Care Quality Commission

Buckinghamshire Healthcare NHS Trust

Wycombe Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and family planning	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Wycombe Hospital is one of seven hospitals that formed part of Buckinghamshire Healthcare NHS Trust. This hospital was an acute hospital and provided medical care, surgery, critical care, maternity, children and young people's services, end of life care and outpatient services, which are seven of the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. Accident and emergency (A&E) services were not inspected at this trust because the minor injuries unit was managed by the Buckinghamshire Urgent Care Service. We did inspect the Cardiac and Stroke Receiving Unit for emergency admissions.

Wycombe Hospital had 250 beds. The hospital offered a wide range of surgical services and specialist medical care for stroke and heart conditions. The hospital also offered specialist cancer and urological services. There was a modern midwife-led maternity unit aimed at providing a more home-from-home environment for women and their partners. Wycombe Hospital saw more than 36,000 inpatients and 145,000 outpatients a year.

We carried out this inspection because the Buckinghamshire Healthcare NHS Trust had been flagged as a potentially risk on CQC's intelligent monitoring system. The announced inspection took place between 18 to 21 March 2014 and an unannounced inspection visit took place between 6pm and 10pm on Saturday 29 March.

Overall, we rated this hospital as 'Requires improvement'. We rated it 'Good' for effectiveness and caring for patients, but it required improvement in providing safe care, being responsive to patients' needs and being well led.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect, although staff shortages and busy ward areas meant the patients care needs were not always met.
- Staff followed infection control practices and infection rates in the hospital were similar to those of other trusts.
- Patients were supported to eat and drink, where appropriate, and standards to ensure that patients were properly hydrated had improved.
- The trust had worked to improve emergency care and had improved its mortality rates. Patients whose condition might deteriorate were identified and escalated appropriately and mortality rates were now within the expected range.
- There were concerns about nurse staffing levels. Wards and patient areas were staffed appropriately but there was a heavy reliance on nurse bank and agency staff and in some instances this affected the delivery and continuity of patient care. The trust was investing to improve nurse staffing levels.
- There were still concerns, however, about the presence of senior medical staff out of hours and at weekends, and the number of medical patients that a junior doctor had to cover out of hours.
- There was multidisciplinary approach to the discharge was improving, but there were discharge delays for some medical patients with complex needs.
- The support for patients living with dementia or who may have a learning disability was inconsistent.
- Some patients could wait a long time for surgery. Surgery was effective but some safety procedures for surgery required improvement and patients could be unnecessarily fasted for long periods before surgery.
- Critical care services, which included the ITU and coronary care unit, provided safe and effective multidisciplinary care.
- The midwife-led birth centre provided safe and effective care and women were involved in decision making about their care and birth plans. The centre was modern and comfortable and well equipped but women still had concerns about potential delays in transfer to Stoke Mandeville Hospital if they needed urgent care or further support.
- Children received safe and effective multidisciplinary care but staff were uncertain about the future of children's services at Wycombe Hospital.

Summary of findings

- Patient receiving end of life care had good support from a specialist palliative care team but this level of support was not always available in the ward areas. There were examples of patients who did not have aspects of their care, such as pain relief and distress, managed appropriately.
- Outpatient services were safe and changes were being made to speed up treatment for patients, and bring care closer to people's homes. Clinic appointments, however, were often cancelled at short notice and patients could wait a long in busy clinics for their consultations

We saw some areas of good practice:

- The stroke unit was highly regarded in the region. Outcomes for patients were good and the time patients received for clot-busting medication (door to needle time) and specialist assessment was significantly better than in other trusts.
- The cardiology service had better response times than the average for England for reperfusion therapy for patients who presented with ST segment elevation myocardial infarction (STEMI).
- The 'Evian Project', was a multi-professional group led by the consultant nurse in critical care. This has improved the hydration of patients in the trust.
- The trust had a 'Reflections at Birth' initiative for women. Women were asked to complete a 'birth reflections' questionnaire one month after the birth of their child and their answers were used to inform and improve the quality of the service.
- Where appropriate, children had pre-operative assessments done by phone to reduce the need for additional visits to the hospital.

There were areas of poor practice where the trust needed to make significant improvements.

Importantly, the trust MUST take the following actions:

- The appropriate medicines for end of life care must be available to avoid treatment delays.
- Care plans need to be developed for all patients.
- Patients at the end of life must have person-centred, holistic plans of care to enable staff to assess and treat patients effectively.
- 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms must be accurately completed and records of end of life discussions must be documented.
- Patients at the end of life must be treated according to the National Institute for Health and Care Excellence (NICE) 'End of life care for adults quality standards' (NICE, 2009).

There were also areas of practice where the trust should take action, which are identified in the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

12 June 2014

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Requires improvement 	Most patients received compassionate care and we saw that patients were treated with dignity and respect. There was regular monitoring of key safety measures, and ward areas and equipment were clean. However, nurse staff vacancies meant that there were delays in patients receiving personal care and medical staffing at night and at the weekends needed to improve. Patients were assessed and treated quickly and had good clinical outcomes. There was a lack of patient care plans, and there was a risk that patients could have inconsistent care due to staff, especially temporary staff, not being aware of the individual plans for their care. Risks were being managed but there was no procedure for sharing learning about incidents among the medical staff. Patients living with dementia had inconsistent support and there were discharge delays for patients with complex needs.
Surgery	Requires improvement 	The use of the Five Steps to Safer Surgery checklist was being monitored and was improving and action was being taken to improve compliance which was currently 90%. Staffing levels were appropriate. National guidelines were used to treat patients and care pathways to support and speed patient recovery were followed. Standards were monitored and outcomes in surgery were good and improving. Patients had good pre-admission clinics to prepare for surgery and day surgery rates were higher than national average. The trust, however, was not meeting the national target for patients to wait less than 18 weeks for operations or procedures.
Critical care	Good 	Patients we spoke with gave us examples of the good care they had received. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. There was strong local leadership of the units. Openness and honesty was encouraged at all levels. The units had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality

Summary of findings

			improvement projects and audit. There was good multidisciplinary team working. Patients were effectively monitored and clinical outcomes were good.
Maternity and family planning	**Good**		The ward areas were modern and clean. Women and their partners said that the staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. Midwifery staffing levels were appropriate and there were always experienced staff on every shift to women and provide one to one care. There was good multidisciplinary team working and learning throughout the service. Staff development and continuing professional development in general was a priority within the service. The head of midwifery and her team were well focused and fully engaged. The service did not have a strategy to develop its services and there were concerns about underused services at Wycombe Hospital and potential delays to transfer women who required urgent care to Stoke Mandeville Hospital. The service did have a strategy to manage operational and performance risks and risks were appropriately managed.
Services for children and young people	**Good**		Services for children and young people were good. Parents told us the staff were caring, and we saw that children and their parents and carers were treated with dignity, respect and compassion. The ward areas and equipment were clean. There were enough trained staff on duty to ensure that safe care could be delivered. Children were appropriately prepared for surgery and treatment and clinical outcomes were good. The service was responsive to the needs of children and young people and their families and carers. Staff were positive the service and children's experiences were seen as the main priority. The service did not have a strategy but there were actions around improving the service. The trust long term plans for the service were not clear to staff.
End of life care	**Requires improvement**		The specialist palliative care team provided a safe, effective and responsive service. However, end of life care was consistent across the hospital ward areas and patients were not always appropriately referred

Summary of findings

to the specialist palliative care team. Some aspects of end of life care were not provided in line with national guidance, for example, access to medicines. We saw that there were delays in providing pain relief to patients. Ward staff were not appropriately trained in end of life care and essential nursing care was not delivered appropriately, for example, assessment and monitoring, pressure ulcer management, pain relief, comfort and managing distress.

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

Outpatients **Requires improvement**

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

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

Requires improvement

Wycombe Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

Contents

Detailed findings

Background to Wycombe Hospital

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

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

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

Wycombe hospital had 250 beds and provided a wide range of surgical services and specialist medical care for stroke and heart conditions. The hospital also offered specialist cancer and urological services. Wycombe Hospital saw more than 36,000 inpatients and 145,000 outpatients a year. There was also a modern midwife-led maternity unit aimed at providing a more home-from-home environment for women and their partners.

Wycombe Hospital had been inspected twice since its registration with the CQC in April 2010. It was inspected in March 2012 for the termination of pregnancy review and was compliant. The hospital was also inspected in July 2012 and was compliant with essential standards for cleanliness and infection control, staffing and supporting workers, and assessing and monitoring the quality of service provision and records.

The inspection team inspected the following core services at Wycombe Hospital :

- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity
- Children and young people's care
- End of life are
- Outpatients.

There were no accident and emergency (A&E) services on the hospital site. The minor injuries and illness unit was managed by the Buckinghamshire Urgent Care Service.

What people who use the hospital say

- We held two community focus groups that were run by Regional Voices for Better Health. There were 15 participants in total representing individual views as well as community and voluntary organisations. The groups identified that the replacement of the A&E with a Minor Injury and Illness Unit was a concern. They considered this was a good service but people had to travel further to an A&E and this left a feeling of uncertainty about the future of the local hospital service. There were positive experiences shared about the Wycombe Birth Centre and good clinical care for patients having day surgery.
- We spoke to 12 people at our listening events. Two people told us about us that they had good care at Wycombe Hospital at the breast clinic and having day surgery. Some people noted the hospital had old buildings.

Detailed findings

- Between September 2013 and January 2014 a questionnaire was sent to 850 recent inpatients at the trust as part of CQC Adult Inpatient Survey 2013. Overall trust was rated the same as other trusts. Comparison with the Adult Inpatient Survey in 2012 showed that the trust had improved its performance overall. The survey asked questions about waiting times for appointments, waiting for admission to a hospital bed, the hospital environment, having trusting relationships with doctors and nurses, care and treatment and operative procedures, being treated with dignity and respect, and leaving the hospital. However, patients rated the trust worse than other trusts for being given information on health and social care services on discharge and on the letters written by the trust to their GP that were understandable.
- The Cancer Patient Experience Survey 2012/13 indicated that the trust performed better in some areas and worse in others.
- In December 2013, the trust performed above the national average in the inpatient Family and Friends Test. Most hospitals wards were above the national average with the exception of Ward 5B (older people's step down ward) and Ward 8 (hyper acute stroke unit).
- Between January 2013 and February 2014, Wycombe Hospital had 128 reviews from patients on the NHS Choices website. It scored 4 out of 5 stars overall. The highest ratings were for cleanliness, excellent food, excellent care, respectful and dedicated staff, and good aftercare. The lowest ratings were for staff attitude, waiting times and cleanliness of toilets. .
- Patient-Led Assessment of the Care Environment (PLACE) are self-assessments undertaken by teams focus NHS and independent healthcare staff and also the public and patients. In 2013, Wycombe Hospital scored below the national average for cleanliness (69.3% compared to the national average of 95.7%), for food and hydration (83.6% compared to 85.4%), for privacy, dignity and well-being (65.7% compared to 88.9%) and for facilities (64.6% compared to 88.8%).
- The Survey of Women's Experiences of Birth, CQC, 2013, showed that the trust performed about the same as other trusts on all questions on care, treatment and information during labour and birth, and care after birth.
- During our inspection, patients told us staff were caring and helpful.

Our inspection team

Our inspection team was led by:

Chair: Heather Lawrence, Non-Executive Director, Monitor

Team Leader: Joyce Frederick, Head of Hospital Inspection, Care Quality Commission (CQC)

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

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?

Detailed findings

- Is it well led?

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

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

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

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

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

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

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

Facts and data about Wycombe Hospital

1. Context
- Around 731 beds (250 beds at Wycombe Hospital)
- Population around 500,000
- Staff: 5,750
- Deficit: £1.8m in 2012/13

2. Activity
- Inpatient admissions: 91,307pa
- Outpatient attendances: 473,949pa
- A+E attendances: 93,806pa
- Births: 5,684pa (300 at Wycombe Hospital)

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

4. Intelligent Monitoring – (March 2014)
- Safe: Items = 8, Risks = 1, Elevated = 0, Score = 1
- Effective: Items = 32, Risks = 0, Elevated = 0, Score = 0
- Caring: Items = 10, Risks = 0, Elevated = 0, Score = 0
- Responsive: Items = 11, Risks = 2, Elevated = 0, Score = 2
- Well led: Items = 25, Risks = 2, Elevated = 1, Score = 4
- **Total:** Items = 86, Risks = 5, Elevated = 1, Score = 6

5. Safety
- 3 never events (2 previous Never Events now reclassified under STEIS as serious incidents).
- STEIs 127 SUIs (Dec 2012-Jan 2014)
- NRLS - Deaths 10; Severe 31; Moderate 833
- Safety thermometer: Pressure ulcers = High but variable; VTE = High; Catheter UTIs = High; Falls = Low but variable
- Infections - Cdiff = 34, MRSA = 0

6. Effective
All within expectations

7.Caring
- CQC inpatient survey: within expectations
- FFT Inpatient: Above average
- Maternity survey 2013: within expectations

Detailed findings

- Cancer patient experience survey: Performed better than average for 5 out of 69 questions and worse than average for 8 out of 69.

8. Responsive

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

9.Well led

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

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

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

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

- Overall satisfaction
- Clinical supervision
- Adequate experience

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that overall CQC is able to collect enough evidence to give a rating for effectiveness for outpatients.
2. The effectiveness of services were judged to be good overall

Medical care (including older people's care)

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

Information about the service

Wycombe Hospital provided inpatient medical services for older people, cardiology and stroke rehabilitation. There was a cardiology and stroke receiving unit (CSRU), a cardiology ward (2A), a hyper acute stroke unit (Ward 8), an acute stroke unit (Ward 9) and a medicine for older people ward (5B).

