

Oxford University Hospitals NHS Trust

John Radcliffe Hospital

Quality Report

Headley Way,
Headington,
Oxford OX3 9DU

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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



Accident and emergency

Requires improvement



Medical care

Good



Surgery

Requires improvement



Intensive/critical care

Good



Maternity and family planning

Good



Services for children & young people

Good



End of life care

Good



Outpatients

Good



Summary of findings

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Summary of findings

Overall summary

The John Radcliffe Hospital, Oxford is the largest hospital in the Oxford University Hospitals NHS Trust, with 832 beds, and serves a population of around 655,000 people. It provides acute medical and surgical services, trauma, and intensive care and offers specialist and general clinical services to the people of Oxfordshire. The John Radcliffe Hospital site includes the Children's Hospital, Oxford Eye Hospital, Oxford Heart Centre, Women's Centre, Neurosciences Centre, Medical Emergency Unit, Surgical Emergency Unit, and West Wing. It is Oxfordshire's main accident and emergency (A&E) site. The trust provides 90 specialist services and is the lead hospital in regional networks for trauma; vascular surgery; neonatal intensive care; primary coronary intervention and stroke. It also works in collaborative networks with Stoke Mandeville, for specialist burns services and with Southampton for paediatric specialist services in cardiac care, neurosurgery, and critical care retrieval.

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

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Nursing care
- Personal care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

Many of the services provided by the John Radcliffe hospital were delivered to a good standard, but overall the hospital required improvement. The hospital was failing to plan and deliver care to patients needing A&E, surgical and outpatient care and to meet their needs and ensure their welfare and safety. Patient records were not being completed in some areas of the hospital.

Shortages of staff within the maternity department, on surgical wards and in operating theatres meant that staff were not able to provide the best care at all times. There were not sufficient numbers of qualified, skilled, or

experienced staff to meet patients' needs at all times. The trust delivers a number of induction programmes for new staff. However, some staff we spoke with did not always feel appropriately inducted or supported.

Staffing

Although in many areas of the trust there were sufficient staff to meet people's needs this was not the case in the maternity department, surgical wards and operating theatres.

The trust told us that they had difficulties recruiting staff because of the high cost of living within Oxford and because of the difficulties and cost of parking on the hospital site. The trust told us there had been a recruitment drive and a recent cohort of registered nurses from Spain had recently started work. Recruitment was ongoing and further recruitment drives in Scotland and Wales were planned.

There were nursing and healthcare assistant staff shortages reported on surgical wards and in theatres. In December 2013 the vacancy rate for nursing staff was 16.4% in the neurosciences, orthopaedics, and trauma and specialist surgery division. We saw evidence of patients who were fit to be transferred from the intensive care unit onto a surgery ward, but because of staff shortages, there were no beds available in the surgical wards. This put pressure on staff to discharge patients to create capacity.

In theatres the vacancy rate for nursing and medical staff was 19% in January 2014. There was regular use of temporary (bank and agency) staff. Staff told us they worked long days or did overtime on the bank. However, many staff were fatigued and were volunteering less. Staff reported high levels of stress and low morale due to workload.

We were told that operating lists were cancelled about once a week due to staff shortage. Theatre staff told us that sometimes theatres had only two theatre staff supporting the surgeon and anaesthetist. The Association for Perioperative Practice (AfPP) recommends that there should be three staff (three nurses or two nurses and one

Summary of findings

operating department practitioners (ODPs). Staff in the main theatres told us that they regularly had only two staff. They said this occurred approximately once a week. They said this had the potential to be unsafe.

In neurosurgery junior doctors told us that sometimes the medical staffing levels felt unsafe. Out of hours there was one junior doctor (Senior House Officer) looking after 74 inpatients, while a registrar provided emergency cover. There was no phlebotomy service, which added further to their workload. We saw this in practice during our unannounced visit.

In maternity services the delivery suite had been without a manager for 18 months. Elements of the role were being covered by three band 7 midwives over three days a week. The trust had attempted to recruit to this role. Although the delivery suite provided women in labour with one to one care, staffing levels were not always sufficient to ensure women received the care and support they needed. Where recruitment to new posts occurred this was of newly qualified midwives who needed support from the experienced midwives within the department. This added further pressure to those staff. In addition, newly qualified midwives reported not receiving adequate preceptorship. The number of supervisors of midwives was below that recommended in national guidance from the Nursing and Midwifery Council. There was not sufficient consultant presence within the delivery suite to meet national standards, although midwifery staff reported that consultants were supportive.

Staffing levels had been recently increased on medical wards due to audit and assessment of patients' needs. We were told that this had improved morale on the wards.

Cleanliness and infection control

Within the hospital there were suitable infection control procedures and practices. Hand-washing facilities were clearly indicated in departments and hand sanitising gel was placed appropriately. Staff said they had enough personal protective equipment including gloves and aprons. In most areas nursing staff were wearing standard uniforms and all staff we saw were adhering to infection control protocols (such as being "bare below the elbow", without nail varnish, and wearing minimal jewellery).

Infection control procedures, for example, hand hygiene and cleaning audits, were undertaken monthly and the results displayed in specific areas of hospital. The hospital was clean. We saw staff washing their hands and wearing aprons and gloves. On the adult intensive care unit hand hygiene was assessed at only 87% completed and cleaning at only 83%. The matron advised that ongoing works takes place to review all areas audited. We observed good hand hygiene taking place in all areas. However, we noted that staff in intensive care did not adhere strictly to the uniform policy with hair touching collars and earrings which was not in line with the trust policy.

The level of hospital acquired infections was monitored within the hospital. Reported *Clostridium Difficile* and methicillin resistant *Staphylococcus Aureus* (MRSA) bacteraemia were within expected limits. Each reported case underwent an in-depth review, and were discussed at the infection control committee. We saw good practice in the children's A&E department where a child with chicken pox was cared for in a cubicle.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

We found the services at the hospital were safe however some improvements were required. Staffing in maternity, operating theatres and on surgical wards was not sufficient to meet people's needs. This was recognised by the trust. However, they were finding it difficult to recruit staff because of the cost of living in Oxford. Some patient records did not provide sufficient information to staff about how to support patients. This could mean that patients' care was not as effective as it could be.

Although there was reporting of incidents within the hospital, learning from incidents was variable. In some areas there was clear learning which had been shared and disseminated to staff. However, in others it was not clear that learning or awareness that incidents had occurred. This included learning from never events in operating theatres at the Churchill hospital. Despite two 'never events' occurring in May and August 2013 within theatres, three theatre nurses we spoke with had no knowledge of never events or serious incidents occurring in theatres. It was noted in the investigation report of the second never event in December 2013, that there had not been widespread dissemination of information about the first never event.

Monitoring of safety occurred throughout the hospital. This included monitoring of pressure ulcers, falls, venous thromboembolism and patients with catheter related urinary tract infections and action to minimise the occurrence of these.

There were suitable arrangements in place to safeguard children and vulnerable adults from abuse. Staff were aware of reporting processes. There were also processes in place to monitor and identify when a patient's condition deteriorates. This was tailored to the patient needs within the hospital divisions.

Requires improvement



Are services effective?

Outcomes for patients were good and the hospital performed well when compared with other similar organisations. Care and treatment was delivered in line with most national guidance and best practice. Adherence to guidance was monitored in divisional areas and reported through the governance system within the hospital. Staff worked in multidisciplinary teams with care focused around the patient. Although adherence mandatory training was good within the hospital, in some areas staff had not received specific training to support people with dementia or a learning disability.

Good



Are services caring?

In most areas of the hospital we observed staff providing care with compassion and treating patients with dignity and respect. Privacy was respected and curtains were pulled around patients' beds while care was

Good



Summary of findings

being provided. Most patients spoke positively about the kindness and care provided by staff. However, at busy times within the A&E department some patients were not made to feel safe or comfortable. We saw patients being placed in an atrium or corridor at the front of the A&E entrance before moving to a ward or going home. Although patients were unhappy about waiting in this area, they said the nursing staff had been fantastic.

There were privacy issues within the A&E department. People could be heard providing personal information at the reception desk and most of those we spoke with said they felt they had to provide information to the reception staff about why they were visiting the department.

Emotional support was provided to patients and their families in all areas of the hospital.

Are services responsive to people's needs?

Patients experienced difficulties in accessing services to meet their needs in a timely manner within A&E, surgery and outpatients because national targets for waiting times were not met. Patients were not provided with suitable information about the waiting times in A&E and outpatient departments.

Bed occupancy within the hospital was at a level which had an impact on the quality of care and caused A&E to miss waiting time targets. The A&E department did not have capacity to meet patient's needs at all times. The resuscitation room only had provision for four patients at any one time. However, staff said they had been required to use this space for more patients and to "share" the equipment.

There was a lack of awareness of vulnerable people within the A&E department. We observed a lack of support for a patient with dementia, who was restrained by security guards. Equally there was not suitable attention paid to the identification, assessment and planning of care needs for vulnerable patients within surgery and in some medical wards.

There was a lack of capacity within operating theatres in the hospital. The hospital was working towards achieving national targets in relation to waiting times for operations, cancelled operations and delayed discharges and scored similarly to expected when compared with other trusts. However, staff said that operations were regularly cancelled due to lack of theatre capacity, shortage of staff or inefficient planning. They said there were issues around the management of the waiting time target which led to theatre lists being overbooked. There were dedicated emergency theatre sessions and an emergency bookable theatre list process which was monitored through monthly reporting to the trust board. However, we were told that if emergency cases arose, planned surgery was cancelled.

Similarly in outpatients, "referral to treatment" targets were not being met, with patients waiting longer than agreed standards for outpatient appointments. There were not enough appointments to meet demand and clinic "templates" (which set out the number of appointments in each clinic)

Requires improvement



Summary of findings

did not reflect that demand following year on year increases. Clinics were overbooked causing long waiting times. The hospital was also not meeting standards within the Choose and Book service. The impact on these systems was that patients may experience late cancellations of appointments or multiple letters which proved confusing. Work to reprofile (redesign) clinic templates had been in progress since May 2013 and was on schedule.

Are services well-led?

Overall the services within the hospital were well led. There was a clear trust vision and a set of values, which were patient focused. Staff in some areas did not know what the vision and values were but portrayed similar values and passion and motivation to provide excellent patient care.

