre and a plan was in place to migrate all guidance as it is due for renewal.

Leadership and culture

At a local level there was strong clinical leadership. However, a senior clinician told us there was poor engagement from senior management. For example, they told us that a decision had been made to change the

suture material used in surgery without any clinical consultation. The trust told us that this change was part of a cost improvement programme and had been led by a consultant surgeon. Issues and concerns which were raised by surgeons were considered as part of the clinical governance committee in December 2013 and a list of procedures for which alternative sutures could be used was in place. The senior clinician also told us that concerns raised by surgeons and anaesthetists about inadequate anaesthetist cover during the twilight shift (6.30pm to 9.30pm) had not been acknowledged by management and a business case for increased resources had been rejected. This was raised by a further three senior clinicians. The trust received and approved a trust wide anaesthetic workforce plan in June 2013 which was reviewed by the board in March 2014.

One of the consultant radiologists described concerns about management style and decisions. This was particularly in relation to the employment of agency staff at short notice and a concern about the outsourcing of radiology and the impact of that on quality. We reviewed an audit report provided to us by the trust. This did not corroborate the view of this consultant and provided assurance on the quality of the service.

Patient experiences, staff involvement and engagement

Patients' views and experiences were a key driver for how services were provided. There was information displayed in wards showing how the ward was performing and what the friends and family test results were telling them. At local level staff felt involved and engaged in making things work and constantly improving standards of care. However, there was less engagement about, or understanding of, other drivers, pressures and challenges and staff did not see opportunities to have open dialogue about problems or solutions.

Learning, improvement, innovation and sustainability

There was eagerness to learn and to constantly improve care and treatment. However, some senior clinicians were concerned that innovation was stifled and opportunities for learning were limited because of financial and demand pressures. Consultants told us they were having their time for supporting professional activities (SPAs) cut to the minimum (one SPA). This meant that they had less time for teaching, research, and personal development, which was vital to their role. The trust sent us a sample of eight anonymised job plans, of which four had one SPA. The remaining four had between 1.5 and two. The trust had approved job planning process which had been consulted on. This process required all job plans to be structured at a baseline of nine direct clinical care programmed activities and one supporting programmed activity. All job plans were negotiated from this baseline dependent on the trust's needs and individual roles. This incorporated specific additional SPAs for approval trust activities including clinical, managerial, teaching or research.

Good

Outpatients

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

Information about the service

The Nuffield Orthopaedic Centre provided routine, planned specialist orthopaedic, rheumatology and rehabilitation services. In 2012/13 the hospital saw 112,123 patients, which accounted for 14.8% of the total trust-wide activity. We visited the outpatients department and the triage team for musculoskeletal (MSK) services. We spoke to five staff and eight patients.

Summary of findings

Patients received safe and effective care delivered by sufficient numbers of staff with relevant training. The triage team ensured that patients were assessed and each appointment was booked to ensure a smooth transition to investigations and treatment within the hospital.

We spoke with eight patients and most were complimentary about the service. Patients were well informed, had their appointments booked in a timely manner and did not wait long to be seen. All patients' records were computerised and accessible. The environment was clean and spacious and the department was well led.

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

Patients were protected from avoidable harm. The hospital had a good safety record, with no major risks reported on the hospital's risk register. Patients told us that they felt safe in the hospital.

Premises were modern, having been commissioned in 2008. Waiting areas were spacious and there was room for patients with physical disabilities to manoeuver.

There were sufficient staff of an appropriate skill mix to deliver effective care and treatment. Staff told us there was always a nurse available when clinics ran late. We observed a calm and pleasant environment where patients and staff were unhurried.

Learning and improvement

A member of staff told us that complaints were passed down to the staff to learn from the information and improve patient experience. Complaint data from each directorate was collated on a monthly and quarterly basis to identify themes and root cause. Complaints were also discussed on an individual basis at directorate governance and staff meetings to ensure staff were aware of issues and learn as a group. The themes from the PALS feedback and complaints trust wide identified areas for improvement in the January 2014 board meeting. There were no themes that related to outpatients.

Systems, processes and practices

Premises were modern, having been commissioned in 2008. Waiting areas were spacious and there was room for patients with physical disabilities to manoeuver. The clinic was clean, spacious, and clear of clutter. There were hand cleaning gels for patients and staff to use and we saw them using these.

There was resuscitation equipment in the department. Staff told us that the resuscitation equipment was regularly checked to ensure it was ready for use when required.

There were sufficient staff of an appropriate skill mix to deliver safe and effective care and treatment. Staff told us there was always a nurse available when clinics ran late. We observed a calm and pleasant environment where patients and staff were unhurried.