We visited the CSRU and the medical wards. We spoke with 10 patients and three relatives and over 20 staff of different grades, including nurses, doctors, pharmacists, therapists, managers, administrators, housekeepers and porters. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital

Summary of findings

Most patients received compassionate care and we saw that patients were treated with dignity and respect. There was regular monitoring of key safety measures, and ward areas and equipment were clean. However, nurse staff vacancies meant that there were delays in patients receiving personal care and medical staffing at night and at the weekends needed to improve. Patients were assessed and treated quickly and had good clinical outcomes. There was a lack of patient care plans, and there was a risk that patients could have inconsistent care due to staff, especially temporary staff, not being aware of the individual plans for their care. Risks were being managed but there was no procedure for sharing learning about incidents among the medical staff. Patients living with dementia had inconsistent support and there were discharge delays for patients with complex needs.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

There was regular monitoring of key safety measures, and ward areas and equipment were clean. However, the use of bank and agency staff was having an impact on the continuity of care for patients, and resulting in some delays to treatment. Senior medical presence and the number of junior doctors at night and at the weekend needed to improve. There was no procedure for sharing learning about incidents among the medical staff. Medicines were appropriately stored in locked cupboards or fridges although fridge temperatures were not regularly checked and this could affect the efficacy of medicines. Avoidable harms such as falls, pressure sores, catheter urinary tract infections, and medication errors needed to be reduced. Staff also expressed concern about night time security arrangements.

Incidents

- There had been no recent "Never Events" (incidents that should never occur) reported in the division of medicine. For the period December 2012 to January 2014, there had been 14 serious incidents at Wycombe Hospital. These were mostly falls and pressure ulcers.
- All the staff we spoke with said they were aware of how to report incidents. However, unless staff were involved in an incident, they did not receive feedback and lessons learned from incidents were not widely shared.

NHS Safety Thermometer

- The NHS Safety Thermometer measures a monthly snapshot of four areas of avoidable harm: falls, pressure ulcers, catheter-related urinary tract infections and new venous thromboembolism (VTE). For the period November 2012 to November 2013, VTEs, new catheter-related urinary tract infections, and falls with harm were higher than the average for England, particularly for patients aged over 70. New pressure ulcers for patients over 70 were generally better than the average for England.
- Safety Thermometer information for a ward was clearly displayed at the ward entrance. These key measures of safety were monitored regularly and made available to staff and patients.
- On Ward 8, repositioning charts for patients were in place to reduce the risk of pressure ulcers, but these were not used consistently in the patients' care. Figures recorded in January 2014 identified one reported avoidable pressure ulcer on the stroke units.
- Patient falls and VTE were higher than expected for the division. Falls ranged from three on Ward 5B (older people step down ward) to 10 on the stroke unit; VTE risk assessments were monitored and ranged from 30% on Ward 2A to 100% on the stroke unit.

Cleanliness, infection control and hygiene

- The ward areas were clean but cluttered. Staff followed the trust policy on infection control. Staff wore clothes that kept their arms bare below the elbow, and they regularly washed their hands and used hand gel between patients.
- The medical division's hand hygiene audit indicated that it was performing at 97.5%, which was above the trust target of 98%.
- Infection rates for meticillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile for the trust were within an acceptable range.
- There was no single room on Ward 8 to accommodate patients who required isolation to reduce the risks of cross infection.
- At the time of the announced inspection, Ward 5B had been closed because of an outbreak of norovirus. Staff had followed guidance from the trust's lead infection control nurse to reduce the risk of further spread of infection.

Environment and equipment

- The wards were well lit and tidy, except for ward 8, which appeared disorganised and cluttered. On ward 8, unlocked wooden cupboards in patients' bays contained a variety of ward stock items, such as cables and catheter bags.
- Equipment was clean and functional. Items were labelled with the last service date and large green stickers that gave the date of cleaning. However, on Ward 8, there were two commodes that appeared clean but were not labelled as clean. Staff told us there was a shortage of commodes on Ward 8.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues.
- Staff expressed concerns for their safety due to the limited on-site security at night (one guard), particularly if challenging situations arose with patients or relatives.

Medical care (including older people's care)

Medicines

- Medicines were stored correctly in locked cupboards or fridges.
- Most ward fridge temperatures were checked regularly and adjusted if they were found to be outside the accepted range. However, some were not and this did not ensure the efficacy of the medicines they contained.
- There was a ward pharmacy service and a wide range of audits conducted on medicines management, including audits on the prescription of antibiotics. A pharmacist attended the ward daily and met with patients to discuss their medication before discharge.
- Medication errors were reported monthly on the ward scorecard. In January 2014, there was one medication error reported on the stroke units and one on Ward 2A. In December 2013, there had been a peak in medication errors of five on the stroke units and six on Ward 2A. The trust was monitoring this to ensure improvements.
- Serious and moderate medicine incidents were reviewed.

Records

- All records were in paper format and all healthcare professionals used the same documents so that a clear chronological record for patient care was maintained.
- Documentation audits were undertaken and monitored at the monthly clinical governance meetings.
- Confidential information was not being securely stored because the confidential waste bin on Ward 8 was not securely sealed.
- Nursing documentation covered risk assessments; most was completed appropriately but care plans were not used. When care plans were in place (for example, the 'stroke patient portfolios') they were incomplete or blank. There was a risk that patients could have inconsistent care due to staff, especially temporary staff, not being aware of the individual plans for their care.
- A trust 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) audit of 88 forms in January 2014 showed that the decision had been made and recorded in 95% of cases and by the appropriate clinician in 91% of cases. We saw a sample of DNA CPR records that had been completed appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

- Patients were asked for their consent to procedures appropriately and correctly.
- The Mental Capacity Act 2005 was adhered to appropriately and the Deprivation of Liberty Safeguards (DoLs) were applied for patients who did not have capacity to consent.
- The Trust DNA CPR audit identified that one of the main areas that was not always completed was associated mental capacity assessments, only 20% of forms were completed.

Assessing and responding to patient risk

- The medical wards used the early warning system tool to escalate the care for acutely ill patients. There were clear directions for escalation printed on observation charts.
- Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring were identified and cared for appropriately.
- We looked at a sample of completed charts on the medical wards and saw that staff had escalated correctly, and that repeat observations had been taken within the necessary time frames.
- Monthly ward national early warning system (NEWS) audits were undertaken of the compliance with scoring and the medical response within one hour. For the cardiac and stroke wards, the results were 94–96% and for Ward 5B the result was 92%. Medical response was 100%.
- Patients were intensively monitored for the first 24 hours after admission to CSRU and Ward 8 and appropriate action taken in response.
- Nursing handovers occurred three times a day at the start of each shift. Staffing for the shift was discussed as well as any high-risk patients or potential issues. A formal medical handover took place at the start of each shift. Staff on duty were familiar with the needs of patients under their care.
- A safety triangle was in place above some patients' beds as a visual reminder to staff of the patient's specific needs, for example, diabetes, risk of falling, or assistance required with eating and drinking.

Nursing staffing

- Nursing staffing levels had been reviewed using the national Safer Nursing Care Tool to set minimum staffing levels.
- All wards had vacancies. The trust recorded 6.2 whole time equivalent (WTE) nurse vacancies on the stroke wards and 6.1 wte nurse vacancies on the cardiac

wards). However, staff told us there were 16 registered nurse vacancies on the stroke wards. These were filled, whenever possible, with regular bank and agency staff. Patients' needs were met by the right numbers of staff, but staff skills and experience differed and it was not always possible to provide care from the same staff. This was having an impact on the continuity of care and efficient working practices because temporary staff were less familiar with the wards' procedures.

- At the time of the announced visit, Ward 8 appeared to have the least calm environment compared with the other wards, and this was commented on by both patients and staff. Some patients had not been helped with washing as much as they would have liked. Call bells were not answered promptly. The ward had one registered nurse less than the staffing level set for the shift. During the unannounced visit, the ward was calm and fully staffed.
- The trust identified that agency nurses who had had training elsewhere could administer IVs if they were observed for competency. Most staff however, were not aware of this. Staff told us that agency nurses were not routinely allowed to administer IV medications unless they had undertaken the trust's IV training. This meant that, when high numbers of agency staff were not allowed to administer IV drugs, additional pressure was placed on the bank and permanent staff. .
- One serious incident involved the delay in administration of an intravenous (IV) drug because of unavailability of suitably trained nursing staff.
- The CSRU and cardiology ward 2A had specialist trained nurses. Staff were redeployed across the stroke and cardiac wards to reduce the risk of unsafe staffing levels when temporary staff were unavailable. When staffing levels were below the minimum, ward managers alerted the site shift coordinator and completed an incident form.
- Nurse staffing was recognised as a priority for the trust as a whole and substantial investment had been agreed for an international recruitment drive.

Medical staffing

- There were consultant-led teams of junior doctors and a registrar on the cardiac and stroke units Monday to Friday 9am to 5pm, and vacancies were covered by long-term locums.
- There was one junior doctor (foundation year 1 [FY1]) to cover the medical inpatients (approximately 70–100 patients) at night and at weekends. The trust told us the FY1 was well supported by a medical registrar and on-call consultant; however, junior doctors told us it was "difficult" and "sometimes stressful" to cover patients out of hours and at weekends.

Mandatory training

- All staff we spoke with said they were up to date with their mandatory training.
- Training records demonstrated, for December 2013, that 75% of staff were up to date with annual statutory training (80% for infection prevention and control, and 72% for adult safeguarding) which was on track to meet the trust target of 100% by the end of the year.

Are medical care services effective?

Good

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

Evidence-based care and treatment

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

Medical care (including older people's care)

In 2012/13, the trust reviewed 16 national clinical audits to report on outcomes. Outcomes for patients with stroke and heart disease, for example, similar or better than expected when compared with other trusts.

- The department had an annual clinical audit programme and local audit were done by junior doctors and nursing staff. These were discussed in monthly team meetings. .

Patient outcomes

- The trust was an outlier for mortality for congestive heart failure and non-hypertensive and nephrological conditions in 2012/13.
- Since the Keogh Mortality Review in 2013, the trust had changed its clinical governance structures and arrangements. Mortality reviews of all unexpected deaths were carried out with independent oversight; if the death was considered to be potentially avoidable, an action plan was developed.
- In March 2014, the trust had no mortality outliers and overall mortality rates were within expected range.
- The trust was similar to other trusts in the Myocardial Infarction (MI) National Audit Project for heart patients seeing a cardiologist and being treated on a cardiac unit or ward. The cardiology service had better response times than the England average for reperfusion therapy for patients who presented with ST segment elevation myocardial infarction (STEMI).
- The stroke unit had outcomes that were better than national average for patients, particularly in regard to speed of scanning and treatment ('door to needle time') and specialist assessment and therapy. The stroke unit was highly regarded in the region.
- There was a very clear thrombolysis pathway followed by the multidisciplinary team, and this resulted in good outcomes for patients.
- Emergency readmissions, which could be an indicator of the quality of care and discharge, were similar to those in other trusts.

Hydration and nutrition

- Red trays, jugs and coloured beakers were in use for patients who needed their food and drink intake monitored. This ensured they received adequate nutrition and fluids as part of their treatment plan.
- Trust-wide audits of patients who had a jug of water within easy reach had significantly increased from 60% in September 2013 to a current average of 99%.
- Trust-wide audits of the percentage of patients with an appropriately completed fluid balance chart reached a peak of 80% on average in February 2014. However, these were not always completed at Wycombe Hospital.

Competent staff

- The core teaching programmes were in place for junior doctors (FY1 and FY2 trainees) and attendance was recorded as 64% and 57% respectively. The trust reported that alternative educational activities had been provided but junior doctors said they were concerned at the number of cancelled teaching sessions, which was approximately 50%.
- The National Training Scheme Survey, GMC, 2013, for general medicine, indicated that the trust had performed worse than expected in six areas including clinical supervision and providing adequate experience for junior doctors.
- Staff said they had regular appraisals and were supported to undertake development to meet identified needs.
- Clinical supervision for nursing staff was being introduced for assessing competency, reflective learning and supportive practice.

Equipment and facilities

- Funding had been approved for additional medical equipment to replace old stock in the cardiology department, and for a new catheter laboratory.

Multidisciplinary team working and working with others

- Stroke unit staff reported very good multidisciplinary working arrangements with physiotherapists, occupational therapists, speech and language therapists, and the discharge coordinator.
- Therapy staff provided instructions, displayed above patients' beds to assist nursing staff in the care of the patient (for example, soft or puréed food only (speech and language therapy) or assistance needed to transfer from bed to chair (physiotherapy).
- Staff contacted the palliative care team or end of life team for support in meeting the needs of patients and their families if appropriate.
- There were good links with the integrated respiratory service. This meant there was effective support for patients discharged into the community with respiratory conditions.

Medical care (including older people's care)

- There were good links with the integrated heart failure service. This meant there was effective support for patients discharged into the community with related conditions.

Seven-day services

- There was a cardiology trainee and junior doctor on duty at night and at weekends.
- A cardiology or stroke consultant was on call at night and at weekends.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

Are medical care services caring?

Good

Most patients received compassionate care and we saw that patients were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care. Patient feedback on most wards was above national average.

Compassionate care and emotional support

- The NHS Friends and Family Test results were variable for the medical wards. The results for the trust as a whole were above the average for England. . In December 2013, there were two medical wards at Wycombe hospital that scored below the national average, Ward 5B (the older people's step down) and Ward 8 (the hyper acute stroke unit).
- 'You said, We did' boards were displayed on every ward with examples of how the ward had responded to patients' feedback.
- Throughout our inspection, we witnessed that patients were treated with dignity and respect by all staff on all the wards. On most wards call bells were answered promptly and patients we spoke with were very positive about the care they had received. One remark from the CSRU summed up their experience: "We couldn't have had better treatment…exceeds expectations."
- Most patients appeared to be well cared for. For example, they looked comfortable and were washed and dressed in day clothes.
- At the time of the announced visit, Ward 8 appeared to have the least calm environment compared with the other wards, and this was commented on by both patients and staff. Some patients had not been helped with washing as much as they would have liked. Call bells were not answered promptly. The ward had one registered nurse less than the staffing level set for the shift. During the unannounced visit, the ward was calm and fully staffed.
- We saw that doctors and nurses introduced themselves appropriately and that curtains were drawn to maintain patient privacy. The curtains had a 'Do not disturb sign' to deter people from entering inappropriately. One female patient said, "Staff have been respectful…with personal care…male staff avert their eyes as much as possible."
- Ward 8 was exempt from the Department of Health's requirement for single-sex sleeping accommodation because of the intense level of care provided. The ward had two bays, each with four beds. At the time of the unannounced visit, both bays contained men and women (one man and three women).
- Patient boards were in place behind every bed as a reminder to staff of individual patients' needs. On ward 8, a new patient had been admitted but the patient board had prompts relating to the previous patient. Three patients did not have their names written above their beds.

Patient involvement in care

- Patients and relatives we spoke with said they felt involved in their care.
- The stroke units arranged individual meetings with the patients' families, nurse in charge and consultant to 'meet and greet'. Patients and their relatives had the opportunity to speak with the consultant in charge at these meetings.