Leadership within divisions and departments was generally good with staff saying they felt supported by their immediate line managers. Among staff, there was variable feeling about the accessibility and visibility of executive level management within the hospital. Some staff did not know who their divisional lead was or who to contact with any board level questions. Others did not feel they were visible or accessible. We were approached prior, during and following our inspection by senior clinicians (doctors and nurses) working in surgery within the hospital who felt they were disempowered and did not have a voice.

There was a clear governance structure with reporting lines from departments through directorates and divisions, ultimately to the trust board.

Good



Summary of findings

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

Accident and emergency

The A&E department at the John Radcliffe Hospital provided safe care to patients. The local leadership in the department was strong. Staff told us, and we observed, strong and committed leadership and support from the matron, the consultants, and the senior nursing staff team. Staff told us they felt part of a team who cared for and supported one another.

Most patients were treated with consideration but care in the emergency department was not always effective to meet patients' human rights. Staff said they had not been trained to support and effectively care for people with dementia. On our visit we observed the restraint of an elderly person with dementia who had been waiting in the department for eight hours. Staff were not clear about whether there was a pathway for checking on a patient following restraint or documenting its use.

Most staff were well supported, trained and experienced. Some support from other departments was slow to be delivered due to the pressures on the whole hospital. This, and the pressure on available bed space, resulted in patients waiting more than they should for discharge onto wards for more specialist care.

Requires improvement



Medical care (including older people's care)

Staff provided a safe service to patients receiving medical care. Systems were in place to report, respond, and monitor safety issues across all levels of medical care. Safe staffing levels had recently been reviewed and several medical wards had increased their staffing to support the needs of frail, elderly patients. Recruitment of staff to medical wards had been successful and the hospital continued to recruit into vacancies.

Integrated care pathways for those patients who had suffered a stroke were in place and performance was monitored to improve the service being provided. Action plans were in place to ensure sufficient rehabilitation therapists were available to improved patient outcomes. Integrated care pathways for inpatients with diabetes were still being formalised. Diabetes affects 14.7% of all adult inpatients in the trust. The diabetes quality group was responsible for the monitoring and delivery of the "Think Glucose" project to improve the quality of care.

Some patients had multiple health, social and/or psychological needs, which required the input of several specialist teams. The multidisciplinary teams in the division were well integrated and had a strong collaborative approach to care. Care and treatment that was agreed and delivered was not always recorded. A written record was not always available to all parties to ensure continuity of care.

Staff were caring. Patients and relatives told us they were treated with dignity, compassion, and respect. Patients were involved in planning their treatment

Good



Summary of findings

and staff knew how to protect the rights of patients who lacked capacity to make decisions about their treatment. Efforts were made to ensure patients stayed in contact with friends and relatives. The hospital had taken account of relatives concerns and action plans were in place to improve communication between staff and relatives.

The hospital staff faced significant challenges when discharging patients to community services. It was working with stakeholders to deliver the discharge improvement programme. Additional resources had been made available to the medical wards to improve internal and external discharge arrangements. These included the recruitment of discharge planners responsible for co-ordinating patients' discharge.

The hospital's supported discharge service enabled patients who no longer needed the hospital environment to be cared for at home while waiting for local authorities to set up care packages. Ward staff had developed effective relationships with transport and care providers to facilitate discharge.

The service was well-led. Clearly defined governance arrangements were in place in the division which led to improvements in quality. Staff felt supported, valued, and proud to be part of the organisation. Opportunities were available for staff to develop their leadership skills. Patients and staff informed service delivery and their views were understood at trust board level.

Surgery

There was consensus among patients, carers, and staff that staff were dedicated and provided compassionate, empathic care. However, there was frustration expressed by many staff at all levels that they were not always able to provide safe and effective care. This was due to a lack of capacity, brought about by insufficient resources, work flow, and inefficient management.

Pressures within the wider health economy presented significant challenges in terms of demand versus capacity. There was evidence that the hospital was working with other partners to respond to this but pressures were compounded by significant and ongoing staff shortage and management of resources.

There was an overwhelming sense of discontent expressed by senior clinicians that the trust board was motivated by financial, rather than by clinical motives. This was at odds with the one of the stated values of the trust; "putting patients at the heart of everything we do". We saw evidence of strong clinical leadership at a local level but senior clinicians felt disempowered and believed they had no voice. We saw evidence of good team working at ward and departmental level but there was silo working across sites and divisions.

Requires improvement



Summary of findings

Intensive/critical care

Patients received safe and effective care. While staff recruitment and retention was recognised by the senior staff as an issue, the levels and skills of staff on a day-to-day basis were consistently managed. Clinical outcomes were monitored and demonstrated good outcomes for patients.

Patients and relatives told us the caring, consideration and compassion of staff was of a very high level. Considerable work had recently been undertaken to improve the responsiveness of the service to ensure patients were discharged when they were ready and delays were minimised. This also improved the responsiveness for pre-planned admissions following surgery to take place. The departments were well led and demonstrated a positive leadership and culture. A business case had been submitted to the trust board for future improvements for an increase in high dependency beds to meet the identified demand as the service sometimes runs at over 100% capacity.

Good



Maternity and family planning

Women received care and treatment from caring, compassionate, and skilled staff. We received positive comments from women and their families about the care and support they received.

The delivery suite had been without a manager for the 18 months prior to our inspection due difficulties in recruitment. Elements of this role were being covered by three band 7 midwives, but this did not provided consistency in the management of the delivery suite. Although the delivery suite provided women in labour with one-to-one care, staffing levels were not always sufficient to ensure women received the care and support they needed. Recruitment that had occurred was of newly qualified midwives who needed support from the experienced midwives within the department. This added further pressure to those staff. In addition newly qualified midwives reported not receiving adequate preceptorship. There were insufficient supervisors of midwives in post to meet guidance from the Nursing and Midwifery Council. There was insufficient consultant presence within the delivery suite to meet national standards, although midwifery staff reported that consultants were supportive.

Despite this the maternity service was effective. Care and treatment was mostly provided in line with national guidance, with the exception of a higher number of forceps deliveries and best practice with regards to supporting new mothers with breast feeding was not always followed.

The patients were safeguarded from the risk of abuse. Staff had received training in safeguarding and were aware of the process to report any concerns. These ensured patients were not put at risk as appropriate safeguards were in place.

Good



Summary of findings

There were systems in place for the safety of the patients and staff. There was equipment for the safe management of a range of patients which included some larger tables in the theatres and larger beds in the unit. Training and support for the staff was promoted to ensure safe working practices.

Women and their partners told us they were treated with kindness and received compassionate care from staff, although the hospital had lower than expected scores in the friends and family tests. They received sufficient information in order to make informed decisions about care.

The maternity unit was clean and staff followed the internal procedures for hand washing. Hand gels were available at different points and visitors were encouraged to use them. Staff had completed training in infection control to ensure women and babies were protected from the risk and spread of infection.

The service was responsive to women and their babies' needs. There was cohesive multidisciplinary working; staff commented this worked well with good support from clinicians at all levels which, in turn, had positive impacts on patients care.

There were clinical governance strategies and regular meetings which looked at development of the service. Staff felt supported within the ward and units; however, they told us they felt disconnected from the wider organisation.

Despite the absence of a manager in the delivery suite, the service was well led. Staff reported that they felt supported by their immediate line managers and there was suitable governance processes in place.

Services for children & young people

We visited all the wards in the children hospital including the paediatric intensive care unit (PICU), the paediatric high dependency unit (PHDU) and the neonatal intensive care unit (NICU). We spoke to 45 members of staff. This included health care assistants (HCAs), student nurses, staff nurses, midwives, senior nursing staff, doctors, registrars, consultant, and anaesthetists, operating department practitioners, nurse practitioners, administration staff, physiotherapists, and play specialists. We also spoke to 14 parents and relatives, three children and two young people.

Parents, children, and young people were positive about the care and support they received. They told us they were kept informed and involved in making decisions. Staffing levels were considered when managing the number of beds available to be used. The trust was aware of areas where additional staff were required and they were actively recruiting to these areas. Staff told us they felt supported and the children's hospital was a good place to work. There were systems in place to ensure children at risk of harm or considered to be of concerns were identified and protected if seen in the hospital. Staff were aware of how to report incidents and this information was monitored, reviewed and learning shared with the staff. There was an

Good



Summary of findings

established governance system in place that included monitoring complaints, incidents, outcomes from audits and the adherence to national guidelines. Young people's opinions and input was actively sought through the Young People's Executive.

End of life care

Patients received safe and effective end of life care based on evidence based guidelines, national standards, and protocols. Staff were caring and motivated. They demonstrated commitment to meeting patients' end of life needs and to supporting patients' relatives at this time.

A specialist palliative care team was based in the hospital and provided advice, training and support to hospital staff Monday to Friday. 24-hour, specialist advice was provided by staff at Michael Sobell House hospice, based at the Trust's Churchill Hospital. The hospital palliative care team were part of a wider specialist team who worked collaboratively across the Trust's four hospital sites and in the local community. A member of the team was the National Director for End of Life Care and chair of the Leadership Alliance for the Care of Dying People.

Feedback from patients receiving end of life care, and their relatives, was positive. They were well informed, had been asked what was important to them, and were involved in decision-making. They told us that staff were sensitive to their needs and treated them as a whole person.

Good



Outpatients

Patients received safe care because risks to patients were understood and were being managed. Hospital policies were based on national standards and evidence-based guidelines and adherence with these was monitored. An uncommissioned 10% rise in demand for outpatient appointments over the past year meant the Trust struggled to meet national standards for referral to treatment time (RTT) for patients. The trust agreed to fail RTT targets for January, February, and March 2014 with the NHS Trust Development Authority, who provide oversight and governance for all NHS trusts, to enable patients who had been waiting longest to be prioritised. This meant that patient safety was prioritised over meeting targets.

Patients were unable to book into appointments using the Choose and Book system on 50% of attempts as this could not be done online and there were not enough administrative staff available to answer calls and make bookings. This resulted in poor experiences for some patients when trying to book appointments, to make queries or change appointments. The way clinics were set up in booking systems did not make the best use of clinic facilities available, which meant that patients sometimes faced unnecessarily long waits to be seen in clinic. In order to address capacity issues, a trust-wide project was in progress to increase the number of appointments available and to ensure that clinic facilities were used more efficiently. This project was on schedule and was due to be rolled out to clinics in May/June 2014.