Monitoring safety and responding to risk

The sister and deputy sister attended monthly governance meetings and ensured that staff were informed about safety matters or changes in practice. Minutes from these meetings were shared.

Anticipation and planning

Planning was done well to reduce any risks to patients. The referral pathways identified where patients were prioritised by the triage team to complete their treatment, including specialist advice and investigations.

Staff told us the imaging department occasionally had free slots available and they informed outpatients to ensure they were used. Urgent imaging was usually done the same day. Patients were escorted to radiology to book appointments and were seen within one week and sometimes the next day to include a follow up appointment.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment was delivered in line with evidenced based guidance. A patient told us they had chosen the hospital for treatment because it had a good reputation for orthopaedic treatment.

Performance, monitoring and improvement of outcomes

The national outpatient survey in 2011 showed that the trust had performed "as expected" in comparison to other trusts.

The trust participated in national clinical audits, reviews of services, benchmarking and clinical service accreditation. A member of staff told us that an audit had been completed to show how the clinics worked. Observation and clinic times had informed a change in work planning and there

Good

Outpatients

were plans to make some adjustments to clinic times. Patients we spoke with were pleased with the way the clinics were organised and there were no complaints about waiting times.

Staff, equipment and facilities

The facilities were modern and well maintained. Monitor screens in the clinic provided patients with information about how long they had to wait. We observed there were times when the waiting times required updating.

A member of staff told us that mandatory training for staff was all up-to-date. A computer system alerted staff when training needed to be completed. Mandatory training included life support and safeguarding children and adults. They told us that there were occasions when study leave was difficult to take.

Multidisciplinary working and support

There was good multidisciplinary working to ensure that patients had investigations completed quickly. The triage team ensured that patients were assessed when required before they visited the clinic. This enabled investigations to be completed before a consultant appointment which improved efficiency.

Are outpatients services caring?

Good

Compassion, dignity and empathy

Patients they told us they felt safe and comfortable and were treated with kindness and dignity. Patients had their consultation in private rooms. We observed staff gently supporting a patient when they were uncomfortable from waiting too long on a hard chair. They were directed to a more comfortable chair. Two staff from the triage team were chaperoning patients and helping them to book appointments.

Involvement in care and decision making

Patients told us they were involved in decisions about their care and treatment. Patients had been given sufficient information to enable them to give informed consent to treatment.

Trust and communication

We observed that staff greeted patients with respect and warmth. Most patients told us their experience was positive and their care was excellent. Patents told us that the 'choose and book' system worked well for them and appointment reminders were sent. Patients told us they did not wait long for x-ray and scan appointments. One patient was concerned that their GP did not know their operation had been cancelled for health reasons and the letter for their appointment did not say who they would see this time.

Emotional support

One patient told us they had a very happy experience in the hospital after having three operations.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Waiting times in outpatients had improved from 70% satisfaction in June 2013 to 85% satisfaction in January 2014. There were improvement actions displayed on star shapes on the notice board to show patients what actions had been taken to improve the service.

The choose and book system was working well. Each referral required the triage team to make a phone call to patients at a pre-arranged time. The team dealt with a lot of queries about appointments and sent out appointment letters for face-to-face appointments and secondary care if required. We saw an example of a letter that contained relevant information for patients about procedures.

We spoke with the service improvement manager in the triage team, where ten staff operated the phone lines and booked appointments. The team dealt with 125 referrals daily at the first triage stage. Patients were offered choice on the choose and book system, to include the most convenient location and appointment time. The second stage of the triage pathway was a face-to-face appointment with a specialist clinician, which could include treatment from specialist physiotherapist consultants. A small percentage of patients had an appointment for secondary care (stage three) to see a consultant about possible surgery. We saw that the system was working well and GPs were able to access the choose and book system to see what stage of the pathway their patients were at.

Good

Outpatients

We observed that staff spoke politely and slowly on the telephone so that patients were able to understand. The choose and book appointments system had been piloted and had been running successfully for eight months. Most patients waited three weeks for a face-to-face appointment with a doctor. The service was flexible and additional clinics could be arranged in the evening or at weekends.

Six clinics run at one time and were rarely cancelled. Staff told us that patients were informed by telephone or letter and provided with an explanation for the cancellation. Staff told us the spinal surgery team sometimes cancelled clinics. Staff told us they recommended patients used the Patient Liaison Service (PALS) and encouraged them to make a complaint. A member of staff told us that a new director had started to look at how spinal patients' experience could be improved. New staff had been recruited for spinal surgery.