Emotional support

- Rooms were available for private conversations with family members, if needed.
- Visiting times were flexible to accommodate families who wanted to stay with their relative, if appropriate, and for patients at the end of their lives. One relative of a patient who had been on the ward several weeks said the care had been "excellent" throughout. The family's need to stay long periods beyond visiting times had been accommodated and a reclining chair had been provided for their comfort.

Medical care (including older people's care)

Are medical care services responsive?

Requires improvement

Patients with chest pain or stroke had rapid assessment and treatment. The trust had a dementia strategy and a dementia specialist nurse had been appointed to provide leadership and expert advice across the trust's hospitals. However, patients living with dementia had inconsistent support. Initiatives by the Alzheimer's Society to inform staff about patients living with dementia (such as the 'This is me' booklet) were optional and not widely used by staff. In addition, support for patients with a learning disability was inconsistent because of the recent departure of the learning disability nurse. Discharges could be delayed because of the pathways for further care in the community were not appropriately identified to meet the needs of some patients.

Access to services

- All patients with suspected chest pain and stroke were accepted by the cardiac and stroke receiving unit (CSRU) triage and treatment if appropriate. Patients were admitted directly to the CSRU by ambulance.
- After triage and treatment, patients would be transferred to Ward 8, or the coronary care unit or the cardiology ward (2A) if appropriate.
- The beds on the cardiac and stroke units at Wycombe Hospital were protected from the capacity pressures of the medical wards at Stoke Mandeville Hospital to ensure they were available for appropriate patients. Bed occupancy, however, was consistently higher than the 85% target, ranging between 85% and 100%. Occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally.
- The trust achieved its referral to treatment times of less than 18 weeks in cardiology. Diagnostic waiting times and cancer waiting times were within the expected targets.
- We did not visit the medical day unit but consultant staff told us that this provided a range of day services including patient assessment, treatment, therapeutic and clinical care. GPs referred patients for an urgent and intensive review of their medical condition and treatment. The unit was consultant led and was working to avoid unnecessary attendance or admission to hospital.
- Daily discharge meetings were undertaken five days a week on all medical wards. Medical staff, nursing staff, physiotherapists, occupational therapists, speech and language therapist and discharge coordinators attended.
- Every ward had a discharge coordinator and discharge planning was started as soon as patients were admitted to the ward. Discharge was delayed for patients with complex needs (for example, one patient on Ward 8 had been waiting for a nursing home placement for over 3 days).
- Discharge from the unit for non-cardiac or stroke patients was sometimes delayed because of unclear pathways. This resulted in longer lengths of stay and affected patient flow through the hospital. Three patients had been on the ward 8 longer than the designated 72 hours and it was not clear if some of the patients were still there because of their clinical needs.
- The average length of stay for the medical division was 7.8 days, which was higher than the trust's own target and the national average of 4.7 days. This affected the capacity and flow of patients through the hospital.
- A paper discharge summary was sent to a patient's GP by post. This detailed the reason for admission and any investigation results, treatment and discharge medication

Meeting the needs of people

- A trust dementia strategy was in place with an action plan. A dementia specialist nurse had been appointed to provide leadership and expert advice across the trust hospitals. However, patients living with dementia had inconsistent support. Initiatives by the Alzheimer's Society to alert and inform staff about patients living with dementia (such as the 'This is me' booklet and the butterfly scheme to identify and meet the needs of patients living with dementia) were optional and not widely used by staff. We saw some used on Ward 5B.
- Support for patients with learning disabilities was inconsistent because of the recent departure of the learning disability nurse.
- Interpretation services were available. However, staff said they often used family members to translate if necessary.

Medical care (including older people's care)

Complaints

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Complaints leaflets were available at the entrance to the hospital and outside the wards.
- Patients were confident to raise their concerns with ward managers without fear of reprisals.
- The medical division, however, responded to 71% of complaints within the trust's 25-day target. This was below the trust target of 85% and lower than the other divisions. In January 2014, none of the wards had received a formal complaint.
- Complaints response times in the cardiology and stroke units met their targets.

Are medical care services well-led?

Requires improvement 

All nursing staff spoke highly of the ward managers and matron as leaders. The medical division had a strategy and this included priority areas for each service such as the response to bed capacity. Risk registers did not identify how the division would respond to immediate concerns such as junior doctor cover arrangements, nurse staffing levels, the need for agency IV administration training and patient experience concerns. The results of the 2013 NHS Staff Survey showed that the trust was worse than expected for the percentage of staff able to contribute to improvements at work. This was replicated in the medical division, where staff shortages and workload meant that many staff were not involved in quality improvement projects and audit.

Vision and strategy for this service

- The trust's vision was encapsulated in the strapline 'Safe and compassionate care every time'. This was visible on every ward.
- The medical division had a strategy and this included priority areas for each service area. For example, the medicine for older people service included the development of pathways to improve health and avoid admission. There were also plans to deal with capacity issues and ensure the presence of senior medical staff at night and at weekends.
- A trust dementia strategy was in place with an action plan. A dementia specialist nurse had been appointed to provide leadership and expert advice across the trust hospitals.

Governance, risk management and quality measurement

- Structured monthly governance meetings were held within each service delivery unit consistent with the new overall trust clinical governance framework. Complaints, incidents, audits and service performance information were discussed and actions agreed. However, there was not a systematic approach to reviewing clinical guidelines.
- A dashboard for each ward and service in the division showed the performance and quality measures which were presented monthly at the clinical governance meetings. Some of the information about nurse vacancies was not accurate, for example staff on ward 8 told us of higher numbers of staff vacancies than the number recorded.
- Bi-monthly division performance review meetings took place and were reported to the trust board. These were chaired by the director of operations and involved senior divisional leaders. Quality, risk and performance issues were discussed and actions agreed.
- The integrated medicine risk register highlighted risks across all the trust's medical departments, and actions in place to address concerns: for example, bed capacity issues. The risk register did not indicate risks specific to wards at Wycombe Hospital, for example, junior doctor cover arrangements, nurse staffing levels, the need for agency IV administration training and patient experience concerns.
- Staff said there was a robust system to ensure changes to practice were communicated to all staff in writing and at team meetings.

Leadership of service

- A medical leadership programme and leadership training to support staff at different levels of the organisation were provided.
- Ward sisters had attended a leadership training programme.

Medical care (including older people's care)

- All nursing staff spoke highly of the ward managers and matron as leaders.

Culture within the service

- All staff within the medical division directorate spoke positively about the service they provided for patients. Since the Keogh Mortality Review in 2013, quality and patient experience were seen as top priorities and everyone's responsibility.
- The results of the NHS Staff Survey 2013 indicated that the trust was worse than expected for the percentage of staff reporting good communication between senior management and staff.
- On the cardiac and stroke units, staff described good team work and pride in the service they delivered. They recognised that the valued contribution of the multidisciplinary team resulted in very good audited outcomes for patients.
- Some staff expressed dismay that their perception regarding staffing levels were "Not taken seriously." They had identified that they had used the Safer Nursing Care Tool but had not undertaken assessments as described in the tool.

Innovation, improvement and sustainability

- The results of the NHS Staff Survey 2013 indicated that the trust was worse than expected for the percentage of staff able to contribute to improvements at work. This was replicated in the medical division where staff shortages and workload meant that many staff were not involved in quality improvement projects.

Surgery

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

Information about the service

Wycombe hospital had general surgical wards that covered general surgery, urology, elective orthopaedics and day surgery. There was also a surgical admissions unit. Patients for elective surgery were assessed before their admission in a pre-admission assessment clinic

We visited the pre-admission assessment clinic, the surgical admissions unit and Wards 12a (surgery), 12b (orthopaedics) and 12c (day surgery unit). We spoke with nine patients and nine staff, including matrons, surgeons and nursing staff. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital

Summary of findings

The use of the Five Steps to Safer Surgery checklist was being monitored and action was being taken to improve compliance which was currently 90%. Staffing levels were appropriate. National guidelines were used to treat patients and care pathways to support and speed patient recovery were followed. Standards were monitored and outcomes in surgery were good and improving. Patients had good pre-admission clinics to prepare for surgery and day surgery rates were higher than national average. The trust, however, was not meeting the national target for patients to wait less than 18 weeks for operations or procedures.

Surgery

Are surgery services safe?

Requires improvement

Surgery staff told us they were encouraged to report any incidents, and these were discussed at weekly meetings and action was taken to prevent reoccurrences. The environment was clean and medicines were appropriately stored. The use of the Five Steps to Safer Surgery checklist was being monitored and action was being taken to improve compliance currently at 90%. Avoidable harms, pressure ulcers and blood clots were higher than expected but these were improving. Staffing levels were appropriate.

Incidents, reporting and learning

- There had been three 'never events' (incidents that are so serious they should never happen) in the trust between December 2012 to January 2014. One of these was in surgery in December 2012. The never events led to full root cause analyses. The results of these were shared with members of staff.
- Between June 2013 and July 2013 there had been 147 incidents in surgery reported to the National Reporting and Learning System (NRLS). More recent figures from January to February 2014, the surgical division had had eight incidents. The majority were moderate harm and one was severe. These reports were for avoidable harms such as pressure sores and falls and staffing levels that caused a failure to monitor patients effectively.
- Information provided by the trust showed that for the surgical division there had been a large number of incidents that had not been addressed in a timely manner. Incidents at the hospital had been investigated.
- Staff in the operating theatre told us that outcomes from incidents were fed back via the team briefings.
- Information relating to significant events was available for staff to read and showed that, when required, action was taken.
- Incidents, including learning and action taken, were discussed at clinical governance meetings.
- During our inspection, we attended a sisters' meeting for the surgery division. We saw evidence that information about incidents was discussed as well as plans of actions to prevent further incidents of a similar nature. The sisters told us that incidents were then discussed at staff meetings on the surgical wards.

NHS Safety Thermometer

- NHS Safety Thermometer information was clearly displayed at the entrance to each ward and all new episodes of harm to patients including falls with harm, new venous thromboembolism (VTE), catheter-related with urinary tract infections and pressure ulcers.
- The surgery division was not meeting its targets for pressure ulcers, VTEs and medication errors. Targets were met for patient falls.
- The surgical wards had taken action, for example, to improve risk assessments of patients with potential VTEs.

Cleanliness, infection control and hygiene

- The ward areas were clean. Staff followed the trust policy on infection control. Staff wore clothes that kept their arms bare below the elbow, and they regularly washed their hands and used hand gel between patients.
- The surgery division's hand hygiene audit indicated that it was performing at 98%, which was meeting the trust target of 98%. The results were on display in the ward areas.
- Infection rates for meticillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile for the trust were within an acceptable range.

Environment and equipment

- Two-person instrument checks took place in the operating theatre. All equipment required for surgery was available for staff to use.
- Equipment was cleaned and labelled ready for use after cleaning.
- The emergency trolley in the operating theatre was checked regularly to ensure that it was ready for use if required.

Medicines

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

Records

- The records on the surgical ward were kept securely at the nurses' station. The records we reviewed were detailed and the appropriate risk assessments had been completed. People's charts, recording their fluid balance and staff observations, were mostly up to date.
- Nursing risk assessment documentation was kept at the end of a patient's bed and was completed appropriately. Patients, however, did not have care plans.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

- Patients were asked for their consent to procedures appropriately and correctly.

Assessing and responding to patient risk

- The Five Steps to Safer Surgery guidance should be used at each stage of the surgical pathway from when a patient is transferred to theatre until their return to the ward. The trust was regularly monitoring its use. The latest audit in February 2014 showed the use of the checklist was improving and was currently fully completed for 90% of patients.
- The surgical wards used the early warning system tool. There were clear directions for escalation printed on the reverse of the observation charts.
- Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring were identified and cared for appropriately.
- We looked at a sample of completed charts and saw that repeat observations had been taken within the necessary time frames.
- Nursing handovers took place when shifts changed. Staffing for the new shift was discussed as well as any high-risk patients or potential issues.
- Daily ward rounds were undertaken five days a week on all surgical wards.

Nursing staffing

- Nursing staffing levels had been reviewed using the national Safer Nursing Care Tool to set minimum staffing levels. When necessary, staffing levels were being, or had been, increased.
- The recovery area in the operating department was fully staffed. The operating theatre had some staff vacancies and were using agency staff to cover. The correct number of staff were present in the operating theatre for the operations we observed.
- There was an escalation policy for staff who had concerns about staffing levels or skill mix.

Medical staffing

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

Mandatory training

- Staff mandatory training was mainly completed as e-learning. Electronic training records were kept for each staff member. Those we reviewed were current and up to date but training records up to December 2013 demonstrated that only 62% of staff had completed their mandatory training; the trust target was 100%.
- Staff were required to attend resuscitation training and records showed that this was had occurred.

Are surgery services effective?

Good

National guidelines were used to treat patients and care pathways to support and speed patient recovery were followed. Standards were monitored and outcomes in surgery were good and improving. Day surgery rates were higher than national average. Some patients were however, were unnecessarily fasted before surgery for longer than necessary.

Evidence-based care and treatment

- National guidance (for example, from the National Institute for Health and Care Excellence [NICE] and the Royal College of Surgery [(RCS]) was used to determine the treatment provided. Local policies were written in line with this and departmental meetings had a standing agenda item to discuss any changes to national guidance or changes needed as a result of outcomes from audits.
- National guidelines were being considered and used in the management of patients seen in the pre-admission clinic.
- However, some patients were unnecessarily fasted before surgery for longer than currently recommended in national guidelines.
- There were pathways for patients to follow depending on the reason for their surgery. If appropriate after assessment, patients would be admitted on the day of their surgery via the surgical admission unit and then transferred to a ward after their operation.
- The surgical directorate contributed to all national audits that it was eligible for, although data for the National Joint Registry was not always completed. This Registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations, and

monitors the performance of joint replacement implants. The completion rate was 75% and this would not provide a full picture of how the trust was performing.

Patient outcomes

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

Pain relief

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

Competent staff

- The number of staff who had completed their annual appraisal was below the trust's expected number. Staff told us that they were supported in their development through their appraisal.
- Clinical supervision for nursing staff was being introduced for assessing competency, reflective learning and supportive practice.
- Staff in the operating department were being helped to develop their skills through supported and observed practice.
- The National Training Scheme Survey, GMC, 2013 indicated that the training given to junior doctors in trauma and orthopaedics was overall similar to other trusts but was worse than expected for overall satisfaction, adequate experience and access to educational resources.