Good



Summary of findings

Clinics and waiting areas were clean and well-maintained but space was limited, which meant waiting areas were often overcrowded. Initiatives were in place to improve the experience for patients and keep them informed of waiting times but these were not used consistently in all clinics.

Despite administrative challenges, patients were highly complimentary about the clinical care they received. Staff were appropriately trained, motivated, and worked well together to ensure that outcomes for patients were good.

Summary of findings

What people who use the hospital say

The hospital trust was rated about the same as other trusts in the 2012 Adult Inpatient Survey. It performed above the national average in the inpatient and the A&E department Friends and Family test, although the rate of

return for the A&E test was poor. The trust was ranked better than other trusts in five out of 69 questions in the 2012/13 Cancer Patient Experience Survey, and only worse than other trusts in two of the questions.

Areas for improvement

Action the hospital **MUST** take to improve

- Staff in the A&E department must have effective training for caring and supporting people presenting in the department who have dementia or a learning disability.
- The trust must ensure that nurses coming from overseas to work in the A&E department, receive induction to ensure their competencies are evaluated and they are trained in any procedures they are expected to carry out but have not been previously undertaking.
- The flow of patients through the hospital must be improved to enable the A&E department to meet waiting times and enable patients to have timely access to specialist care and treatment.
- Patients must be treated with confidentiality, privacy and dignity at all times in A&E triage and when waiting to be discharged from the department
- The trust must ensure that adequate staffing levels are consistently maintained within the maternity department, on surgical wards and in operating theatres.
- The trust must take steps to improve theatre capacity management to ensure that patients do not wait too long for appropriate care and treatment.
- The trust must improve the quality of care plans to ensure that they reflect patients' individual needs. In particular the trust must ensure that the care needs of older people and those with dementia are promptly identified, and care planned to meet those needs.
- The trust must take steps to improve access to patients requiring outpatient appointments in order to that they do not wait too long for appropriate care and treatment.
- The trust must ensure that midwives receive appropriate supervision and newly qualified midwives are appropriately supported.

Action the hospital **SHOULD** take to improve

- The trust should evaluate the provision of resuscitation beds in A&E so they are meeting the needs of patients at all times.
- Staff in the A&E department should ensure that patients who have dementia are treated with care and the challenges of their condition considered within the context of receiving emergency care.
- Staff in the A&E department should be made aware of complaints from patients to enable them to understand the need for changes and improve their practice.
- The bed meetings should conclude with actions for staff and departments to take to proactively manage identified pressures.
- Some specialist departments should work more co-operatively with the A&E team.
- The response to the Friends and Family test should be improved in A&E and Maternity.
- The trust should ensure that patient records accurately reflect the care and treatment that had been planned and agreed for each patient in line with clinical guidelines and good practice standards, especially for those patients who cannot direct or inform staff of their needs.
- Identified shortcomings in the care and treatment pathway of inpatients with diabetes were being addressed but the trust needs to ensure that outcomes are delivered to these patients in line with good practice and clinical guidelines.
- The trust should continue making improvements to the internal and external discharge arrangements so that people who do not require a hospital environment are discharged to community services timely and effectively.

Summary of findings

- The trust should continue to ensure that positive outcomes are delivered for frail, elderly patients and those with dementia, especially when working with relatives/carers.
- The trust should continue with their plans to ensure sufficient therapeutic staff, like speech and language and physiotherapists are available to meet patients' needs in a timely manner.
- The recording of patients observations could be improved to ensure the plan of care is followed and any changes in patients' conditions are quickly identified and actions taken.
- The trust should ensure that lessons learnt from serious incidents are promptly disseminated and embedded in practice.
- The trust should ensure that issues relating to the safety and suitability of premises and equipment in the main theatres are promptly resolved.
- The trust should take further steps to engage with staff and investigate reasons for disempowerment and low morale within the surgical domain.
- The hospital should ensure a better environment within critical care.
- The Trust should reduce the number of delayed transfers from ICU due to the limited high dependency beds within the hospital.

Good practice

Our inspection team highlighted the following areas of good practice:

- There was strong leadership in the A&E department from the experienced, caring, and professional matron and sisters.
- The system the trust used to identify and manage staffing levels was effective and responsive to meet the needs of the hospital except on surgery wards, operating theatres and in maternity.
- There were good care pathways for patients attending the A&E department following a stroke.
- The A&E department recognised its pressures and had been proactive in looking for ways to be more efficient.
- The risks and challenges facing the A&E department were well understood by staff and there was an active governance framework, which included an excellent urgent care meeting every two weeks.
- The acute stroke service provided by the Medical Division was recognised for its treatment pathway and delivering good outcomes to patients.
- There was a strong sense of improving the outcomes for frail elderly patients and those with dementia on the medical wards. The psychological medicine service was supporting staff to understand the care and support needs of these patients. Wards on level 7 were being redesigned to make it more accessible for patients with dementia.
- Caring compassionate staff throughout the hospital.
- Staff were caring and hardworking in medical areas and many were experienced, compassionate, and champions for their patients. They spoke highly of their colleagues and management.
- Managers of medical areas had a strong understanding of the risks in the service and improvements required. Incident reporting and monitoring was well managed and the learning from incidents was evident. There was a strong commitment, supported by action plans, to improve the service.
- Staff worked well between teams. The value of an effective multidisciplinary approach, in improving outcomes for patients, was understood and actively encouraged.
- It was evident that significant efforts had been being made to improve the effective discharge of patients within medical areas. The hospital was working closely with commissioners, social services, and providers to improve the transfer of patients to community services.
- Two gerontologists worked in trauma wards to provide medical input and an integrated approach to trauma patients who were older people with co-existing illnesses.
- The nurse consultant in trauma care. This was the first such appointment in the UK and enabled the facilitation and co-ordination of shared care for complex trauma patients.

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- The acknowledgement of excellence of junior medical staff within the trauma directorate by leaders.
- The trauma service in general was praised by patients and staff. It was well led with well-supported staff and happy patients.
- There was good learning from incidents within critical care which translated into training and safer practice.
- The approach to caring for adolescents, within an environment designed to meet their needs and a clear team approach.
- Involvement of young people in developing artwork which was made into posters to promote the values that are important to the young people themselves.
- Patients within maternity expressed a high degree of satisfaction about the care they were receiving and the staff who supported them.
- Patients had the expertise of specialist midwives such as diabetes, breast feeding to ensure they received appropriate care and treatment.
- Patients received care in a compassionate way which included a designated bereavement suite and pastoral care in the maternity unit.
- There was good multidisciplinary team working for the benefits of mothers and their babies
- There were processes in place throughout the hospital which took into account patients' diversity. These included interpretation service and information provided in different formats according to the patients' needs.
- The trust internal peer review process, in which over 100 clinical areas had been reviewed in a three month period across the trust.

John Radcliffe Hospital

Detailed Findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Services for children & young people; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

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

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

The team of 51 (31 of which inspected this location) included CQC inspectors, managers and analysts, consultants and doctors specialising in emergency medicine, obstetrics and gynaecology, oncology, diabetes care, cardiology and paediatrics. It also included junior doctors, a matron, nurses specialising in care for the elderly, end of life care, children's care, theatre management, cancer, and haematology and two midwives together with patient and public representatives and Experts by Experience. Our team included senior NHS managers, including two medical directors, a deputy chief executive, and a clinical director in surgery and critical care.

Background to John Radcliffe Hospital

The John Radcliffe Hospital, Oxford, is the principal provider of acute services for Oxfordshire. It is a large-sized

teaching hospital providing acute, specialist and community healthcare to the people of Oxfordshire. The hospital has a 24-hour emergency department and maternity service. It serves a population of around 655,000 people. There are around 832 beds and the trust sees around 186,000 patients as inpatients each year, the majority at the John Radcliffe Hospital. The trust arranges around 878,000 outpatient appointments each year.

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

Why we carried out this inspection

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

Detailed Findings

How we carried out this inspection

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

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

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

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





- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital.

We carried out an announced visit on 25 and 26 February 2014. During our visit we held focus groups with a range of staff in the hospital, including nurses below the role of matron, matrons, allied health professionals, junior doctors, student nurses, consultants and administration staff. Staff were invited to attend drop-in sessions. We talked with patients and staff from all areas including the wards, theatres, outpatients departments and the A&E department. We observed how people were being cared for, and talked with carers and/or family members. We reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the location.

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

Accident and emergency

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

Information about the service

The Accident and Emergency (A&E) department was large and open 24-hours a day, seven days a week to provide an emergency service to the people of Oxford and the surrounding areas. The department treated people with both minor and major injuries and illnesses and was part of the Major Trauma Network in the South of England. About 120,000 patients (adults and children) were expected to attend the department each year. The department triaged patients as they were admitted to ensure they were quickly assessed for the need for any urgent intervention. The department used the adjacent Emergency Admission Unit (EAU) for patients who needed ongoing observation or assessment before they were admitted to hospital, transferred, or discharged. The department had a 'minors' unit (for treating minor injuries or illnesses) and 'majors' unit (for treating major injuries or illnesses) and a separate paediatric A&E unit which saw around 19,000 children each year.

We visited the adult A&E department on a Tuesday afternoon and Wednesday during the daytime and again on a Sunday evening as an unannounced visit. During these visits we talked with around 30 patients. We spoke with staff, including nurses, doctors, consultants, support staff, and ambulance personnel. We visited the paediatric A&E department, the Children's Clinical Decision Unit, and the minor injuries department on a Tuesday morning and again on a Sunday evening as an unannounced visit.

We received information from our listening events and from people who contacted us to tell us about their experiences. We collected comment cards from a designated box set up for our visit. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

The A&E department at the John Radcliffe Hospital provided safe care to patients. The local leadership in the department was strong. Staff told us and we observed there was strong and committed leadership and support from the matron, the consultants, and the senior nursing staff team. Staff told us they felt part of a team who cared for and supported one another.

Most patients were treated with consideration but care in the emergency department was not always effective to meet patients' human rights. Staff said they had not been trained to support and effectively care for people with dementia. On our visit we observed the restraint of an elderly person with dementia who had been waiting in the department for eight hours. Staff were not clear about whether there was a pathway for checking on a patient following restraint or documenting its use.