Clinic cancellations were rearranged promptly to reduce delays and inconvenience. We were told about a recent example where a clinic was cancelled and all the patients were seen within 24 hours.

Vulnerable patients and capacity

All staff had completed mandatory child and adult safeguarding training. Trust policies and procedures which included safeguarding and the Mental Capacity Act 2005 could be accessed on line by staff. Staff attended regular mandatory in safeguarding. There had been no safeguarding alerts recorded in outpatients.

Access to services

Patients could make appointments to access the right care at the right time and appointments were easy to make. Patients could access care as close to their home as possible. GPs could refer patients electronically or by letter. The musculoskeletal team triaged appointments to ensure they were appropriately prioritised. Specialist clinicians arranged investigations that may be required prior to seeing the doctor.

Leaving hospital

There were information leaflets available for patients about inpatient facilities and the arrangements for being discharged from hospital.

Learning from experiences, concerns and complaints

The Oxfordshire Clinical Commissioning Group (OCCG) were working with the trust to reach the 18-week target for referral to treatment times. The biggest delay for patients occurred when GPs did not enter the patient's provider of choice on the booking form. This resulted in the booking form being returned. Six out of 35 GP practices were not using the Choose and Book system which prolonged the appointment time for patients. We were told there were few complaints but they were mostly about car parking and waiting times in clinics. The trust had responded to this feedback and had begun to make changes to improve patient experience. Some changes had already taken place; pre-operative assessments were now taking place in outpatients, which meant that patients required fewer hospital attendances. The introduction of weekend and evening clinics and the appointment and the employment of additional spinal consultants were also examples of actions taken in response to patient feedback.

There were regular governance meetings where feedback was discussed. At the meeting in January 2014 there had been discussion about patient questionnaires and providing a regular view of all outpatient departments on a specific week each quarter. One outpatient clinic had already used a monthly questionnaire for patients. Other initiatives were being trialled to capture patients' views. A tablet computer was used for patients to provide their feedback.

There were few complaints but some had been received about car parking and waiting times. We were told that patients were not required to pay excess parking charges if their appointments were delayed.

Triage staff had received very few verbal concerns from patients, which were mainly about appointment delays caused by the GP not completing the referral form correctly. They had only cancelled two patients' appointments in the last six months. This had been due to staff illness. Staff told us the reason for cancellation was always explained to the patient.

Good

Outpatients

Are outpatients services well-led?

Good

Vision, strategy and risks

There was a clear trust strategy underpinned by a drive to deliver high quality care to patients. The trust board was aware of and understood the risks to achieving this. It was evident that staff shared the values of the trust and expressed pride in the service they provided.

Governance arrangements

There was a monthly outpatients steering group meeting where best practice was shared and risks were identified. Any negative issues raised in the outpatient departments would be escalated to the service development directorate and to the board where necessary.

Leadership and culture

The outpatient steering group meeting minutes for January 2014 told us that the project manager had visited the hospital to see how the trial of a handheld computer device had progressed. We also noted that the sister at the hospital had started staff reviews and the information would be sought to inform the next meeting. It was agreed that all sisters in outpatient departments would work on staff reviews collaboratively. The project manager encouraged sisters to visit each other's areas regularly for networking and peer review.

Patient experiences, staff involvement and engagement

Patients' views and experiences were key drivers for change. Staff told us they enjoyed working in the hospital as part of a team. They told us it was a positive experience. Some changes had affected the way they worked. These included merging pre-operative assessment with outpatient appointments. A staff member told us they had been unhappy about this change but a resolution had been achieved.

Learning, improvement, innovation and sustainability

The trust had set out their vision for improving services in "transforming patient experience strategies for 2014-2016". The hospital was currently undertaking a "re-profiling" exercise. This was a review of the way that outpatients was organised and managed to ensure that the capacity was sufficient to meets increasing demand to improve targets. The trust used Royal College guidelines to inform this piece of work. For example, examining the number of patients seen and appointment duration. The outpatients re-profiling report for January 2014 showed that a "lessons learned" exercise had been completed. The trust had used an evidence-based tool designed by the NHS Institute for Innovation and Improvement. All specialties had increased the number of patient slots in clinics compared to old profiles.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider had failed at times to take proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment arising from a lack of proper information about them, by means of the maintenance of an accurate record in respect of each patient, including appropriate information and documents in relation to that care and treatment. Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services. There was no suitable information within care records to inform staff about the individual care patients needed. This was particularly in relation to the needs for vulnerable people, particularly those with dementia and patients requiring complex wound management.