Multidisciplinary working

- Support from allied healthcare professionals, such as physiotherapists, was available.
- Pharmacists visited wards and had a role in stock control and review of prescriptions.
- Surgical divisions worked in partnership with other specialties such as cancer services.

Equipment and facilities

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

Seven-day services

- Consultant rotas ensured that cover was provided seven days a week.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

Are surgery services caring?

Good

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

Compassionate care

- Results from the inpatient NHS Friends and Family Test (September 2013 to December 2013) showed that the trust was performing higher than the average for England. In December 2013, all the surgical wards at Wycombe hospital scored above the national average.
- One family had had a poor experience in recent weeks and had fed back their issues. Their concerns had been listened to and learned from. Their second experience had been much better. On this occasion, staff were compassionate and caring and took into account the patient's individual and special needs.
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect.

Patient understanding and involvement

- Patients were involved in making decisions about their care.
- Patients told us they were able to ask questions and were listened to by staff.
- The CQC adult inpatient survey (2013) demonstrated the trust was similar to other trusts for staff explaining operations and procedure, information on pain relief and informing patients about how their operation or procedure had gone.

Surgery

Emotional support

- Patients told us that staff were helpful and supportive.

Are surgery services responsive?

Requires improvement

Patients were seen and assessed in pre-admission clinics at agreed times. The trust, however, was not meeting the national target for patients to wait less than 18 weeks for operations or procedures. Specialist support for people with a learning disability was unavailable and information leaflets were only printed in English.

Access to services

- Patients booked for elective surgery were seen and assessed in the surgical pre-admission clinic either at the time of their consultation with the surgeon or at an agreed time before their admission. This enabled the assessment and management of risk in advance of the surgery taking place.
- On the urology ward a treatment area had been opened for patients to be seen without requiring admission and a bed.
- There was a surgical admission unit where patients were seen, admitted, prepared and transferred to the operating theatre. They were then admitted to an inpatient bed.
- The trust was not meeting the national waiting time target for 90% of patients waiting 18 weeks or less for elective and day case surgery. In December 2013 only 75.1% of patients had surgery within national waiting times. Diagnostic waiting times also were slightly over the six weeks waiting times. The trust was reviewing how it could reform elective care procedures
- The trust was meeting the national targets for patients being rebooked within 28 days if they had been cancelled.
- Discharge summaries were sent to GPs after a patient's discharge, these included information on admission care and discharge

Meeting people's individual needs

- A specialist nurse had been available to support people with learning difficulties but this resource had been withdrawn. There were plans to once again employ a nurse qualified in the care of people with learning disabilities to provide support across the trust.
- Staff could request a translator and at times, when an interpreter was required at short notice, this could be provided as a telephone service.
- There were multiple information leaflets available for many different minor complaints. These were only available in English.

Complaints

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Information on how to make a complaint was displayed throughout the hospital.
- Patients told us they would be happy to raise any concerns.
- The division responded to 67% of complaints within the trust's 25-day target. This was below the trust target of 85% and lower than the other divisions.

Are surgery services well-led?

Good

There was a matron responsible for the wards in surgery and members of staff told us she was visible and approachable. Staff we spoke with worked well together. The service had a strategy and risks were being managed appropriately. The trust's vision was encapsulated in the strapline 'Safe and compassionate care every time' and staff were aware of this.

Vision and strategy for this service

- The trust's vision was encapsulated in the strapline 'Safe and compassionate care every time'. This was visible on every ward.
- The division had a strategy and this included priority areas for each service area (or service delivery unit).

Governance, risk management and quality measurement

- Clinical governance meetings were held for each service delivery unit and complaints, incidents, audits and quality improvement projects were discussed.
- Information was cascaded to staff by email and in team meetings.

Surgery

- The directorate had a performance dashboard that it used to monitor the quality of care provided and performance information was displayed in ward areas.

Leadership of service

- Each ward had a band 7 ward manager. There was a matron who oversaw all the wards and staff told us he was visible in her role and easy to contact.
- Each of the surgical specialties had a clinical lead and there was also a divisional lead.

Culture within the service

- Staff spoke positively about the service they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility.
- Staff worked well together and there was obvious respect not only between the specialties but also across disciplines.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Junior doctors and nursing staff were involved in audits and the results shared within the department.
- Improvements were not shared across hospital sites. There were improvements in ensuring safer surgery procedures observed at Wycombe Hospital that were not implemented at Stoke Mandeville Hospital.

Critical care

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

Information about the service

The critical care department at Wycombe Hospital included an intensive therapy unit (ITU) and a coronary care unit (CCU). The ITU had 7 beds and the unit admitted approximately 376 patients last year. The CCU had 22 beds; 12 of these were monitored beds and 10 were step-down beds.

We visited the ITU and CCU and wards in the hospital. We talked with nine patients, two relatives and 18 staff. These included nursing, domestic and administration staff, junior and senior doctors, physiotherapists, a pharmacist and managers. We observed care and treatment and looked at 10 care records. Before the inspection, we reviewed preformance information from, and about, the hospital.

Summary of findings

Patients we spoke with gave us examples of the good care they had received. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. There was strong local leadership of the units. Openness and honesty was encouraged at all levels. The units had an annual clinical audit programme to monitor how guidance was adhered to. All staff, including student nurses, were involved in quality improvement projects and audit. There was good multidisciplinary team working. Patients were effectively monitored and clinical outcomes were good.

Critical care

Are critical care services safe?

Good

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

Incidents, reporting and learning

- There had been no never event (incidents that should never occur) in the critical care unit.
- Between June 2013 and July 2013 there had been 53 incidents in anaesthetics and critical care reported to the National Reporting and Learning System (NRLS). More recent figures from January to February 2014 identified that critical care had three incidents. All were moderate harm and described delays to treatment because of a lack of available intensive care beds.
- All staff we spoke with said that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at staff meetings.
- Staff were able to tell us how practice had changed as a result of incident reporting. For example, people who had an intravenous (IV) infusion had a visual infusion phlebitis (VIP) score to make sure the IV site remained healthy, and this was discussed at their bedside handover.

NHS Safety Thermometer

- One of the ways the units checked the safety of their care was by using the NHS Safety Thermometer. This took the form of an audit carried out each month. Safety Thermometer information was clearly displayed at the entrance to both the ITU and the CCU. It included whether there were any infections such as meticillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile and whether any patients had developed a new pressure ulcer or blood clot, known as 'venous thromboembolism' (VTE). The units were performing as expected for these.
- Risk assessments for patients for infections, pressure ulcers and VTE were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. Hygienic hand washing facilities and protective personal equipment (PPE), such as gloves and aprons, were readily available. Staff wore PPE and regularly washed their hands and used hand gel between patients. The 'bare below the elbow' policy was adhered to.
- There were effective arrangements for the safe disposal of sharp and contaminated items.
- The anaesthetic directorate hand hygiene audit indicated that it was performing at 96.7% and hand hygiene in CCU was 99%, which was above the trust target of 95%. The results were on display in the units.
- The units contributed their patient data and outcomes to the Intensive Care National Audit and Research Centre (ICNARC) so they were evaluated against similar departments nationally. ICNARC data showed that infection rates (for example, for MRSA) were low and below the national average.

Environment and equipment

- The environment in each unit was safe.
- Equipment was appropriately checked and cleaned regularly.

Medicines

- Most medicines were stored correctly, including in locked cupboards or fridges when necessary. However, IV fluids were stored on wire racks and were accessible to patients or visitors to the units.
- Fridge temperatures were not always checked daily so there was a risk that medication was being stored at an incorrect temperature, which could reduce its effectiveness.

Records

- All records were in paper format. They were all filed in an identical way, which meant that information could be found easily.

Critical care

- All professionals involved with a patient during their admission to one of the units added their notes in the same records. This ensured continuity and a team approach to care delivery.
- Standardised nursing documentation was kept at the end of each patient's bed. Observations were well recorded.
- The units used a daily ward round proforma that was completed during the morning ward round. There were clear records of the treatment people had received and any further treatment or follow- up they required.

Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

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

Assessing and responding to patient risks

- The National Early Warning Score (NEWS) escalation process for the management of acutely unwell adult patients was used to identify and care for patients whose condition was deteriorating. This ensured early, appropriate treatment from appropriately skilled staff.
- Nursing handovers occurred two or three times a day. A short handover when staff were updated on a patient's condition initially took place in a room with a closed door to maintain patient confidentiality. This was followed by an individual handover at the patient's bedside, which ensured that key pieces of information were communicated (for example, what medication a patient had received).
- Visiting professionals to the units (for example, a physiotherapist or speech and language therapist) also received an update on the patient's condition and progress before giving any treatment.

Nursing staffing

- Both units had staffing levels that met the needs of patients. In the ITU all level 3 patients were nursed one to one, and all level 2 patients one to two. There was also a supernumerary nurse and one or two healthcare assistants per shift.
- If staffing levels were not met from permanent staff, agency or bank staff were used to cover absences. There was a regular cohort of bank and agency staff, most of whom had experience of working on the units before.
- There was a supernumerary senior nurse who led each shift.
- Seventy per cent of the nursing staff in the ITU had achieved a post-registration award in critical care nursing. Twenty-five per cent of the nursing staff in the CCU had achieved a post-registration award in coronary care. There were two nurses currently completing the coronary care course. All nurses working in the CCU had attended a course on managing a deteriorating patient, as well as intermediate life support.

Medical staffing

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

Mandatory training

- Training records confirmed that 73% of surgery and critical care staff were up to date with their mandatory training. Seventy-eight per cent of integrated medicine staff were up to date with their mandatory training The trust did not hold separate information about training compliance relating to only critical or coronary care staff.

Are critical care services effective?

Good

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

working and patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit. Patients in CCU were monitored effectively and had good clinical outcomes.

Evidence-based care and treatment

- The critical care department used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment it provided. Local policies were written in line with this.
- The units had an annual clinical audit programme to monitor how guidance was adhered to. All staff including student nurses were involved in quality improvement projects and audit. Clinical audits during the past year, for example, had demonstrated improvements in infection control and fluid balance monitoring.
- There were care pathways in ITU to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.
- There were care pathways in CCU to ensure appropriately and timely care for patients. The thrombolysis pathway, for example, was followed by a multidisciplinary team, and this resulted in good outcomes for patients.

Patient outcomes

- The department contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. This showed that mortality was below the national average and unplanned readmissions were similar to those in other trusts.
- ICNARC data was displayed in the department so that patients, their relatives/carers and staff could see the quality of care provided.

Hydration and nutrition

- The 'Evian Project', was a multi-professional group led by the consultant nurse in critical care. This has improved the hydration of patients in the trust. The team had raised staff awareness around hydration levels, how to monitor patients effectively and using food and fluid balance charts correctly.

Competent staff

- Seventy per cent of the nursing staff in the ITU had achieved a post-registration award in critical care nursing. Twenty-five per cent of the nursing staff in the CCU had achieved a post-registration award in coronary care.
- There were two nurses currently completing the coronary care course. All nurses working in the CCU had attended a course on managing a deteriorating patient, as well as intermediate life support.
- The National Training Scheme Survey, GMC, 2013 indicated that the training given to junior doctors in anaesthetics was overall similar to other trusts but was worse than expected for clinical supervision but better than expected for regional teaching.

Multidisciplinary team working

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

Seven-day services

- A consultant was present on the ITU from 8am to 9pm at weekends. They were supported by a senior registrar and junior doctor.
- There was a consultant on call at the weekend in the CCU. Junior doctors told us they were easy to contact.
- A physiotherapist was on duty at weekends and pharmacy support was provided by an on-call pharmacist.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.

Critical care

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

Are critical care services caring?

Good

Patients we spoke with gave us examples of the good care that had received. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support, and throughout our inspection, we saw patients being treated with compassion, dignity and respect.

Compassionate care

- Throughout our inspection we saw patients being treated with compassion, dignity and respect. Patients and relatives we spoke to were highly complimentary about all of the staff in the department.
- Privacy and dignity arrangements were acceptable. The wards were mixed-sex wards although the units had side rooms and bays that meant male and female patients could be cared for separately most of the time.
- Patients we spoke with gave us examples of the good care they had received in the units.
- Relatives were encouraged to visit and routine visiting hours were from 10am to 9pm. Flexible visiting time was at the discretion of the nurse in charge for new admissions and patients who were at the end of their life.

Patient understanding and involvement

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

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support. For example, one relative told us, "People [staff] are ready to talk to you when you need it."
- Staff made people aware of support groups or services they could access, such as the chaplaincy services.
- After admission to the unit, the consultant covering the unit would arrange to meet with relatives to update them on the patient's progress.
- When necessary, further face-to-face meetings were organised, and all relatives we spoke with said that they had been kept fully updated and had had opportunities to have all their questions answered.

Are critical care services responsive?

Good

The critical care services were responsive to the needs of their patients. Support for patients with physical and learning disabilities was available if needed, and staff demonstrated a good understanding of people's social and cultural needs. Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those receiving them into their care. Bed occupancy on the critical care unit was high and patients could often be transferred between Wycombe Hospital and Stoke Mandeville Hospital for an intensive care bed.

Access to services

- Between November 2013 and February 2014, figures showed that the combined bed occupancy for adult critical care beds across the trust was 82%. This was above the Royal College of Anaesthetists' recommendations of 70%.
- Persistent occupancy of more than 70% suggests a unit is too small and occupancy of 80% or more is likely to result in non-clinical transfers, with associated risks. The trust had recently made two further beds at Wycombe Hospital to increase its service capacity. There were protocols to manage the safe transfer of patients.
- The length of the stay for the department was below the average for England.

Critical care

- Most discharges occurred during the day between 8am and 10pm, which followed national guidelines. Between November 2013 and February 2014, figures showed that discharges outside these hours were below the national average.
- Patients who were discharged from the ITU or CCU were aware of their discharge plans, and had appropriate records or information given to them or provided to those receiving them into their care.
- All professionals involved with a patient during their admission to the department contributed to the plan for their discharge. This ensured continuity and a team approach to care delivery.

Meeting people's individual needs

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

Complaints

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained
- Complaints leaflets were available throughout the department and information displayed on posters.
- People knew how to raise concerns or make a complaint.

Are critical care services well-led?