Most staff were well supported, trained and experienced. Some support from other departments was slow to be delivered due to the pressures on the whole hospital. This, and the pressure on available bed space, resulted in patients waiting more than they should for discharge onto wards for more specialist care.

Care was delivered with consideration and respect by staff. However, the triage of patients and the use of the atrium as a holding area prior to transfer or discharge did not provide privacy and dignity. Private conversations were overheard in the triage area and at reception.

The department was not meeting patients' needs at all times. The four-bedded resuscitation area was, we were

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told by staff and the local ambulance personnel, sometimes full, and this compromised the delivery of care. Most patients we met said they waited for long periods to see the doctor. Staff had, nevertheless, worked hard to reduce pressure and come up with innovative solutions to improve the service. The pressure on the A&E department was predominantly due to a lack of available beds in the department. Data the trust provided about the number of breaches showed the department breached the target for 95% of patients to be seen within four hours in seven months of 2013.

Are accident and emergency services safe?

Good 

Safety and performance

People were protected from abuse and staff were trained to deal with suspicions of abuse. Training records showed almost all staff, including housekeeping staff, were trained in safeguarding vulnerable adults, and this was a topic for all new staff at induction. Staff were able to tell us how they would recognise signs of potential abuse and how they would report this to safeguarding teams. Staff knew they had a duty to raise an alert if they were concerned about the safety of any patient or someone accompanying them.

Mandatory training for staff was on track. The mandatory training required for staff in various roles was appropriate in both subject and frequency required. For example, fire safety was refreshed following induction every year, as was resuscitation. Health and safety and safeguarding, for example, were updated every three years. We saw records for mandatory training for nursing staff and these were clear and comprehensive. The hospital used an electronic staff record system where staff were alerted to any training due for updating. Senior nursing staff were able to oversee training and ensure staff were completing their required courses.

Learning and improvement

The department had a good approach to incident reporting. We saw from our data the hospital was an active reporter of incidents when compared with other similar organisations. We reviewed the incidents relating to A&E from November 2013 to 24 February 2014. The reporting was varied and covered a range of incidents. It appeared open and honest. The majority of incidents resulted in no harm to the patient. The earlier incidents in the report had been analysed, actions taken were recorded, and the incident was closed. Some more serious incidents or those needing the input of other teams or departments were on hold waiting final approval.

Systems, processes and practices

There were adequate infection control processes and practices. There were clearly indicated hand-washing

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facilities in the department including hand sanitising gel placed appropriately. Staff said they had enough personal protective equipment including gloves and aprons. Nursing staff were wearing standard uniforms and all staff we saw were adhering to infection control protocols (such as being 'bare below the elbow', without nail varnish, and wearing minimal jewellery). The department was clean, well-organised to help effective cleaning, and fixtures and fittings were maintained. We saw good practice in the children's A&E department where a child with chicken pox was cared for in a cubicle.

Where needed, areas of the department were locked and secure. Medicines, equipment, and consumables were in locked rooms or cabinets. Wheelchairs and trolleys were able to move safely through the department as needed.

The layout of the department and adjacent facilities was good despite the capacity issues within the resuscitation area. The x-ray department was located next to the department and the computerised tomography (CT) scanner, which took 3-D images of the inside of the body, was also closely located. This equipment was used for patients, for example, who had experienced a major trauma. We met with the staff of this department who were preparing for a trauma patient to arrive. They had advised another patient who was waiting for an elective (pre-arranged) scan they had to wait slightly longer than anticipated due to an emergency.

Monitoring safety and responding to risk

Staff were supported to raise concerns without fear of reprisals. Staff said they were encouraged to speak up about any concerns. We read the hospital Trust's whistle-blowing policy dated August 2013. This policy outlined the duty of staff to report concerns, how they would be dealt with, and the support available to staff who raised concerns. The policy went on to describe the process for managers who were dealing with complaints.

The staffing levels had improved and the department was usually safely staffed. We spoke with staff from a wide range of disciplines about staffing levels. We saw some good levels of recruitment to previously high vacancies in band five nurses. There was now a relatively low vacancy rate for nursing staff in the emergency department at 5%. Sickness rates at the hospital were, overall, below the national average. Staff were joining regularly and inductions were underway. A senior member of the nursing team said the lack of ability to recruit was,

however, sometimes "soul destroying." A recent recruitment drive for healthcare assistants shortlisted 20 people and only three turned up for interview. All the staff we talked with said the staffing establishment levels (how many staff the department needed) were generally good. But, as one member of staff said: "we don't shut the doors here and sometimes patients keep coming and then you have not got enough staff or enough space either." The nurse went on to say they felt they saw patients in the priority needed most of the time; they evaluated patients quickly; patients got good care; and most patients understood changing priorities and that "staff are doing their best".

The response to changes in the needs of patients in terms of staffing levels was good. A member of the senior staff told us the hospital had a "really very good" system of responding and managing staffing levels when the hospital was under bed-space pressure. They said the model used was "excellent" at identifying risks in wards and units when the acuity or needs of patients changed. This enabled wards to send staff to help busier departments when they could, and extra staff to be drafted in when needed. The model worked in real-time and enabled staff to quickly respond to emerging risks and triggers.

Bed-pressure meetings brought staff together to look at each area's capacity, but the actions were not proactive. We attended a hospital bed meeting where the capacity across the hospital was reviewed. A&E staff were present at this meeting. Bed-pressure reports were collated at meetings held twice daily. In the bed meeting we attended, where there was a shortage of beds reported, there were no clear action plans, or response to what the hospital was going to do about this capacity trigger, despite there being clear actions to take in the escalation policy.

The children's emergency department was staffed by a paediatric trained nurse for the majority of the day. This enabled the service to deliver effective care and treatment for children. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identified there should be always be registered children's nurses in emergency departments, or trusts should be working towards this, and that staff should, as a minimum, be trained in paediatric life support.

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The children's emergency department was generally staffed by two trained nurses; one trained in the care of sick children and one general trained nurse with an interest in caring for sick children. One nurse started at 7:15am with a second nurse starting at 10am. We were told there was always a nurse trained in the care of sick children on duty between 10am and 6pm. We were told that at times the department could be very busy with around 20 children. At these times the department may be allocated an additional nurse. We were told when the department was busy this impacted on the nurses' ability to give good high-quality care. The nursing staff were supported by play specialist four days a week which was said to help. At the time of our inspection there were no nurses trained in the care of sick children on duty overnight. The department was being staffed by general trained nurses. Staff said there were usually two nurses on at night with one being a children's nurse. We were told recruitment of nurses trained to care for sick children was ongoing with an aim to recruit six more nurses. The department was staffed by a paediatric specialist doctor with support from the consultant of the week. The trust told us they had undertaken a risk assessment of the situation and that they felt there was suitable cover and processes in place to gain support from the adult A&E staff and the paediatric service in the children's hospital.

In response to demand, and using winter pressure money, additional specialist registrars had been appointed to cover the children's emergency department. Further cover was provided by the consultant of the week.

Anticipation and planning

The department had plans to respond to major incidents or emergencies. There were plans held by senior staff to be implemented in relation to different emergency scenarios. The hospital worked within a network of other local A&E departments and had back-up plans for transferring or redirecting patients to other units if the department or hospital needed to close or reduce arrivals in an unplanned emergency.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

The department used national recognised clinical guidance to deliver care and treatment to meet people's needs and give good outcomes. For example, the department followed an approved pathway for hip fractures. People who had suffered a stroke were cared for quickly and placed on the agreed stroke care pathway. The pathway had been developed in line with the latest National Institute for Health and Clinical Excellence (NICE) guidelines for stroke care. We reviewed the stroke pathway and saw records showing quick identification and how the patient was managed. The stroke pathway for patients not suitable for thrombolysis showed the duties and decisions in the first and second hours after admittance to the department. This included ensuring staff did not admit the patient to the Emergency Assessment Unit, but straight to the Acute Stroke Unit. The department used a standard abbreviated mental test to determine a patient's memory function or cognitive ability, often at triage. The document used included other indicators which should trigger a referral to a doctor. This included the blood pressure range, oxygen saturation, and if there were multiple injuries.

Performance, monitoring and improvement of outcomes

The department recognised the pressures it often faced and was proactive in looking for ways to be more efficient. There was a nurse triage service where patients were seen as soon as possible after arrival. Notes were made for the doctors about why the patient had come to the A&E department along with some preliminary observations and simple pain relief prescribed. There was also a recently introduced Rapid Nurse Assessment (RNA) system, where more seriously unwell patients who presented at the hospital (referred to as "majors") were quickly handed over to an emergency nurse practitioner by the ambulance team. We spoke with the Hospital Ambulance Liaison Officer (HALO) who provided a service to help facilitate the more rapid turnaround of ambulance crews and co-operative working. The HALO

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said their working in the department that winter had meant the handover times had been improved. The RNA system had also been instrumental in reducing the handover time of patients from ambulance crews. The rapid assessment target for the nurse team was to carry out observations and any chest x-rays if needed within 15 minutes of arrival. We saw that this was happening most of the time.

Staff, equipment and facilities

Although there were training programmes in place for staff in supporting people with cognitive impairment, staff said they had not had specific training in caring and supporting people with dementia or a learning disability. There was no automatic screening for patients (unless they were over 75 years of age and to be admitted for more than 72 hours) to determine if they had dementia or a learning disability and may have additional needs. There was no evidence staff were treating people with cognitive impairments without empathy and consideration, but they had not been specifically trained to recognise the signs and risks. We met three staff who had come from a mental health facility with an unwell patient. They said experience of the department had made them feel patients with a mental health illness were delayed due to the potential challenge they presented. They felt staff had a good understanding of mental capacity and assessments, but supported the concern around staff not having had training in caring for people with cognitive impairment.

Support to nurses coming from overseas needed improvement. One nurse who had joined the department from overseas two months ago said they were not sure about what they could and could not do. They said they had been trained in their own country in a different skill set from the nurses in the UK and were expected to perform tasks which they had not been trained to do. For example, the administration of intravenous drugs, which they had not been trained to do and their competency checked. The nurse had a general corporate induction, but had not had an induction into the department. Some training had been provided, but they said they did not feel adequately supported. Other staff in the department supported this and said the department lacked a practice development nurse. We were told by a senior nurse this was needed “desperately” to support the significant

recruitment of new staff, many from overseas. The trust told us they had a two week development programme for new overseas nursing staff in the emergency department which involved clinical skills competency assessments.