Good

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

Vision and strategy for this service

- There was no overall vision or strategy for this service. A strategy for increasing overall bed capacity was in place. Two new beds had opened in the ITU and a business case was being prepared identifying medium- to long-term proposals for resolving critical care capacity.

Governance, risk management and quality measurement

- There were monthly governance meetings in which complaints, incidents, audits and quality improvement projects were discussed. The outcomes from these meetings were cascaded to staff during regular unit meetings and minutes of the meetings were available in the staff room.
- Quality and performance dashboard were used to monitor the quality of the service delivered
- Risks inherent in the delivery of safe care were clearly identified on the trust's risk register: for example, the risk of insufficient critical care capacity to meet fluctuations in demand. Supporting actions were identified and discussed at governance and board meetings.

Leadership of service

- The ITU was led by a manager, matron , consultant nurse and consultant clinical lead.
- The CCU was led by a matron and senior nursing staff and a consultant clinical lead.
- There was strong local leadership of the units. The leadership team for the ITU worked across the trust site at Stoke Mandeville Hospital, providing critical care, and there was shared learning and support for staff.
- Each shift was led by sisters who had supervisory responsibility for the staff working for them.

Culture within the service

- Staff within the intensive/critical care directorate spoke positively about the service they provided for patients.
- Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty were expected in the units and encouraged at all levels. We observed shift and unit leaders who were compassionate and led by example.
- Staff were encouraged to complete incident forms or raise concerns.

Critical care

- Staff worked well together and there was obvious respect.
- Staff were engaged and worked well with other departments within the hospital.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. All staff including student nurses were involved in quality improvement projects and audit. Staff were able to give examples of practice that had changed as a result: for example, red stickers that were attached to patients' notes in the ITU to remind doctors to complete the risk assessment for venous thromboembolism.

Maternity and family planning

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

Information about the service

The trust had one maternity service delivered across two main hospital sites and in the community. There were 5,684 births in 2012/13 across the trust. Of these births, 300 were delivered at the Wycombe site in the standalone midwife-led birth centre. The birth centre was for mothers whose pregnancy has been uncomplicated and whose birth was likely to be natural and low risk. Should more be required, mother and baby would be transferred to the labour ward at Stoke Mandeville Hospital. There were also antenatal services at Wycombe Hospital.

We visited the birth centre and antenatal services. We talked with 10 women and 10 staff. These included midwives, doctors, administration staff and managers. We observed care and treatment and looked at care records. Before the inspection, we reviewed preformance information from, and about, the hospital.

Summary of findings

The ward areas were modern and clean. Women and their partners said that the staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. Midwifery staffing levels were appropriate and there were always experienced staff on every shift to women and provide one to one care.

There was good multidisciplinary team working and learning throughout the service. Staff development and continuing professional development in general was a priority within the service. The head of midwifery and her team were well focused and fully engaged and risks were effectively managed. However reporting lines to the trust board were not clear and the maternity service did not have a written vision or strategy. There were concerns about the sustainability of underused services at Wycombe Hospital, potential delays to transfer women who required urgent care to Stoke Mandeville Hospital and differences in culture between community-based and hospital-based midwives.

Maternity and family planning

Are maternity and family planning services safe?

Good

The maternity ward areas were modern and clean, and equipment was regularly checked. The service used the modified early obstetric early warning score to escalate care if women became acutely ill. Staff we spoke with were aware of the appropriate action to take if women scored higher than expected and required close monitoring or transfer for more specialised care. Incidents were reported and action was taken to share learning and improve the service.

Incidents, reporting and learning

- Between June 2013 and July 2013 there had been 117 incidents in Obstetrics and gynaecology across the trust reported to the National Reporting and Learning System (NRLS). More recent figures from January to February 2014, demonstrated that there had not been an incident reported at Wycombe Hospital.
- The service had a thorough reporting system and a strong culture of seeking to learn lessons from Never Events and serious incidents. One member of staff said, "We are beginning to understand that it is not about looking for someone to blame."

Cleanliness, infection control and hygiene

- The birth centre and antenatal clinic were clean and uncluttered.
- Staff followed the trust policy on infection control. Staff wore clothes that followed the 'bare arms below the elbow' policy, and regularly washed their hands and used hand gel between patients.
- There were bi-annual assessments of hand hygiene techniques for staff and hand hygiene audits indicated that the unit was performing at 98%, which was above the trust target of 95%.
- Infection rates for meticillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile for the trust were within an acceptable range.

Environment and equipment

- Equipment was appropriately checked and cleaned and there was regular training available. There was an adequate supply of equipment in the birth centre.
- We saw green stickers on equipment that indicated 'I am clean' and ready to be used.
- Birthing pools were available at Wycombe Hospital and there were also birthing balls and birth mats and plenty of room for mothers to move around in labour.

Records

- The trust was using the National Maternity Notes that would be carried by the expectant mother. This system was working well with additional notes available for cases where higher risks had been identified.
- Several staff told us that timely access to historical records had become an issue because of storage arrangements. This has been identified as a risk on the risk register because turnaround times were a problem for clinic appointments, dealing with complaints and litigation. The storage arrangements had been altered and the situation was improving.
- The procurement for a new maternity information system had begun. This was a priority for the service because statistics could not be generated electronically.
- Medicines were stored correctly, including in locked cupboards or fridges when necessary. Fridge temperatures were regularly checked.

Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

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

Midwifery staffing

- The average midwife to birth ratio had been one midwife to every 37 births (1:37), for 2012/13. This was above the South of England average of 1:31 and the national recommendation of 1:28. The trust had appointed additional midwives and there had also been a slight fall in the birth rate in recent months. The trust ratio was now 1:30 and the service was providing 1:1 midwife care in established labour. The trust did not use agency staff but it did have some midwives on fixed-term contracts to cover for colleagues on maternity leave.
- The midwife to supervisor ratio was 1:14, which was within the required ratio.

Maternity and family planning

- The head of midwifery told us that there were always experienced staff on every shift to support the recently qualified workforce. She said that the service had not had to be suspended or diverted in the past four years and was 'safe and responsive'.
- There was a community midwife who ran the antenatal clinics at the birth centre and at a GP's surgery. She also visited women at home for postnatal care.

Assessing and responding to patient risks

- The birth centre had a handover meeting daily at 8am. This meeting was used to identify any issues relating to the women in the centre and to escalate concerns.
- The unit used the Modified Early Obstetric Warning Score (MOEWS) system to escalate care if women became acutely ill. There were clear directions for escalation printed on observation charts and these were completed by midwives on the labour ward.
- Staff we spoke with were aware of the appropriate action to take if women scored higher than expected and required close monitoring or transfer for more specialised care.
- The time taken to transfer from the birth centre at Wycombe Hospital to the labour ward at Stoke Mandeville by ambulance was between 30 and 40 minutes. Approximately 30% of births planned at Wycombe were transferred (15% during labour and 15% immediately after labour) The staff we spoke with said that this was a concern for some women and placed a limit on the number of births at Wycombe but this was in line with national expectations.

Mandatory training

- Compliance with mandatory training was at 92%. In addition to this, all newly appointed midwives were required to attend training for the management and administration of medicines including intravenous (IV) drug administration. Competence was assessed regularly by the supervisors of midwives.
- Midwives attended mandatory training on safeguarding and the training was informed and updated by experience and learning from casework and serious case reviews. There was no data available for Level 3 safeguarding training which is the level expected for staff that work with children or young people.

Are maternity and family planning services effective?

Good

The maternity services used evidence-based national guidance, that was systematically kept up to date. There was good multidisciplinary team working and learning throughout the service and specifically between community and hospital midwives, clinicians and midwives and at the perinatal meetings between obstetricians and paediatricians. Staff development and continuing professional development in general was a priority within the service and programmes were updated with learning from complaints and incidents.

Evidence based care and treatment

- The maternity service used evidence-based national guidance from the Department of Health, NHS Choices, the National Institute for Health and Care Excellence (NICE) and the UK National Screening Committee.
- Clinical and procedural guidance were also available for staff on the trust's intranet. The guidance was up to date.
- There was a systematic process for updating guidance based on national updates and local review. For example, guidance on 'Perineal tear description and repair including management of packs' had been updated after an investigation into a recent Never Event.
- There was a rolling audit programme with a specialist midwife taking the lead

Patient outcomes

- The maternity department dashboard was comprehensive and was used to monitor outcomes and identify any that were unexpected.
- Outcomes targeted for action included caesarean section rates, which were just above the target level of 24% of all deliveries, the more frequent use of instrumental delivery and the higher rate for induction of labour. Staff were monitoring the service and taking action when necessary. Vaginal birth after a caesarean section in a previous pregnancy had been promoted for several years within the service and had helped reduce the numbers of caesarean births.
- Audit work was ongoing aimed at reducing the numbers of caesarean sections. This included topics such as keeping the first birth normal and reducing the number of maternal request caesarean sections.

Maternity and family planning

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

Competent staff

- Staff development and continuing professional development in general was a priority within the service and programmes were updated with learning from complaints and incidents.
- The year to date average for appraisals was just under the 80% completion target.
- Newly qualified midwives had preceptorship for 12 months and there were four mandatory study days per year.
- The National Training Scheme Survey, GMC, 2013 indicated that the training given to junior doctors was similar to that expected for trusts and better than expected for regional teaching.
- Good-quality professional education and training were available and delivered via e-learning, face-to-face workshops and facilitated programmes of learning.

Pain relief

- Pain relief was available for birthing mums who could access entonox and pethidine, for example. Women had alternative forms of pain relief such as access to birthing pools.

Multidisciplinary working

- There was multidisciplinary team working and learning throughout the service and specifically between community and hospital midwives, clinicians and midwives and at the perinatal meetings between obstetricians and paediatricians.
- Midwives worked closely with the GPs and social care services while dealing with safeguarding concerns or risks for child protection.
- Investigations of incidents and Never Events were multidisciplinary.
- The maternity training booklet for 2014 set out a range of multidisciplinary learning opportunities such as the obstetric emergencies training day that was 'compulsory for all midwives, midwife care assistants and doctors of all grades. We also welcome anaesthetists, theatre staff and ambulance crew'.

Equipment and facilities

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

Seven-day services

- The service was available seven days a week. There was a night-time rota for midwives with additional resources for covering breaks. There was also an experienced midwife providing 24/7 on-call support. Consultant on-call support was also in place.

Are maternity and family planning services caring?

Good

Women and their partners that we spoke with said that the staff were caring and friendly. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in planning and making decisions about their care. There was a plethora of information available for women to make birth choices appropriate to their needs and a high level of emotional support for women, for example to breastfeed or to deal with unexpected complications in labour and birth.

Compassionate care

- The results from the Friends and Family Test for maternity services at Wycombe Hospital was higher than the England average with a score indicating that patients would be 'extremely likely' to recommend them to family and friends.
- The Survey of Women's Experiences of Birth, CQC, 2013, was for women who had had a live birth in February 2013 and were over 16 years old. Responses were received from 239 women from the trust, a response rate of 7.1%. The trust was performing as well as other trusts for care during labour and birth and care in the hospital after the birth.
- The trust also asked women for feedback and asked them to complete a 'birth reflections' questionnaire within 1 month of the birth. In the period from 1 July to 31 December 2013, 181 questionnaires were returned

and 175 contained positive comments. Some of the comments were "should be proud of staff in antenatal, labour and postnatal wards" and "nothing was too much trouble".

- We spoke with women and their partners in all areas of the service including those awaiting day, antenatal and postnatal care. People we spoke with said that the staff were "caring and friendly" and "I was able to ask questions and the nurses took the time to explain what was happening".
- We observed staff with women and their new babies and saw that they were attentive and patient. One women wrote on her 'birth reflections' questionnaire: "I remain overwhelmed by the level of care that is given and thankful that I live in Bucks as, having spoken to other pregnant ladies in different boroughs, I feel that Bucks is really leading the field."
- We observed the staff on the postnatal ward and saw how they answered call bells quickly and efficiently and helped patients move around the ward. Curtains were pulled round in the bays as women had requested, and staff were careful to respect the privacy and dignity of patients.
- One member of staff informed us that partners were welcome but, in order to respect the privacy of other women, they were encouraged to remain with their partner and not walk around the ward. We noted that toilet facilities for men were limited on the wards.

Patient involvement in their care

- Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. The 'place of birth' was discussed early on in pregnancy and a sticker had now been introduced into the notes to remind midwives to discuss 'place of birth' again at 36 weeks of pregnancy.
- Women we spoke to told us they were involved in decisions about their care.
- A leaflet was available for women with information about 'Your birth choices'. Subject to appropriate risk assessment, women could choose a home birth, or birth in the 'calm, homely environment' of a midwife-led unit. Women were informed that they would be transferred to the labour ward at Stoke Mandeville Hospital should they require additional monitoring and support with the birth.

Emotional support

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

Are maternity and family planning services responsive?

Good

The maternity and family planning services were responsive to women's needs. Women had access to the full range of options for birth, subject to the appropriate risk assessment. There was a social assessment undertaken by community midwives at the first booking and this would identify, for example, any communication or language issues, difficulties with housing or the previous involvement of social services. Care was available for vulnerable patients through the community midwives in liaison with the family nurse partnership for young mothers and specialist midwives for conditions such as diabetes. Women, however were concerned about potential delays in care if they needed to be transferred to Stoke Mandeville Hospital for urgent care and treatment.

Access to services

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

Maternity and family planning

- Mothers had access to the full range of options for birth, subject to the appropriate risk assessment. The midwifery led unit included a day assessment unit for antenatal assessment and screening.
- Women who required further monitoring or support or interventions during birth would be transferred from the birth centre at Wycombe Hospital to the labour ward at Stoke Mandeville by ambulance. This journey took between 30 and 40 minutes. The staff we spoke with said that this was a concern for some women and placed a limit on the number of births at Wycombe.
- The number of births at the midwife-led birth centre at Wycombe Hospital was relatively low at about 300 per annum. The bed occupancy rate for maternity services in the trust was 60.9% between July and September 2013, which was above the national average of 58.6%. The birth centre at Wycombe was under-used but the right balance was needed for women to exercise their choice in how they accessed services.
- A discharge summary was sent to the person's GP by email automatically on discharge from the hospital. This gave details of the reason for admission, any investigation results and treatment

Meeting people's individual needs

- There was a social assessment undertaken by the community midwife at the first booking and this identified, for example, any communication or language issues, difficulties with housing or previous involvement of social services.
- Care was available for vulnerable patients through the community midwives in liaison with the family nurse partnership for young mothers and specialist midwives for conditions such as diabetes. There were also close liaison with social care should there be any learning difficulties or mental health issues.
- Interpreters were available and leaflets were available in the other languages that were spoken locally.
- The trust website included a wide range of up-to-date leaflets for patients on birth choices and services at the trust as well as information on particular concerns and issues such as screening options, multiple birth and induction of labour. These leaflets were also available in printed form in the hospital and gave details of the facilities available at the day assessment unit, for example, or for antenatal screening for diabetes in pregnancy. The leaflets were clear and informative and all had printed issue and review dates. There was also clear version control on the leaflets with the dates of approval by the maternity guidelines group.

Complaints

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained
- Complaints leaflets were available throughout the department and information displayed on posters.
- Women knew how to raise concerns or make a complaint.
- The service received an average of two complaints a month. We saw evidence that the service responded well and used complaints to improve.

Are maternity and family planning services well-led?

Good

The leadership of the service was described as strong and effective. The head of midwifery and her team were well focused and fully engaged and staff told us they felt well supported. Reporting to the board required improvement but information was available and reported at divisional level. The maternity service did not have a written vision or strategy and there were concerns about the sustainability of underused services at Wycombe Hospital and potential delays to transfer women who required urgent care to Stoke Mandeville Hospital. There was a risk management strategy for operational and performance issues and risk issues were effectively managed. The service was good at implementing innovations in care.

Leadership of this service

- Local leadership of the maternity services was described as strong and effective. We found that the head of midwifery and her team were well focused and fully engaged.
- The consultant midwife said, "We are all easy going and of equal standing, we are clear about our roles and that helps." She also said that the head of midwifery had a "strong, inclusive, consultative style and that encourages good respectful listening all round".

Maternity and family planning

Culture within this service

- Leadership within the service prioritised safe, high-quality compassionate care. We found a keen sense of enquiry, enthusiasm for learning and improvement in maternity services, and a culture of professional respect.
- The audit report by the local supervisors of midwives mentioned 'differences' in culture between community- and hospital-based midwives and that community midwives had a more inclusive style. This was actioned and a leadership programme was designed for hospital midwives to introduce the skills required for a more coaching style of leadership when appropriate.
- The National Staff Survey 2013 results for the trust overall revealed that staff were reporting issues (but were within the bottom 20% of trusts nationally) to do with work pressure, working extra hours, support from managers and communication. Several staff we spoke with mentioned that, with the trust under such pressure in general and colleagues working so hard, they sometimes had a need for greater acknowledgement. We noted that colleagues in maternity services had recently received awards for 'going the extra mile'.
- Sickness absence rates were just 2.5% and under the trust target of 3%.

Vision and strategy for this service

- The maternity service, however, did not have a written vision or strategy. Several staff spoke about the need for greater overlap between community and hospital midwives to make better use of available resources and to reduce the size of caseloads. They also spoke about the need to build on the merger and centralisation of services, maintain high standards of care and treatment, and manage capacity (which was under-used at Wycombe Hospital) in a more proactive rather than reactive way.
- There was a maternity risk management strategy that reinforced the approach within the service of learning from mistakes, and the processes to obtain assurance.

Governance, risk management and quality measurement

- There were monthly governance meetings within the service. Complaints, incidents, audits and service performance information were discussed and actions agreed.
- The maternity dashboard was regularly reviewed and there was target monitoring of performance and service quality measures. Action was taken when necessary.
- The risk register for women, children and sexual health included a risk relating to the heavy community midwife caseloads. Concerns regarding sustainability and transfer times for women were not noted.
- A quarterly newsletter was produced and circulated within the department by the maternity practice development team. This was called 'Baseline: listening and learning: women's views, lessons from risk management, guidance for best practice'. There was also a newsletter, produced by the supervisors of midwives, which contained information on recent audits, surveys and continuing professional development.

Innovation, improvement and sustainability

- There were innovations in care that were simple but effective adjustments or additions to processes as a result of learning from complaints and incidents (for example, changes to the care and support for women after a still birth and the introduction of a sticker to check that all swabs were removed).
- The 'Reflections at Birth' initiative, which involved feedback from women one month after giving birth, had helped to inform management and improve the quality of care.

Services for children and young people

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

Information about the service

The services provided at Wycombe Hospital included a children's day unit (ChDU; Ward 7), which had 16 beds and was open Monday to Friday for children admitted for planned day case procedures from across Buckinghamshire or who were referred by local GPs for emergency review and treatment. There was also a children's outpatient department.

We visited Ward 7 and outpatients. We spoke with three children, seven parents and 9 members of staff including nurses, medical staff, healthcare assistants, a ward clerk, domestic staff and a manager. We observed care and treatment, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Services for children and young people were good. Parents told us the staff were caring, and we saw that children and their parents and carers were treated with dignity, respect and compassion. The ward areas and equipment were clean. There were enough trained staff on duty to ensure that safe care could be delivered. Children were appropriately prepared for surgery and treatment and clinical outcomes were good.

The service was responsive to the needs of children and young people and their families and carers. Staff were positive the service and children's experiences were seen as the main priority. The service did not have a strategy but there were actions around improving the service. The trust long term plans for the service were not clear to staff.

Services for children and young people

Are services for children and young people safe?

Good

Services for children and young people were safe. Ward areas and equipment were clean. Children at risk of, or suffering from, an infective illness were cared for in single rooms to reduce the risk of spreading infection. There were enough trained staff on duty to ensure that safe care could be delivered. Children's or their parent's consent to treatment was obtained appropriately and children were assessed appropriately for surgical procedures.

Incidents, reporting and learning

- Between January 2014 and March 2014 there had been 21 incidents in paediatrics reported to the National Reporting and Learning System (NRLS). All were low or no harm and the majority were for unplanned readmission of babies. There were no serious incident reports for paediatric services provided at Wycombe Hospital.
- All staff we spoke with told us they were encouraged to report incidents. Learning from incidents, involving paediatric services, was shared across sites as appropriate. Learning from incidents was incorporated in updates to training material if required.

NHS Safety Thermometer findings

- The NHS Safety Thermometer was used, covering information on falls, medication errors, pressure ulcers, serious incidents, meticillin-resistant staphylococcus aureus (MRSA) bacteraemia, and hand hygiene.
- Information was displayed on the ward and there were no areas of concerns as a result of these findings.

Cleanliness, infection control and hygiene

- Ward areas and equipment were clean.
- Staff followed the trust policy on infection control. Staff used hand hygiene gel and personal protective equipment, such as aprons and gloves, appropriately.
- Children with low resilience to infections, or children with an infection, were cared for in single rooms.
- Ward 7 had an infection control nurse who was responsible for coordinating and performing audits. Audits of cleanliness were regularly performed and showed good results that were displayed on notice boards.
- There were minor concerns about the process for washing toys in the outpatient areas. Children with an unknown infection status played with toys in the waiting areas. Toys were cleaned daily but not between children. This could put those vulnerable to infection at risk.

Medicines

- Medicines were stored securely, and dispensed and recorded correctly.
- Guidelines were available for injected paediatric medicines and sedation for children.
- There was a paediatric pharmacist based at the hospital whom staff were able to contact for advice.

Environment and equipment

- Wards had sufficient equipment that was checked according to schedules to ensure it was fit for purpose.

Records

- The ward used multidisciplinary notes and all staff wrote in the same set of notes. This ensured all disciplines had access to current information centred on the child.
- Notes were kept in a supervised environment to maintain confidentiality.
- Most notes were paper based but were being transferred to an electronic system.

Safeguarding

- Child or parental consent to treatment was obtained appropriately.
- There were clear policies and procedures available for handling potential safeguarding concerns. Staff could describe the safeguarding process and a copy of the policy was readily available to all staff.
- The local authority had undertaken a trust-level audit of safeguarding in November 2013. Some of the issues identified included the need for review of training and of policies to ensure they reflected the latest national guidance. The trust had an action plan to respond to these issues. The safeguarding board was monitoring progress.

Assessing and responding to patient risks

- There were clear pathways for managing deteriorating patients. Staff used the Paediatric Early Warning System (PEWS), which included escalation pathways printed on

the reverse of the observation charts. Staff were aware of the appropriate action to take to ensure children whose condition deteriorated were quickly and appropriately managed.

- We observed a nurse handing a child over to the care of the operating department assistant before surgery. All relevant information was included about the child and as part of the Five Steps to Safer Surgery guidance. On the child's return to the ward the theatre nurse gave a verbal handover to the ward staff to ensure appropriate care was then planned.
- Medical cover was provided by a team of doctors and individual case discussions took place as needed.
- The children's ward was open from 8am to 9pm. If a child needed to be transferred to Stoke Mandeville Hospital, they would be accompanied by a nurse and direct handover would be carried out.

Nurse staffing

- The ward staff were present for the full opening times of the ward, and therefore no shift changes.
- There were enough trained staff on duty to ensure safe care could be delivered. Duty rotas showed staffing levels were generally within the safe staffing level. There were newly approved vacancies for 1.37 wte staff.

Medical staffing

- A paediatric registrar provided on-site cover in the hospital together with two junior doctors. There was a paediatric consultant on call. Specialties (for example, urology and dental) were staffed by their respective consultants. The paediatricians were available to provide "support if needed".
- Children were seen by a paediatrician after their admission.

Mandatory training

- Staff attendance at mandatory training was monitored. Local learning and development managers supported staff to remain compliant with training requirements.
- Training records showed that staff were compliant with completing mandatory trust training. All staff had completed level 2 safeguarding training. There was no data available for Level 3 training which is the level expected for staff that work with children or young people.

Are services for children and young people effective?

Good

Children were treated according to national guidance and these were systematically kept up to date. The services had an annual clinical audit programme to monitor that guidelines for best practice were being adhered to. Children's received multi-disciplinary and appropriate specialist care and treatment and outcomes of their care were good.

Evidence-based care and treatment

- Children were treated according to national guidelines, such as the National Institute of Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH). Local policies and procedures were written based on national guidelines that were up to date.
- Children's protocols were developed that were specific to the needs of children when trust-level documents were not appropriate.
- Children attending for day surgery had specific care plans that included preparation for surgery, recovery and discharge after surgery.
- Procedures were developed for children with specific needs, for example, processes were developed for the insertion and position checking of naso-gastric tubes for children and one child in outpatients was on the 'prolonged jaundice screening pathway'.
- The trust had participated in five national audits related to paediatrics over the past two years. Topics included paediatric asthma, paediatric diabetes and childhood epilepsy.
- There was a comprehensive schedule of audits to continually monitor the quality and safety of services provided.
- The results of internal audits were displayed on notice boards. Topics of audits included infection control, disposal of sharps, isolation and personal protective equipment, and the results indicated compliance with standards. Results of the latest hand hygiene and pressure area audits had been submitted to the trust and certificates were awaited.

Services for children and young people

- Monthly departmental meetings were used to discuss any changes to guidance and the impact that they would have on practice. For example, a recent change required two people to check children's weights, the second checker being a parent.

Patient outcomes

- The trust performed similar to other trusts for paediatric national audits.

Pain relief

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

Competent staff

- Practice development nurses were involved in the design of dedicated paediatric training programmes. They supported staff to complete the required training. They issued reminders and set up induction programmes for new staff and study days.
- Senior nurses provided supervision to student nurses and healthcare assistants. Staff told us they felt supported and most had had opportunities for clinical supervision during which they discussed and reflected on incidents occurring at work.
- Training for paediatric doctors had been accredited by the Oxford Deanery.
- Staff told us they had an annual review when they discussed progress and training needs.

Equipment and facilities

- Play facilities were provided in the children's outpatients department for both younger and older children.
- Drinks were available in the outpatient waiting area.
- The ward area had plenty of space and a small play area with games.
- Cubicles were available on the ward to provide a quiet environment.

Multidisciplinary working

- Diabetes, cystic fibrosis and oncology nurse specialists were available to support children, parents and staff.
- The outpatient clinic included supporting disciplines, and psychologists and dietitians attended the diabetic clinic.

Seven-day services

- There were no seven day services at Wycombe Hospital for paediatric patients. Ward 7 and the outpatient department were from 8amto 9pm, open Monday to Friday only. Out of hours GP or ambulance referrals were directed to Stoke Mandeville Hospital.

Are services for children and young people caring?

Good

Parents told us the staff were caring and we saw many cards displayed that expressed thanks to ward staff. Children and their parents/carers were treated with dignity and respect, and compassion. Play specialist were used to support children to understand and be involved with their care.

Compassionate care

- We observed that children and their parents/carers were treated with compassion. Nursing staff prepared children for theatre and parents were able to accompany their child to the anaesthetic room.
- The Friends and Family Test results were available on the ward. The February score was 76.5; this was a reduction from the previous month (88.2) but higher than the national average score of 72.
- We saw many cards displayed that expressed thanks to ward staff for the quality of care, and one parent told us the staff had been "friendly, upfront and honest".

Patient understanding and involvement

- Children and their parents/carers were involved in an initial assessment and their ongoing care planning.
- Play specialists were used to support children to understand their illness and any procedures. This helped them to make informed decisions and choices.
- One child expressed a preference not to have their parent with them during a procedure. Their wishes respected and the nurses handled this in a sensitive manner.
- Information on notice boards in the children's care centre was not kept up to date and some information was no longer relevant for patients and staff.

Services for children and young people

Emotional support

- Parents were able to stay with their child throughout their stay. This helped parents to support their child to adapt to the hospital setting.
- One parent in outpatients commented they felt unsupported in adapting to their child's recent diagnosis.

Are services for children and young people responsive?

Good

The services were responsive to the needs of children and young people and their families and carers. Some children had pre-operative assessments done by phone to reduce the need for additional visits to the hospital. Access to the service was good and recently discharged children had an open door policy to the ward to be able to speak to a doctor or nurse. Children were assessed so that their special needs could be met appropriately. There were multidisciplinary networks that supported the early discharge for children. These included links to community nursing and children's outreach services.