The facilities in the children’s emergency department enabled effective treatment delivery of care for children. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) states that there should be one or more child-friendly clinical cubicle or trolley space per 5,000 annual child attendances. Children should be provided with waiting and treatment areas that are audio/visually separated from the potential stress caused by adult patients. There was a dedicated children’s emergency department within the main emergency department. This had seven bays/cubicles, a nurse assessment room, and a waiting/play area. One cubicle in the children’s emergency department was set up and equipped as a resuscitation area for very sick children. This was in addition to an area in the main department’s resuscitation area, which was also equipped for children, though we were told that this space was usually used for adults.

Multidisciplinary working and support

Multidisciplinary working within the department was good. However, support from other departments for patients within the A&E was not always timely. Most staff said they felt supported by other departments and almost always by their colleagues in the A&E team. We were told by a senior nurse the trauma team were “pretty good”. On the day of our inspection we saw that the plastic surgery department were not attending the department in a timely way to help with patient care. There was an incident (as described below) with a patient we met in the department and an incident recorded another delay of at least three hours in December 2013. The action plan said a new pathway had been agreed with the plastic surgery team.

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Are accident and emergency services caring?

Requires improvement 

Compassion, dignity and empathy

Observations of staff showed that people were treated with compassion and kindness in the department. Patients confirmed this. Although the response to the “Friends and Family” test was low, the majority of patients said they would be “extremely likely” or “likely” to recommend the department to friends and family.

Some patients’ privacy was not respected or their confidentiality maintained. Most patients at the department were assessed in private, but this did not happen for patients being seen by the nurse triage team. The triage room was adjacent to the waiting room in the A&E department and was a corner room with windows and doors on both sides. On both our visits the window blinds in the room were open and people outside the room in the waiting area and corridor were able to see inside (although less so from the waiting room). The door was kept open on the side facing the corridor and we could observe the nurse examination and heard the discussion with the patient. When we briefly approached the room close to the door where the conversation could be clearly overheard, no one questioned our presence in listening to the conversation. We spoke with the patient who was being examined afterwards and they said: “I’m really glad you witnessed that and have told me who you are, but you could have been anyone. This seems normal around here, and has no one thought about it?” Staff agreed they had not considered the privacy and confidentiality for the patient, and accepted there could be some serious breaches of dignity with some examinations or conversations. They said they thought the blinds would be closed if necessary and the door closed, but we saw the blinds were in a poor state of repair and they would not have entirely obscured the room from outside. The “majors” area of the department had recently introduced a system where patients who were able sat in chairs outside of bays when they were not being treated. The department recognised this had some issues for privacy and dignity but it had meant more patients were able to be treated and significantly improved ambulance crew handover times.

Involvement in care and decision making

Patients were involved in the care and taking decisions when they were able to be. One patient we met said they had been able to explain all their symptoms and answer and ask questions. They said nothing had been done or given to them without their consent. They said they did not feel they were asked to do anything or follow a course of action without knowing why this was the best option for them. They said they were given alternatives and the risks and benefits of all options. Staff knew the importance of gaining valid informed consent for patients, and involving them in all decisions.

Trust and communication

People booking into reception in the waiting area could be overheard. There were chairs in the area immediately in front of the glass screens of the reception area. The glass screens did not require people to talk loudly as there were gaps in the glass, but people could be clearly overheard, particularly by people waiting in the chairs located close to the reception desk. Four patients we spoke with in the waiting room told us they did not mind giving their name and address or date of birth, as they expected to do this. But none of them liked telling the reception staff what the reason for their attendance was, as they said this could be overheard by others. One said they thought they could have withheld this reason if they chose to, but all the patients said they felt they had to provide this information. One patient said: “I can see why this is important, but the area does not exactly give you any privacy. Perhaps as this is an A&E they think that doesn’t matter to us, but they could have thought this out a lot better.” The reception staff said if a patient did not want to disclose why they had come to the department, they would write “personal problem” in the notes and the triage nurse would discuss it with the patient directly. The reception staff said they felt safe in the department. They said the security team were excellent and there were always security staff on duty, including weekends and nights.

Patients were given some information about waiting times, but this was often difficult to manage. The system used by the department was a manually updated display of the approximate waiting time. When we arrived on the department on Wednesday, the waiting room was almost empty. The waiting time was showing as three and a half hours. One of the support staff said it needed to be changed and it was amended to one hour. A patient we

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met said they were about to leave the department before the waiting time was changed, as they were concerned about leaving their unwell relative. When the time was changed they decided to wait and were seen shortly afterwards. One member of staff said the displayed time was “a mixed blessing.” They said most patients wanted this information and it was one of the questions most asked of reception staff. However, the situation could and would change very frequently in a department not able to anticipate activity. The member of staff said patients would then want to know why they were waiting longer than they were “promised” and this was often a source of patients being abusive with staff. One patient we met said they had been to the department before and the waiting time was “usually about right, and if anything, sometimes not as bad as they say.” They said they had been required to wait much longer on one occasion, but staff had explained about the arrival of patients from a major road traffic accident. They said patients were understanding and accepted the change of priorities.

Some patients said they knew what was going on, but others felt communication could be improved. One patient said they had been offered and given some pain relief when they had been seen by the triage nurse and were now waiting in the “minors” area for some test results. A relative of the patient said: “Although I am sure this has been said before, it’s really hard for patients when we see doctors and nurses sitting at work stations for long periods of time and no one seeming to do anything for [the patient].” They went on to say: “I know about the four-hour target and I feel things only start happening when that’s beginning to approach.” Another patient in the “majors” area said: “The care here is very good. We were seen quickly and have been given a cup of tea.” The patient and their relative said they knew what was happening, what they were waiting for (admission to a ward) and staff had been “nothing but helpful and kind”.

Emotional support

There was emotional support to patients and their relatives. There were two relatives’ rooms in the department. These had facilities for making drinks and comfortable chairs. There were times in the busy A&E department when relatives had to be excluded from areas for the safety of themselves and the patient. Staff said they kept relatives informed, and relatives were permitted to be with the patient if they were at the end of their life. There was a bay reserved in the “minors”

treatment area for deceased patients who were waiting to be taken to the mortuary. This provided privacy for the patient and their relatives who were able to sit with them if they wanted to. The department was arranging for the room to be refurbished in order to make the environment less like a cubicle.

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

Requires improvement 

Meeting people’s needs

The department did not have the capacity to meet patients’ needs at all times. The A&E department at the John Radcliffe Hospital was part of the major trauma network in the South of England. This meant patients who had suffered major injuries would attend a major A&E centre as long as it was no more than a 45-minute journey by ambulance. Provision in the resuscitation room at the hospital was only for four patients at any one time (with one bed able to adapt to care for a child). Staff said they had been required to use the space for more patients when this was needed and “share” the equipment. The staff we met said they did not know whether there was any evidence captured to be able to say how often this happened although we did see one incident report from November 2013 about the capacity in the resuscitation room being increased to six beds: two of these being in a shared space. There was no action plan recorded for this incident. We reviewed the incidents for the last three months, and staff said they were sure this had happened more often in the last three months. An ambulance crew we spoke with said they were sure the resuscitation room was full “fairly often” and “it’s not really enough provision for a hospital this size”. When we were in the department on Wednesday morning there were two patients in the resuscitation room. At around midday two more patients were brought in by ambulance, one suffering a cardiac arrest. The beds were then fully occupied, including the bed set up for children, which was being used for an adult. Staff said if a fifth patient was to arrive at the same moment, they would work out which bay they could use to double-up care and treatment. Screens would be used, but they had limited

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effect on privacy and dignity as staff needed to share equipment and safely move around the room and the patient. During this time all the nursing staff were engaged with patients in the resuscitation room. This left one healthcare assistant in the “majors” area with the medical staff and no other nursing cover at that time.

The department had an action card for staff to use for changing circumstances in capacity of the department, but the data around this was not being captured effectively to describe pressures. The action card was clear about what situations were considered of higher risk. The triggers for taking action were clear and straightforward. For example, the department would move to amber risk when there had been more than 17 patients arriving per hour for two hours; or there were only two cubicles or four chairs available in the “majors” area. Amber status would involve staff in taking actions such as considering extra resources and identifying patients whose needs could be reprioritised. The triggers for red risk were, for example, more than 17 patients arriving per hour for three hours; no available cubicles in “majors”; and ambulances queuing. Actions would include, for example, “minors” patients being kept informed about delays and made aware of alternative options; ensuring admitting teams of any patient waiting speciality review having been contacted and escalating any unsatisfactory responses to the operations manager for support. Staff were aware of the action cards, but there was no evidence they were used alongside data to communicate the pressures in the department. A senior member of staff said pressure scores were often not based on empirical data linked to the escalation triggers. The department was using some of the data to communicate to stakeholders the pressures they were under. Staff said the waiting time targets were calculated from actual data, but the pressure scores were less actual data and more driven by how staff were feeling. The department had an action card for staff to use for changing circumstances in capacity of the department, but the data around this was not being captured effectively to describe pressures.

Patients said they were experiencing long waits to see a doctor. We spoke with seven patients in the waiting room on the Wednesday morning and they all said they had seen the triage nurse within 20 to 40 minutes. They all said they had no complaints about the treatment or care they had received, but they all said there was a long wait

to see the doctor. A number of these patients had attended the department before and most said there was always a long wait to see a doctor. One patient had attended “several times” in the last year and said: “I think I might be lucky, but I don’t find the waiting times too bad.”

We saw many patients being well looked after when they were in the main area of the department. However, at busy times, some patients’ privacy and dignity was not maintained. On two of our visits to the department, patients (on trolleys) were being placed in an atrium or corridor at the front of the A&E entrance before moving to a ward or going home. This was reported as an incident by staff. Staff were aware this was not ideal and were making efforts to minimise the issues the situation was causing. For example, Heaters had been installed and screens were erected when patients were waiting in this area. The doors to the area at the ambulance-bay end were closed and a portable screen was in place at the other end of the corridor. “No entry” signs were in place. Above this area were windows looking directly down into the atrium, where patients could be seen. An incident report from January 2014 reported a patient being kept in the atrium and being cold due to the draft, despite being given “many blankets”. Staff were not able to provide a temperature management blanket as there were no electrical sockets in this area.

One patient, who was in the atrium area waiting for admission to a ward (they had been there for three hours and in the department for eight hours) said the situation was “dreadful”. “I feel a bit abandoned here.” They said there had been three other patients there in the time they had been waiting. They were helped to go to the toilet, and had been offered a drink. They said the nursing care “had been fantastic” but they were “really unhappy” about how long they had been in the department and being in an area otherwise designed as a corridor. They said they were worried about being infectious to other patients or people as they had diarrhoea and vomiting. They were initially told they needed to be in a bit more isolation from other patients, but there was nowhere available.

There had been some changes made to improve pressure within the department. The trust had been supported by

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the presence of GPs commissioned to work in the department in the evenings and during the day on weekends. Other recent actions to improve patient flow through the hospital included:

Emergency admissions advisors recruited to take calls from GPs and provide alternatives to admission to A&E. One of the three posts was still unfilled but the service was up and running.

A new care pathway developed to divert frail elderly patients to identified wards.

Some additional bed space created in the Emergency Admissions Unit with further expansion planned for April 2014.

The rapid nurse assessment model introduced to use the skills of experienced and qualified nursing staff to rapidly assess patients as they arrived at the department.

An increase in consultant presence in the department implemented in September 2013.

Establishment of an Urgent Care Group that met fortnightly to review performance.

More porters were recruited to improve the service for patient transfers.

Staff told us the portering service was not effective. Although reports said there had been more portering staff recruited, staff said the service was “terrible” and “not working”. A number of staff said this was, for them, one of the “things that could be solved so easily” but “caused some of the biggest frustrations.” One member of staff said they often got “cross” with porters, but they were not really to blame for the situation.

Not all children had direct access at all times to the Children’s emergency department but this did not impact negatively upon their care and treatment. For example, children who had sustained a minor injury could be seen in the emergency department’s general minors’ area due to pressure upon capacity in the children’s emergency department. On these occasions children would be assessed by a general trained nurse but paediatric trained nurses were available, if required, from the children’s emergency department. Treatment was delivered in bays with curtains so children were screened from care of adult patients.

Vulnerable patients and capacity

There was a lack of awareness of the needs of vulnerable people in the department. During our visit on Sunday evening we were concerned about three children who were unaccompanied in the waiting area. The staff on reception were not aware of the children and not able to see them clearly. We observed four members of nursing staff walk past the children and not notice them or that they were unaccompanied. When we asked the reception staff about these children they did not offer a solution to providing any supervision. One of the parents returned to the children 15 minutes after we first became aware of them.

We observed a lack of support for a patient with dementia. We were aware of an elderly patient with dementia who when we first saw them at just after 9am had been in the department for over eight hours. The patient was seen walking around in a confused state, but being supported with kindness by a healthcare assistant. At around 9:30am we heard the patient shouting from a curtained bay. We found the patient being restrained on a bed by his arms and legs by three security guards with the bed rails in place. The patient was restrained in this way for nine minutes. We were told the patient was to be seen by the plastic surgery team and they had requested the patient to be in a bed, despite there being an injury to their finger. The patient had been given a sedative and was being restrained in order to await the arrival of the plastic surgery team. We asked the nursing staff if there was a care plan put in place for patients who had been subject to restraint. They told us there was nothing they were aware of. They did not plan to assess the patient or document the restraint or report it as an incident. The nurse said they did not know if this was documented by the security team. The nurse then asked the patient if “anywhere hurt”. The person said their finger and arms hurt. The nurse made a partial check of the patient’s arms and legs. We saw the nurse then wrote some notes in the patient record in retrospect at 11am. The notes did not record the patient had been restrained. They recorded: “patient’s wrists and legs are slightly red but no apparent bruising visible.” The patient was then moved to a bed in the Emergency Assessment Unit (EAU) at 11:40am and the plastic surgery department had not yet reviewed the patient. The handover to the EAU was done well and staff were advised verbally about the use of restraint with the patient. We had further discussions with the security

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team and they said they had been trained in control and restraint. All three agreed they spent the majority of their time looking after and restraining confused patients or patients with dementia. The trust told us the restraint had been reported as an incident and investigated by the director of development and the estate and independently by the trust security manager between 26 February and 4 March 2014. The recommendation from this investigation was that there was no further action necessary.

The department used assessments to protect vulnerable patients. These included an environmental risk assessment for patients known to be or identified as at risk from self-harm, chronic, or acute confusion. Patients were given mental capacity assessments to determine if they were able to make decisions for themselves. Staff were able to describe scenarios in which these would be used. Staff were knowledgeable about acting in the patient's best interests if the patient was not able to give valid consent. Staff would only proceed with a procedure to save a person's life, or with the input of other health and social care professionals and the people who spoke for the patient.

Access to services

The pressure on bed space meant waiting times in A&E were often not meeting targets, and this impacted upon patient care. The A&E department had regularly breached the Government's four-hour waiting target for 95% of patients to be seen and discharged from the department (to home or a ward, for example). We requested evidence from the hospital trust on the data related to the John Radcliffe Hospital, as opposed to the whole trust. Evidence received from the trust for the year 2013 showed 7% of children being treated in the paediatric A&E unit breached the four-hour waiting time target. Of the patients coming to the adult department 10% breached the four-hour waiting time target. There were particular problems in March, April, and December 2013 when the breaches in children's A&E were 10%, 13%, and 16% respectively. In March and April 2013, there were 24% and 20% of all adult patients breaching the four-hour waiting time target. In January 2014 this figure was 15%.

The breakdown of the reasons for breaches have not been made available by the trust. We know from talking with staff and stakeholders, the reasons for the target not

being met most of the time were predominantly a result of bed space being available in the hospital. The patients we met on our visits who had breached the target were either waiting for a bed, or for a specialist review.

Leaving hospital

Patients were given appropriate information when they left the hospital. Patients were given a copy of the letter being sent to their GP. They were encouraged to make sure the GP had directly received the information, particularly if tests needed to be arranged. The lead consultant we met said the organisation had learned how the electronic transfer of records to a patient's GP had proved to be unreliable on occasion. Staff now gave patients a copy of the letter and a clear explanation of what they should expect to happen next. We met two patients who were going home following treatment. They said they had been offered advice and information to take home with them.

Learning from experiences, concerns and complaints

The department learned from some complaints and concerns, but handled more practical concerns better than other sorts. For example, we were told by the matron the majority of complaints recently had been in connection with patient property being lost; patients not getting anything to drink while waiting; and poor communication. In response to the issue with property, for example, the department had introduced a check on a patient's property to the nurse checklist. A machine was provided to enable staff to more easily give patients a hot drink. Other staff said they had heard the issues around communication were a common topic for complaints and they understood this. However, they did not feel there was anything done about this to really resolve the problem. One member of the senior nursing staff said: "I don't think we really see it from the patient's point and a lot of anxiety could be managed by just much more communication."

Accident and emergency

Are accident and emergency services well-led?

Good



Vision, strategy and risks

The Emergency Department (ED) was aware of its wider risks. Risks were discussed at the monthly clinical governance meetings. The existing risks were reviewed and new risks were agreed to be added to the risk register. There was a comprehensive and clear action plan for the ED. This identified areas of concern and actions to be taken to address these concerns. The staff responsible for the actions were identified and a completion date was set. Progress against actions was reported. The action plan looked at the way the wider organisation affected the ED and problems were shared and addressed across departments to look for ways to tackle problems together.

Governance arrangements

The ED had strong governance arrangements. The A&E department at the John Radcliffe Hospital was part of the directorate covering emergency medicine for the whole trust. Staff therefore met with the team that included colleagues from the Horton General Hospital emergency department. Clinical governance meetings were held each month. We reviewed the minutes from the January 2014 meeting. The meeting was attended by seven consultants in emergency medicine, one of the two matrons, a consultant nurse, and seven other senior staff. The meeting minutes showed good open and honest discussions of, for example, complex cases where not everything worked as it should have done. The minutes included pictures of x-rays and scans for unusual presentations. The minutes described the lessons learned and actions taken. There was also a review of mortality and any lessons or actions arising. This included a screening of all deaths in ED and any points to be noted. Any actions were assigned to a member of the team and these were updated at the next meeting.

Leadership and culture

Most staff said they felt well supported. A nurse we spoke with who had recently joined the department said they team worked well together and supported each other. The matron for the department said they felt the trust

board were aware of the pressures the department was under and were “very supportive”. Doctors we spoke with said they felt supported by the leadership. Staff told us and we observed there was strong and committed leadership and support from the senior staff, including the matron and sisters, the consultants, and the nursing staff team. Staff told us they felt part of a team who cared for and supported one another.

Patient experiences, staff involvement and engagement

Staff were not always engaged with patient experiences. A member of staff told us they did not feel staff were told about patient complaints. We were told it was not an agenda item on team meetings. They said this might have been in an effort to protect staff from complaints, but it meant sometimes there would be changes made without any apparent reason or basis for the change. Other staff we talked with said the department was often so busy, this might be one of the areas they did not have time to be told about. Staff agreed that they wanted to be better informed.

The response rate to the Friends and Family test was poor. In December 2013, for example, the response rate was 2.6% and in November 2013 was only 1.5% (England average 10.4%). Despite the low response rate, of the 75 responses in December 2013, 67 people said they would be “extremely likely” or “likely” to recommend the department to their friends and family. Only two people said they would be “unlikely” or “extremely unlikely” to recommend the department. The only response rate above the England average was in June 2013 with 12.1%. Of the 351 responses, 305 people said they would be “extremely likely” or “likely” to recommend the department to their friends and family. Only 13 people said they would be “unlikely” or “extremely unlikely” to recommend the department.






Learning, improvement, innovation and sustainability

Staff were aware of the issues in their department and responded appropriately. Each fortnight staff from A&E attended an urgent care meeting. We attended one of these meetings and found staff knowledgeable and innovative in their approach to risks and safety. The developments and innovations in the last six months were discussed along with their relative merits and

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effectiveness. Things that were working well were suggested for use in other departments. Lessons from those things not working as well were discussed as well as suggestions for how to improve them.