Access to services

- Most children were admitted via the minor injuries and illness unit run by primary care services, GP referrals or were planned admissions for day case surgery or other procedures such as blood transfusions or medical resonance imaging (MRI) requiring sedation.
- GPs were able to directly contact staff on the ward before referrals being made. All children were assessed by a paediatrician on arrival on the ward. Out of hours or at weekends, children would be directed to Stoke Mandeville Hospital.
- Children with long-term chronic conditions were offered an open-door policy so they could call the ward directly and speak to a doctor or nurse. In addition, children who had been discharged were given 24–72-hour access to call the ward.
- Children having day case surgery were assessed by phone to reduce the need for attendances at hospital. If there were any concerns they were referred to the appropriate services before being given a date for operation. Blood tests and other examinations were undertaken pre-operatively.
- Healthcare assistants streamlined the admission process by weighing and measuring each child as they arrived for their appointment.
- Parents told us they received outpatients' appointments and could change them if needed. Some parents told us they were given choices.
- Staff in the children's outpatient area told us that if clinics were running late a notice would be displayed in the reception area.
- Children would be discharged by the paediatrician or the surgical team, or a decision made to transfer them to Stoke Mandeville Hospital if they were not considered fit for discharge home within the same day. All children were discharged as soon as possible in order not to expose them to the hospital environment for longer than necessary.
- Multidisciplinary networks supported discharge home. Referral to community nursing services and children's outreach services was used to support children in the community after discharge.
- Discharged children were given a time frame in which they could call the ward directly for advice after discharge. This supported the safe discharge of children.
- Discharge letters were sent to GPs to ensure they were aware of all treatment provided.

Meeting children's individual needs

- Children with special needs were assessed on admission and a nursing care plan developed to address their individual needs. Staff gave us examples of how they could support children with special needs. These included nursing them in a quiet area, giving more time to make decisions, offering the opportunity to visit the ward before admission and being supported by a play therapist. There was a lead paediatrician for learning disabilities available for consultation.
- A specific plan was developed to support children to move from paediatric to adult services. The timing and method of support were based on the individual assessment and needs of the child. Children with diabetes would start the transition by attending joint adult and child outpatient clinics.

Complaints

- All complaints were responded to by a senior nurse. Complaints were investigated and these were actioned

in a timely and appropriate way. Complainants were invited to face-to-face meetings or offered a phone call to discuss their issues. Results of actions put in place were communicated to the complainant.

Are services for children and young people well-led?

Good

The ward sisters and matron communicated well with staff, and staff were positive about the service. Children's experiences were seen as the main priority. Staff felt supported by their managers and were involved in areas for improvement and risks were being managed appropriately. The service did not have a strategy but there were actions around improving the service. The trust did not have long terms plans for the service and staff were concerned about the possibility of closure.

Vision and strategy for this service

- The service did not have a clear vision or strategy but there were actions around improving the service.
- The trust did not have long terms plans and two members of staff informed us they thought the day unit and outpatient departments might be under threat of closure.
- Staff referred to the '6Cs' (compassion, care, competence, communication, courage and commitment) and not to the trust's current vision, 'Safe and compassionate care every time'. This indicated that the communication of the new vision had not yet been embedded.

Governance, risk management and quality measurement

- Bi-monthly clinical governance meetings were attended by senior sisters. At the meetings all trends in incidents, risks, compliance with national guidance and outcomes were reviewed.
- Team meetings were held monthly to ensure effective communication of departmental information.
- One nurse had 50% of their time dedicated to governance activities.
- Issues identified at Stoke Mandeville Hospital were shared with the services at Wycombe Hospital.
- There was a wide range of audits performed and the certificates, for example, of compliance with infection control and hand hygiene standards were displayed on the ward. The Friends and Family test and pressure area care results were also displayed on the ward.

Leadership of this service

- There was a matron responsible for the overall service and each area had a ward sister in charge.
- A consultant clinical lead was responsible for managing the medical staff including those in training posts.

Culture within this service

- The ward sister and matron communicated well with staff, and shared information in monthly meetings and via emails.
- Staff felt supported by their managers and the clinical lead

Innovation, improvement and sustainability

- Nursing staff were provided with development opportunities. Some had been given additional responsibilities relating to areas such as tissue viability, record keeping and infection control.
- There were no specific examples of innovation reported by staff.

End of life care

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

Information about the service

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

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

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

Summary of findings

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

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

End of life care

Are end of life care services safe?

Requires Improvement

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

Incidents, reporting and learning

- There had been no recent "Never Events" (incidents that should never occur) in the specialist palliative care service.
- The most recent serious incident in the specialist palliative care service was in January 2014 and it had been fully investigated. The incident involved the inaccurate recording of a patient's own medicines on admission to the hospice. The investigation resulted in changes to the procedure for medicines management.
- Staff understood their responsibilities with regard to reporting incidents. They told us they did not always receive feedback on the outcome of incidents.

Medicines

- The four ward areas we visited did not keep the appropriate dose of sedative required for syringe driver use (a method of continuous delivery of medicines). This may have resulted in a delay in treatment.
- The trust uses a county wide formulary for prescribing and this used by GP and the hospitals. Formulary medicines should be in stock and can be supplied promptly. One relative, however, told us that some medicines were not always available in the pharmacy and they were not told when they would be in stock.

Records

- Charts used to monitor a patient's general health and wellbeing such as food and fluid intake and skin condition. However, patients were not formally assessed as to the appropriate use of these charts at the end of life. The charts were also not accurately completed and staff therefore did not have accurate assessments of a patient's condition, such as if they were properly hydrated.
- The trust audited the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms annually to ensure that they were always completed properly.
- A trust DNA CPR audit of 88 forms in January 2014 showed that the decision had been made and recorded in 95% of cases, and by an appropriate clinician (91%). We saw that a sample of the DNA CPR records had been completed appropriately.

Staffing

- There was a specialist palliative care team to support patients requiring complex symptom management and support during end of life care, as well as their families. The team consisted of two consultants and six specialist palliative care nurses.
- Staff in all ward and outpatient areas told us they were short staffed at times, which had an impact on providing end of life care, particularly on the time available to give emotional support.
- The bereavement office was short of staff. Staff described the only service they were able to offer as "just dishing out death certificates".

Mandatory training

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

Medical staffing

- A peer review undertaken by the lead cancer clinician in 2012 identified that there were not enough palliative consultant staff to cover the multidisciplinary teams and annual leave. There had been no changes to the staffing levels following the review, despite a recommendation to increase the number of consultants from two to three.

Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

- Staff who cared for patients living with dementia said patients' mental capacity was assessed before best interest decisions were made. They told us best interest meetings were documented in patient records.
- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults.

End of life care

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

Safety of the environment and equipment

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

Are end of life care services effective?

Inadequate

The specialist palliative care team coordinated multi-disciplinary care. However, some aspects of end of life care was not provided in line with national guidance, for example, access to medicines and we observed delays in providing pain relief to patients. There was no evidence to that action following audits had been taken or that care or guidelines were regularly monitored. Some nursing staff we spoke with were not clear about the trust's definition of end of life care and some staff were not aware that the Liverpool Care Pathway was no longer in use. Ward staff were not appropriately trained in end of life care and essential nursing care for assessment and monitoring, pressure ulcer management, pain relief, comfort and managing distress, was not delivered appropriately.

Evidence based care and treatment

- End of life care did not consistently follow national guidance. Some provision of end of life care followed national guidance: for example, the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults' (2011; updated 2013). There were examples of how the standards had been applied, for example, specialist palliative care provision and 24-hour chaplaincy support).
- However, some aspects of end of life care were not provided in line with national guidance for example, access to medicines and patients in the last few weeks of life continued to have monitoring of their vital signs. This may have been appropriate for the acutely ill patient but it was not necessary for patients at the end of their life. This may have caused misunderstanding and disruption for patients and their relatives.
- Local policies for managing certain palliative care emergencies were written in line with NICE guidance. However, care was not regularly audited to assess compliance.
- Some nursing staff we spoke with were not clear about the trust's definition of end of life care. A number of staff defined it as care in the last few days of life and not care in the last 12 months of life. This had implications for the support patients received.
- One patient had not been referred to the specialist palliative care team because they did not have symptoms. This demonstrated the lack of awareness of the support that the team could provide.
- In response to the national withdrawal of the Liverpool Care Pathway for end of life care, the trust had rolled out replacement guidance to all inpatient areas. Training sessions had been delivered in ward areas by the specialist palliative care team. However, some nursing staff were not aware that the new guidance was available and should be used.
- The specialist palliative care team told us they ensured that patients referred to them had a plan of care to meet their needs at weekends. However, ward care plans to support patients' end of life care needs did not reflect national guidance. They did not provide sufficient information for staff to provide safe and effective care. Care plans for patients' specific end of life care needs, such as management of pain or distress, were not completed.

Patient outcomes

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

support and ensuring anticipatory prescribing in acute areas. This audit was some time two years ago but is noted here as some areas, for example, access to medicines are still outstanding.
- The actions taken as a result of this audit were not regularly monitored to demonstrate improvement. Data from the most recent audit in 2013 was not yet available for comparison.
- The specialist palliative care service participated in an internal validation (peer review) of the service to evaluate their performance against the NHS England National Cancer Peer Review themes. The results indicated 92% compliance with the standards. The recommendation made was to increase the number of palliative care consultants.

Pain relief
- We observed there were delays in providing pain relief to patients. One patient waited over 35 minutes for pain relief and was left lying flat after care and was distressed and crying.
- The outpatient chemotherapy unit was not equipped to manage end of life symptoms such as pain because there was a limited number of medicines stored.

Competent staff
- Staff within the specialist palliative care team had clinical supervision to support them in their role and all staff had had an appraisal.
- Some wards had palliative 'link' nurses as act as a resource to improve knowledge and skills for ward staff but we did not have evidence of how this worked effectively in practice and how these staff were trained and supported.
- Ward staff were not appropriately trained in end of life care. Essential nursing care was not delivered appropriately, for example, appropriate assessment and monitoring, pressure ulcer management, pain relief, comfort and managing distress. .

Multidisciplinary team working
- A specialist palliative care multidisciplinary team (MDT) meeting with input from the chaplain took place weekly to discuss hospital inpatients' treatment plans and there were also weekly ward rounds.
- The specialist palliative care team worked closely with acute oncology clinicians to coordinate treatment for cancer patients.
- The specialist palliative care nurses worked closely with other nurse specialists (such as those experienced with cancer and heart failure) to avoid overlap and enable well-coordinated care.
- The specialist palliative care nurses attended some cancer site-specific MDT meetings (for example, lung and upper gastro-intestinal tract) although attendance was less than 65% for both. They told us attendance was difficult because of the number and timing of meetings.

Seven-day services
- Ward staff told us the specialist palliative care team were a responsive, supportive service.
- The specialist palliative care team were available for the Wycombe site 9am to 5pm, Monday to Friday. A specialist palliative care nurse was available weekends and out of hours advice was provided by the hospice.
- Medical cover at the weekend was provided by on-call doctors from other specialties who were not necessarily familiar with the patients.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and was then on call over the weekend.
- The pharmacy was open until 1pm Saturday and 12pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications. Staff told us this sometimes meant there were delays in discharging patients.
- The chaplaincy service provided 24-hour on-call support for patients and relatives.

Are end of life care services caring?

Requires Improvement

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

End of life care

Compassionate care

- Most patients and their relatives were satisfied with the care they had received on the wards.
- We observed an example of care that could have been improved. One patient had been left lying flat following assistance with personal care. They told us they wanted to sit up and they were thirsty. They were not able to reach their drink and staff had not helped them to drink. The same patient later on was distressed and crying intermittently. The patient did not have any tissues to dry their face and staff did not stop to comfort them.
- We observed staff treating patients with dignity and respect.
- There was limited patient feedback regarding the hospital specialist palliative care team and the process of collecting that information was under review.

Patient understanding and involvement

- Patients and relatives we spoke with said they felt involved in their care. One patient described their consultant as "excellent". They told us, "They (the consultant) discussed options openly. I feel we have been involved in decision making."
- Patient records demonstrated three of four patients had their medical treatment discussed with them. However, care plans did not show that patients were involved in care planning.
- Patients told us that they did not always have access to appropriate information.
- A trust DNA CPR audit of 88 forms in January 2014 showed that the main areas that were not always completed were discussions with the patient (68%) and relative (39%).

Emotional support

- The specialist palliative care team, chaplaincy, nurse specialists and psychologists provided emotional support to patients and relatives.
- When a patient died, staff in one ward area spent time checking the other patients were not distressed. A designated member of staff was allocated to support bereaved relatives after a death on the ward.
- Patients at the end of life did not always have access to side rooms to help promote their dignity and give their families a private space.
- Normal visiting times were waived for relatives of patients who were at the end of their life.
- Staff in all ward and outpatient areas told us they were short staffed at times, which had an impact on providing end of life care, particularly on the time available to give emotional support.
- The bereavement office was short of staff. Staff described the only service they were able to offer as "just dishing out death certificates".

Are end of life care services responsive?

Requires Improvement 

Patients referred to the specialist palliative care team were seen promptly according to their needs and multi-faith spiritual support was available for patients. However, not all patients were referred appropriately and the specialist palliative care nurses told us that shared care for patients at the end of their lives was more difficult in some areas, for example, in critical care. Patients who had outpatient chemotherapy who became unwell were transferred to Stoke Mandeville Hospital as treatment options were not able at Wycombe Hospital. The trust did not monitor patients' preference on where they wanted to die, to see if it this had improved.

Access to services

- Patients requiring specialist palliative support were referred through one single point of access to reduce the risk of missed referrals. However, not all patients that required specialist palliative care support were being identified for referral by ward staff.
- Patients referred to the specialist palliative care team were seen promptly according to need. The team's quarterly audit consistently showed 100% compliance with response to referral times (within 48 hours of referral).
- The team supported patients with a range of life-limiting illnesses including dementia.
- The palliative care consultant was working with consultants from other specialties, such as critical care, to determine ceilings (limits) of treatment for patients at the end of life so that shared care could be improved.
- The end of life register (details of patients at the end of life) was ready to roll out in April 2014. This would assist practitioners to identify patients early on admission and provide timely end of life care support.

End of life care

- The hospice had its own discharge coordinator. On discharge, a letter was sent to all other healthcare providers informing them of patients' care requirements.
- An electronic records system shared with a regional cancer centre provided staff with up-to-date information on patient chemotherapy treatment and progress.
- Patients in the chemotherapy outpatients who became unwell were transferred to Stoke Mandeville Hospital because there were no oncology beds at Wycombe Hospital. One patient told us they were declined further treatment for their condition because it was not available at Wycombe Hospital.