Medical care (including older people's care)

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

Information about the service

The John Radcliffe Hospital has one acute medical assessment unit and a further 13 medical wards specialising in providing frailty assessment and elderly care, stroke care, gastroenterology/hepatology and cardiac care. The cardiac care department includes a cardiac catheter laboratory and a cardiology and cardiothoracic ward. The hospital also provides a medical day ward to provide care for patients with medical needs, but who do not require admission.

During our inspection, we visited the medical wards, including the stroke and elderly care wards. We also visited the medical admissions unit (MAU) and medical day ward. We talked with 25 patients, 11 relatives, and 56 staff, including nurses, doctors, consultants, therapists, and support staff. We observed care and treatment and looked at care records. We received information from our listening events, focus groups, interviews, and comment cards. We used this information to inform and direct the focus of our inspection. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Staff provided a safe service to patients receiving medical care. Systems were in place to report, respond, and monitor safety issues across all levels of medical care. Safe staffing levels had recently been reviewed and several medical wards had increased their staffing to support the needs of frail, elderly patients. Recruitment of staff to medical wards had been successful and the hospital continued to recruit into vacancies.

Integrated care pathways for those patients who had suffered a stroke were in place and performance was monitored to improve the service being provided. Action plans were in place to ensure sufficient rehabilitation therapists were available to improved patient outcomes. Integrated care pathways for inpatients with diabetes were still being formalised. In the Trust diabetes affects 14.7% of adult inpatients. The diabetes quality group was responsible for the monitoring and delivery of the "Think Glucose" project to improve the quality of care.

Some patients had multiple health, social and/or psychological needs which required the input of several specialist teams. The multidisciplinary teams in the division were well integrated and had a strong collaborative approach to care. Care and treatment that was agreed and delivered was not always recorded. A written record was not always available to all parties to ensure continuity of care.

Staff were caring. Patients and relatives told us they were treated with dignity, compassion, and respect. Patients were involved in planning their treatment and staff knew how to protect the rights of patients who

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lacked capacity to make decisions about their treatment. Efforts were made to ensure patients stayed in contact with friends and relatives. The hospital had taken account of relatives concerns and action plans were in place to improve communication between staff and relatives.

The hospital staff faced significant challenges when discharging patients to community services. They were working with stakeholders to deliver the discharge improvement programme. Additional resources had been made available to the medical wards to improve internal and external discharge arrangements. These included the recruitment of discharge planners responsible for co-ordinating patients' discharge.

The hospital's supported discharge service enabled patients who no longer needed the hospital environment to be cared for at home while waiting for local authorities to set up care packages. Ward staff had developed effective relationships with transport and care providers to facilitate discharge.

The service was well-led. Clearly defined governance arrangements were in place in the division which led to improvements in quality. Staff felt supported, valued, and proud to be part of the organisation. Opportunities were available for staff to develop their leadership skills. Patients and staff informed service delivery and their views were understood at trust board level.

Are medical care services safe?

Good 

Safety and performance

Systems were in place to report, respond, and monitor safety issues across all levels within medical care.

The hospital used the "safety thermometers" to measure their risk performance. The NHS Safety Thermometer Report 2012-2013 showed a fluctuating performance for new pressure ulcers, falls, venous thromboembolism (VTE) and patients with catheter related urinary tract infections. We spoke with the acting divisional head of nursing and governance to understand this performance. They told us that the division had improved the assessment of patients for VTE which resulted in a sudden decline in patients developing thrombosis. Pressure ulcers and falls remained a concern for the division and action plans were in place to improve the management of people at risk of falls and pressure ulcers. Work had also been done to ensure that the same fall was not recorded multiple times as an incident which had happened in the past.

The hospital had reviewed the management of urinary tract infections in people with long-term catheters. This was recorded as a safety incident when infections were treated with antibiotics. The infection control team was incorporating the management of incontinence and sepsis with this review as their analysis showed that these risks were linked and needed to be managed together.

The division produced a monthly safety report which described their safety performance. Data from incident reporting, mortality, hospital acquired infections, complaints and audits were used to judge how safe the wards were. Wards displayed their individual performance and staff were able to describe the areas that required improvement.

Staff received training in health and safety and incident reporting. Staff told us that they were familiar with the electronic incident reporting system. They had been supported by the ward sister to complete their first few incident reports. The matron told us that staff were confident in reporting safety incidents and this was

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encouraged across the wards. Staff told us that they had received a phone call from the occupational health team following incidents they reported to ensure that they had not been injured or if they required support.

Learning and improvement

Safety incidents were investigated by the hospital so that lessons could be learned to prevent similar incidents from reoccurring. Following on from an investigation of a fall with harm, the learning from the incident was shared with staff on the medical wards. This was discussed at the Adams and Bedford wards team meeting on 6 January 2014. As a result nurses were told to ask medical teams to review confused patients. Plans were also in place to review patients' blood pressure medication as this could at times cause dizziness that could increase the risk of falling. The wards were tasked with working closer with the Fall Safe group and the link nurse for falls. A monthly fall learning session was being provided to staff.

Following the investigation of grade 3 and 4 pressure ulcers, a new pressure ulcer management policy was introduced. To prevent grade 1 and 2 pressure ulcers from deteriorating these were now also recorded and monitored closely. A new tissue viability nurse had been appointed to support the medical wards to manage pressure ulcers effectively. Training in the new policy was provided to staff.

Investigations of incidents were monitored at the monthly quality meeting to ensure that they were completed in a timely manner and learning shared.

Systems, processes and practices

Regular audits were undertaken to ensure that staff adhered to procedures to manage risks. To monitor adherence to infection control procedures, hand hygiene and cleaning audits were undertaken monthly and the results displayed on the ward. Improvements had been made to the cleaning audit and on some wards this was completed three times a month. The wards were clean. We saw staff washing their hands and wearing aprons and gloves. The division monitored the level of hospital acquired infections. Reported Clostridium Difficile and MRSA bacteremia were within expected limits. Each reported case underwent an in-depth review, and were discussed at the infection control committee.

Systems were in place to safely manage medicines. The hospitals adherence to these procedures had been assessed and the wards were awaiting the action plan. The

Adams and Bedford wards had discussed medication concerns during their January 2014 team meeting and staff were instructed to ensure that they adhered to the medicine policy.

Staff vacancy rate, turnover and sickness absence were monitored monthly. Many vacancies had recently been filled. Wards staff told us that they were able to maintain safe staffing levels on wards now that that more staff had been recruited.

Staff told us that they were familiar with the ward policies. They were available on the hospital's internet and staff were able to locate them quickly.

Monitoring safety and responding to risk

To safely meet the needs of frail and elderly patients on the medical wards the staff establishments (levels and skill mix) were reviewed in December 2013. The safer nursing care tool (SNCT) and the Royal College of Nursing's recommended ratio of nurses to care support workers (65%:35%) were used to determine the appropriate levels of staff and percentage of skill mix. Following this review staffing levels on the stroke ward, Ward 5A and wards on level 7 were increased.

Green, amber, and red staffing levels were set for each ward. Risk management actions had been agreed when staffing levels fell to amber or red. We saw that amber and red staffing levels were discussed at the twice-daily bed management meeting and action taken to address the risks. All the wards we visited were on green status. During our night visit an additional staff member had been provided over and above the green level to support the risk of one patient falling on Adams ward.

There was sufficient medical staffing on medical wards and areas. This was both during the day and out of hours (at night and at weekends). There had been a review of out-of-hours medical cover and within the medical division which resulted in a change in the medical cover provision, to ensure that only doctors working within this division provided cover. Staff said they had no difficulties in contacting a doctor for support at any time. They said the new cover system was good because it ensured consistency and that the doctors knew the patients as well as the staff on the wards. The out-of-hours medical cover was also in place for stroke patients with a primary thrombolysis emergency response clinician available on all shifts.

Medical care (including older people's care)

The support patients required to manage the risks to their health and welfare was assessed on admission and reviewed weekly or more often if required. Staff could describe how they would support patients at risk of falls and pressure ulcers in line with the hospital's policy. Systems were in place to respond to deteriorating patients. Staff understood what action they needed to take and told us that the response from the resuscitation team, intensive care nurse, on-call doctors, and thrombolysis consultants were good.

Staff understood their duty under the local safeguarding arrangements. Ward sisters provided examples of Deprivation of Liberty Safeguard applications that had been made in line with the principles of the Mental Capacity Act 2005.

Anticipation and planning

In planning the safer staffing levels for the medical wards the division took into account the past trend of 4% staff sickness and high turnover of band 5 nurses. By anticipating this risk they ensured that a staffing level was agreed that could maintain safety even when these risks occurred.

The medical wards had contingency plans in place to respond to winter pressures as well as emergencies and major incident. The actions staff should take were displayed on the ward. The winter escalation plan had recently been reviewed on ward 7C and updated with current telephone numbers and additional actions. Responses included working with local providers to ensure alternative care arrangements were available to patients if required. Staff were familiar with the emergency plans.

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

Good 

Using evidence-based guidance

The hospital's clinical audit, clinical governance, and outcome review committees ensured that the division was kept informed of relevant legislation, guidelines, and quality standards. Each NICE (National Institute for Health and Care Excellence) guideline relevant to the medical

division had a designated lead. They were responsible for assessing the division's compliance with the relevant guideline and agreeing actions where improvements were required.

Integrated care pathways for those patients who had suffered a stroke were in place and performance was monitored to improve the service being provided. The stroke operational group met monthly and ensured that compliance with the stroke guidelines and performance was maintained. In December 2013 the group noted that Barthel, daily living, and mobility assessments had to be reintroduced and a neuroradiology protocol was required to ensure compliance with the guidance. The group also reviewed three local guidelines which had been approved by the clinical governance committee. These related to a new venous thromboembolism (VTE) assessment, the use of intravenous thrombolysis and acute stroke care.

Integrated care pathways for inpatients with diabetes were still being formalised. In the Trust diabetes affects 14.7% of adult inpatients (compared to a national prevalence of 15.3%). The hospital told us that the care for inpatients with diabetes required improvement following incidents of poor diabetes care. Diabetes risk summits were held in October and December 2013 to address these concerns. A diabetes quality group was being set up at the time of our inspection. This would be responsible for the monitoring and delivery of the "Think Glucose" project to improve the quality of care. The first meeting was planned for March 2014. It was to be chaired by the deputy medical director. Actions included a business case to bring diabetes inpatient specialist nurses numbers in line with the national average as well as early and comprehensive standardised assessments.