Meeting people's individual needs

- The chapel had resources to support multifaith groups to worship in keeping with their religion.
- The trust had a rapid response service for discharge to a preferred place of care. This was a team approach facilitated by the discharge coordinator. The only data that was available was historical from 2010 and at this time 60% of patients had expressed a preference to die elsewhere. Recent data however, about preferred place of death was not available.

Complaints

- Complaints about the specialist palliative care service were handled by the matron in line with trust policy. There were few complaints but actions were reviewed at the monthly risk meeting. The minutes from the risk meeting in February 2014 showed a negative comment on a patient feedback survey form and this was discussed at the staff meeting to promote learning from the event.
- Information was available in the hospital to inform patients and relatives on how to make a complaint.
- The hospice staff engaged with the recently bereaved by writing to them all within six weeks of the death of their relative. They used feedback to consistently improve their service.

Are end of life care services well-led?

Requires Improvement

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

Vision and strategy for this service

- There was a trust strategy for adult palliative and end of life care. However, hospital staff we spoke with were not aware of its contents of the strategy and how it had an impact on patient care.
- The Adult Palliative and End of Life Care Strategy (2014) was based on the End of Life Care Strategy (Department of Health [DH], 2008) and did not reflect the strategy and progress made to achieve the Quality Standard for End of Life Care for Adults (NICE, 2011; updated 2013) Action plans regarding the progress made for each work stream identified in the trust strategy were not available.

Governance, risk management and quality measurement

- The specialist palliative care team held regular team governance meetings. Complaints, incidents, audits and quality improvement projects for the specialist palliative care service were regularly monitored and actions implemented for their service.
- There was, however, no evidence of a trust-wide audit programme to assess compliance with the Quality Standard for End of life care for Adults' (NICE, 2011; updated 2013) and other national guidance.
- Patient survey data was presented to specialist palliative care staff to enable them to be aware of service improvement.
- Patient care on wards was not monitored to ensure patients were having essential end of life care needs met, such as pain relief.
- Patient health and well-being monitoring records was not reviewed regularly to ensure staff had accurate information with which to make informed decisions about care.

End of life care

Leadership of service

- The specialist palliative care lead clinician was represented on the medical division board.
- The matron of the specialist palliative care team was described by staff as a good leader.

Culture within the service

- Staff within the specialist palliative care service were passionate about the quality of end of life care provision. They said they were well supported by the matron and team members.
- The specialist palliative care nursing staff had clinical supervision to support them in their role.
- Hospital staff described good, supportive working relationships with the specialist palliative care team.
- There was a culture of sharing knowledge between specialist palliative care and other services through formal and informal teaching opportunities.

Innovation, learning and improvement

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

Outpatients

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

Information about the service

The trust had over 430,000 outpatient appointments in 2012/13. Clinics were held at both Stoke Mandeville and Wycombe Hospitals and in the trust's community hospitals, ensuring local access whenever possible. At Wycombe Hospital there was a dedicated area for breast clinics, which had the facilities to provide a one-stop clinic. There was an early pregnancy clinic and a dedicated gynaecology outpatient area where minor procedures were performed, such as colposcopy. The general outpatient area included a variety of specialisms including ophthalmology and orthopaedics. Allied healthcare professionals such as physiotherapists also held outpatient clinics at this hospital.

We visited the general outpatients, the gynaecology outpatients, the breast clinic and the physiotherapy department. We spoke with eight patients and 13 members of staff including nurses, a physiotherapist, medical staff, administrators and receptionists. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

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

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

Outpatients

Are outpatients services safe?

Good

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

Incidents, reporting and learning

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

Cleanliness infection control, and hygiene

- All of the outpatient areas we visited were found to be clean.
- Infection control practices were monitored through audits, and action planned and followed up when required.
- We saw staff observed the hospital's 'bare arms below the elbow' policy. Personal protective clothing in the form of gloves and aprons was available and staff were observed wearing this when delivering personal care.
- Infection prevention and control policies and procedures were available and accessible to staff on the hospital's intranet.

Environment and equipment

- Work had been undertaken in the general outpatient department to modernise the environment. Some additional work remained outstanding.
- The environment where the breast clinics were held had been purpose built. All the required facilities were in one location and on one level to support a one-stop clinic service.
- Equipment in the department was regularly serviced, tested if electrical, and appropriately cleaned.
- Resuscitation trolleys were located in or close to each outpatient department and were regularly checked.

Medicines management

- Medicines and prescription pads were securely stored and appropriately managed.
- There were systems to ensure medicines were in date.

Records

- Staff told us that, generally, patient records were available for clinics in a timely manner. The trust however, did not monitor the percentage of patients records that were available for patients attending clinics.

Consent, Mental Capacity Act and Deprivation of Liberty, Safeguarding

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

Staffing

- There were 16 staff vacancies across the trust in the booking team, called the 'access team'. Staff worked flexibly to ensure cover was provided.
- Sickness had placed a strain on the staff team in the general outpatient department. They had continued to staff the unit through cross-site flexible working and the sister and matron working clinical shifts.
- In the general outpatients, a document called 'staff mapping' was used to help staff ensure that there were enough staff to meet the needs of the clinics for that day.
- The specialist breast care team had a key worker caseload above that recommended by the Thames Valley Cancer Network. There were 3.7 whole time equivalent (WTE) staff and 5.5 were required to meet recommended caseloads. Staff told us that this had been acknowledged by the trust.

Outpatients

- Staff told us they felt there was enough staff, although patients told us that on occasions staff appeared to be rushed.

Mandatory training

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

Are outpatients services effective?

Not sufficient evidence to rate

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

Evidence-based care and treatment

- National guidance was used to inform practice and in the review of policies and procedures (for example, the multidisciplinary care pathway for patients undergoing treatment for breast cancer).

Patient outcomes

- The trust did monitor the new patients to follow-up patient ratio for outpatient clinics. These figures could be benchmarked nationally and indicate whether patients were being effectively managed and of outpatient appointments were being used efficiently to reduce repeated attendance. Dermatology, neurology, ENT and orthopaedic clinics were being run above the expected new to follow up patient ratio
- The trust had recently introduced a service where, if appropriate, patients could be followed-up over the phone at home. This improved the timeliness of follow-up and capacity in the outpatient areas.

Competent staff

- Staff told us that they had annual appraisals. Records showed that appraisals had taken place or were scheduled, and that staff were supported with their development needs.
- Two new members of staff told us they had been supported through a trust induction programme and a department induction. The induction involved competency-based assessments and staff were supported to do this work.

Multidisciplinary working

- Specialist nurses supported medical staff in clinics (for example, breast care specialist nurses).
- One-stop breast clinics were supported by radiographers and radiologists.
- Medical staff reported there was good access to radiology and pathology services.

Equipment and facilities

- Children were seen in the ophthalmology or orthodontic area and the general area. There were dedicated waiting areas for children.

Seven-day services

- Outpatient services were a five day service and extra clinics, in the evening or on a Saturday, could be added to accommodate requests.

Are outpatients services caring?

Good

Outpatient services caring was good because patients received compassionate care and were treated with dignity and respect.

Compassionate care

- Patient consultations took place in private rooms and chaperones were available if required.
- Patients and their families told us that they were treated with dignity and respect.
- We observed staff talking to patients respectfully while ensuring that they and their families were kept fully informed as to what was happening.

Patient involvement in care

- Patients told us they had enough information, at a level they could understand, to ensure they were fully informed and involved in making decisions about their care.

Outpatients

- There was written information available for patients. Some of these leaflets had been produced by the trust and other items had been provided by external agencies such as the Royal College of Ophthalmologists.

Emotional support

- A patient said that they were well treated and supported. One patient, for example, said I "could not have asked for better treatment. All the staff were kind and considerate, thoroughly professional and they made (him) feel safe".
- Patients receiving treatment for cancer were positive about the emotional support available to them

Are outpatients services responsive?

Requires improvement

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

Access to services

- The number of new and follow up outpatient attendances were lower than national average.
- The overall percentage of patients who did not attend (DNA) outpatient clinics at Wycombe Hospital in 2013 was 6.7%, which was lower than the national average of 8.5%. Medical and administrative staff told us it was trust policy that patients were referred back to their GP if they did not attend an appointment twice. This was a consultant or senior medical staff decision.
- Overall, the trust was meeting the national waiting time of two weeks for urgent cancer referrals and 18 weeks for routine appointments. The 18 week target was not met for oral surgery, ENT and orthopaedic clinics. Diagnostic waiting times were within expected limits.
- Patients, however, had reduced flexibility when choosing an appointment and only 19% of outpatient appointment bookings were done by the electronic 'Choose and Book' system. Senior staff told us that this was a historical problem with GPs choosing not to use the system and this had also extended the time from referral to booking an appointment. New patients waiting times for appointments had increased from 4.2 weeks in July 2013 to 8.8 weeks in January 2014.
- Patients and staff told us one of the biggest challenges for the outpatient department was clinics running late. Outpatient clinics were over-booked; there was not enough time to see patients, so clinics often over-ran. For some specialties, such as ophthalmology, patients told us they could wait for up to two hours. This was a planned arrangement because the letter sent to patients included a statement on this waiting time.
- The number of appointments cancelled by the hospital was below the national average. Clinics, however, were being cancelled at short notice, mainly because consultant medical staff were not giving the requisite six weeks' notice for annual leave as required by the trust's policy.
- The cancellation of clinics meant a patient could have an appointment cancelled by the hospital on more than one occasion. Some patients told us they had waited up to 6 months to get the appointment they needed.
- The trust had a new system to alert staff to any attempt to cancel clinics or appointments. This included the number of times a patient's appointment had been cancelled previously. The impact of this had not yet been established.
- There were one stop breast clinics and ophthalmology clinics. This enabled patients to attend for one appointment and have screening, tests and consultation at the same time.
- The access team was working with the operational team to try and reduce the number of cancelled clinics and thereby increase the capacity of the outpatient clinics.
- Letters were not being sent to the patient and their GP within one week of their outpatient clinic attendance. Some patients told us it could take over a month to receive a letter.

Meeting people's individual needs

- The outpatient facilities were in various locations across the hospital. There was open access to all areas and a lift to travel between floors if required.
- One patient who was using a wheelchair told us that they had no problems accessing the hospital and the department.

Outpatients

- Written information was only available in English. This included information on the back of leaflets that said they could be requested in other languages.
- There was a system in place for alerting staff to any special needs a patient had, including the need for an interpreter, at the time of an appointment being booked. Request for interpreters at short notice could be arranged by telephone.

Complaints

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- In all the areas we visited, information on how to make a complaint was displayed.
- Patients told us that, if necessary, they would not hesitate to raise a concern.

Are outpatients services well-led?

Requires improvement

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

Vision and strategy for this service

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

Governance, risk and quality

- There were monthly governance meetings within each specialty and staff were encouraged to attend. Complaints, incidents, audits and quality improvement projects were discussed.
- There was no governance meeting in the general outpatient department.
- Matron rounds were conducted to monitor the quality of the service. We viewed the results for the general outpatients for the past 12 weeks. On four occasions, the matron round had not taken place because the Matron was working clinically; on the other occasions, the results had been 98% compliance with standards or above.
- There was no risk register for the general outpatient department. There was one entry on the corporate risk register for outpatients and this related to an inadequate booking system for all outpatients. The new general manager and clinical lead had started to explore ways to address this identified risk.
- The risk register for the dermatology department contained one item that related to issues with the telephone system. There were no entries relating to staffing levels or a change in the service provided.
- The outpatient services did not have examples of consultation and did not obtain feedback from patients. A patient questionnaire was being implemented to obtain patients' feedback.
- The physiotherapy department was undertaking a patient survey to capture patients' opinions in a review of appointment times

Leadership of this service

- Staff were positive about local leadership and identified historical problems with senior leadership.
- There was clear leadership in the ophthalmology department but historically staff in the general outpatients, dermatology and the access team did not feel listened to.
- There were now new management arrangements and staff were positive about this change because they felt more supported with their daily challenges and more informed about the service. The change had yet to make an impact in some areas.
- Staff told us the changes to the management within the general outpatient department and the access team were beginning to have a positive impact: some changes that had not been effective were being stopped and some systems, such as having a central team for patients to contact, were being reinstated.
- Staff reported that they did not see the trust level leadership team. However, they did receive emails and regular newsletters.

Outpatients

Culture within this service

- Staff in all departments we visited were clear that the patient experience was important and they worked to ensure that this was positive.
- Services in the outpatient department had recently been restructured to improve capacity. Staff told us that they had been involved in the consultation but they had not been listened to during the change process. In the general outpatient department, staff told us they had struggled to maintain a good service following a recent service restructure.
- Staff told us the changes to the management within the general outpatients and the access team were beginning to have a positive impact. Some changes that had not been effective were being stopped and some systems such as the central contact team were being reinstated.
- Staff worked well together as a team to coordinate patient care.
- Staff told us that, in general, they felt supported in their role. Some staff felt unsupported and felt that they had not been listened to with regard to the pressures of running their department.

Innovation learning and improvement

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

Outstanding practice and areas for improvement

Outstanding practice

Areas of outstanding practice seen at this inspection:

- The stroke unit was highly regarded in the region. Outcomes for patients were good and 'door to needle time' for clot-busting medication and specialist assessment was significantly better than in other trusts.
- The cardiology service had better response times than the average for England for reperfusion therapy for patients who presented with ST segment elevation myocardial infarction (STEMI).
- The 'Evian Project', was a multi-professional group led by the consultant nurse in critical care. This has improved the hydration of patients in the trust.
- The trust had a 'Reflections at Birth' initiative for women. Women were asked to complete a 'birth reflections' questionnaire 1 month after the birth of their child and their answers were used to inform and improve the quality of the service.
- Where appropriate, children had pre-operative assessments done by phone to reduce the need for additional visits to the hospital.

Areas for improvement

Action the hospital MUST take to improve

- The appropriate medicines for end of life care must be available to avoid treatment delays.
- Care plans need to be developed for all patients.
- Patients at the end of life must have person-centred, holistic plans of care to enable staff to assess and treat patients effectively.
- 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms must be accurately completed and records of end of life discussions must be documented.
- Patients at the end of life must be treated according to the National Institute for Health and Care Excellence (NICE) 'End of life care for adults quality standards' (NICE, 2009).

Action the hospital SHOULD take to improve

- The trust should ensure that there are suitably qualified, skilled and experienced staff to meet the needs of patients on Wards 8 and 9.