Systems were in place to ensure that patients nutritional and hydration needs were met. Patients were weighed and screened for malnutrition using the malnutrition universal screening tool (MUST) on admission and weekly. Stroke patients' swallowing was assessed to ensure that nutrition and hydration was provided through an appropriate route. Where concerns were identified a referral to a dietician and/or speech and language therapist was made.

Performance, monitoring and improvement of outcomes

The division took part in national clinical audits. The Sentinel Stroke National Audit Programme (SSNAP) aims to



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improve the quality of stroke care by auditing stroke services against evidence based standards. The SSNAP performance figures were published in 2012 and the trust performed in the upper quartile.

The multidisciplinary stroke team had a good understanding of the areas that required improvement and the action plan implemented by the stroke operational group. Performance against 10 patient outcomes was monitored on a monthly basis. The reasons why targets were not met were analysed and actions put in place. Over the three months prior to our inspection, performance figures showed that a shortage in occupational, speech and language and physiotherapy staff was a concern. This had been discussed at the December 2013 steering group meeting and action was being taken to address the impact of this on patient outcomes.

The hospital commissioned an independent audit in December 2013 to review their safeguarding arrangements for adults and children against good practice and compliance against their policy. The review report noted "an assessment of significant assurance has been given. However, we have identified the scope to improve the capacity of the safeguarding team". A business case had been put forward to recruit additional safeguarding specialists.

The medical division took part in research to improve clinical treatment. Oxford University's Stroke Prevention Research unit had been awarded the Queen's Anniversary Prize for Higher Education. Research carried out by the unit showed the risk of major stroke in the first few hours and days after a mini-stroke was much higher than previously thought. The unit developed simple scores to identify high-risk individuals and showed that urgent use of existing treatments reduced the risk of major stroke by 80%. This highly effective strategy, including emergency clinics for mini-stroke has been adopted nationally and internationally.

Staff, equipment and facilities

Nursing staff were required to complete a programme of mandatory training which included health and safety, infection prevention and control, medicine management, safeguarding and consent. Specialist training was provided to ensure staff could respond appropriately to patients' needs. This included swallowing screening for stroke nurses. Foreign trained nurses confirmed that they attended a competency bridging course and attending

English classes. Care support workers attended the care support worker academy and were supported by practice development nurses to meet their band 2 competencies. Student nurses praised the support provided by practice development nurses and the mentoring by nurses on the ward. Ward sister development programmes were available to facilitate leadership development.

An electronic training system had been introduced to enable staff to complete training online. Staff told us that this system was easy to manage and led to an increase in staff compliance with training requirements. Deficiencies in staff training in dementia were recognised in the National Audit of Dementia (2012). The hospital has addressed this concern by developing a dementia training programme for doctors, medical student, nurses, and other ward staff. Most of the staff we spoke with confirmed that they had completed this training.

Refresher training was offered to ensure staff's practice remained up to date. Ward staff were required to attend pressure ulcer refreshers in February and March 2014 to receive training in the new pressure ulcer policy and reporting. Ward team meetings were held monthly and this was an opportunity to reinforce policy and practice. The Adams and Bedford team meeting in January 2014 reminded staff to be mindful of confidentiality and to check medication expiration dates.

Multidisciplinary working and support

Staff told us that they had good working relationship with local care and transport providers. The discharge lounge sister had met with a transport provider to review the effective use of transport. Delays had occurred due to incorrect vehicle requests. Following the meeting, training was provided to staff to enable them to identify and request the appropriate transport. A matron told us they had met with local nursing homes to discuss ways to improve communication and effective discharge for specific patients.

Some patients had multiple health, social and/or psychological needs which required the input of several specialist teams. Staff told us multidisciplinary teams in the division were well integrated and had a strong collaborative approach to care. We attended the daily handover meeting on the stroke unit. This was attended by

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all members of the multidisciplinary team. Treatment, care, and discharge were collectively reviewed for all patients. A relative's request about a patient's treatment was discussed and a plan agreed to address their concerns.

Handovers between shifts were detailed and staff told us they understood the outcomes that were agreed for patients. Care and treatment that was agreed and delivered were not always recorded so that a written record was available to all parties to ensure continuity of care. Where dieticians required nutritional intake to be monitored we found that fluid and food charts had not always been completed. Physiotherapy plans were on room walls but records did not indicate whether staff had mobilized patients as requested or how long they had been immobile. Staff could describe the care provided to patients. However, mouth care, washing and dressing, mobility, and continence care plans were not seen for people who could not direct staff. Best interest decisions taken by staff for people who lacked capacity and hourly patient welfare checks had not always been recorded. We were told a working party had been set up to review ward paperwork to ensure that it provided sufficient information. The "Knowing Me, Knowing You" document was also been trialled to support people with dementia.

Are medical care services caring?

Good 

Compassion, dignity and empathy

We observed and patients told us they were treated with dignity, respect, and compassion by all staff. Patients' privacy was respected and we observed curtains pulled when care was given. Call bells were to hand and responded to in a timely manner. Patients were clean and dressed in their own clothes. We observed an evening meal on Adams ward for the elderly and saw that patients were supported to eat at their own pace. Some patients could not remember what they had chosen to eat. A nurse comforted a patient, showing them the meal they ordered and reassured them that they could have something else if they did not like their meal.

Staff showed concern for patients' wellbeing when they returned home from hospital. Patients on the discharge lounge were provided with a meal to take home if they lived on their own. Landlords were contacted to ensure

that heating was switch on before patients went home. The ward sister told us "we have put in a request for some track suits so that people do not have to go home in thin pyjamas which is not dignified or warm".

We received many positive comments which included: "the ward is a vibrant friendly place", "they [the staff] are very kind and tender with my father" and "everyone – the housekeeper, cleaners and nurses – all greet me by name and always ask me how I am".

Relatives of elderly patients told us at our listening event and through "Your Experience" feedback that they were not always satisfied with the care their elderly relatives received. They felt that patients waited too long to be helped and at times patients were not treated with patience. Though we did not identify these concerns during our visits to the wards we asked staff about this. Staff at all levels, including the acting divisional head of nursing and governance, were aware that concerns had been raised. They told us action plans were in place to address relatives' concerns as disrespectful behaviour would not be tolerated. Additional staffing had been provided on some medical wards to ensure that staff could respond to people's needs in a timely manner.

Involvement in care and decision making

Information leaflets about a variety of medical conditions and treatment options were available to patients and relatives to support them to plan their treatment. Leaflets were available in several languages, large print, Braille, or audio. Patients could also request a language or British sign language interpreter. Picture symbol cards were available on the stroke ward to support patients to communicate. Records showed that these had been used by the physiotherapist to gain the views of patients. Oxfordshire advocacy service could support people who lacked capacity to make decisions about their treatment.

Information about dementia treatment and support was available to relatives, carers, and patients. We attended the monthly dementia café. This is a drop-in information session held in partnership with local dementia services including Age UK and the Alzheimer's Society. A consultant lead memory clinic was held every Thursday. The dementia care advisor also met with patients and relatives at the clinic to provide information about support and treatment.

Patients and relatives told us they felt involved in the decisions about treatment. They felt discharge

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arrangements were not always clear. Relatives had contact with doctors, at the patients' request, to discuss treatment. When speaking with doctors, they were provided with clear information and understood what the treatment options were. One person told us "it has not always been easy to get hold of the right person that could provide an update". Records showed that relatives and care home staff had been actively involved in patients' discharge planning in Wards 7C and 7D, where the new discharge planners had been recruited. The matron told us that discharge planners would be working across all medical wards once they were fully recruited.

Relatives were given the opportunity to be involved in patients' care. They were welcome to support patients with their meals and we observed this taking place. A relative had expressed the desire to support with a patient's percutaneous endoscopic gastrostomy (PEG) feeding on discharge. Records showed that the dietician had involved the relative in planning the suitable feeding times. Training had been provided to ensure that the relative could undertake this task competently.

Trust and communication

Patients and their relatives described staff as kind and caring. They had high praise for the caring attitude of housekeeping and cleaning staff. Patients told us they felt safe. We saw that the wards were busy. Patients told us staff were supportive and took the time to talk to them, within the available time constraints. The acting divisional head of nursing and governance told us that they were spending time with patients and relatives in the evenings to gain a better understanding of people's needs for effective communication. They would be establishing regular matron or consultant meeting opportunities for relatives to support the development of open, trusting relationships.

Patient confidentiality was respected. We observed personal conversations taking place in private and did not overhear staff discussing patients. Records showed that patients had been asked to give their permission to have their names on the ward boards. We saw that patients' names were removed swiftly as they left the discharge lounge.

Emotional support

Patients were supported to stay in contact with family and friends. Visiting times were flexible and relatives of elderly patients were welcome to spend long periods with patients. We observed staff supporting patients to make

and received phone calls. Adams and Bedford ward had a communal area where patients could sit to prevent isolation as all the rooms were single rooms. Two patients told us that they felt lonely at times being on their own in a room. We observed staff going into patients' rooms to make conversation as well as engaging with patients who sought their company.

The registrar on the elderly wards told us "we support patients and their families when a diagnosis of dementia is shared as this can be an emotional time for everyone". We spoke with psychiatrists in this team and they confirmed that they met with relatives and patients that might require emotional support to manage their diagnoses or condition. They also provided ward staff with guidance in how to meet the emotional needs of patients with dementia.

Chaplains were available to meet with, to be with, to listen or to talk through with patients and their families their concerns and anxieties. NHS chaplains from the Christian, Islamic, and Hindu faith traditions provided a 24-hour on-call service to all patients, relatives and staff, whether or not they have a religious faith.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good 

Meeting people's needs

The hospital worked with stakeholders to plan and design services to meet the needs of the local community. These partners included Oxford County Council, Oxford Clinical Commissioning Group (OCCG), and Oxford Health. The OCCG noted that the group "regularly holds meetings to discuss quality and clinical governance arrangements with the OUH. This meeting is attended by senior clinicians and managers. This has started an open dialogue between the two organisations to discuss the challenges faced within the Oxfordshire health economy."

There were co-ordinated pathways of care agreed with partners to meet patients' needs. The hospital was part of the Oxfordshire dementia development and implementation board which was tasked with implementing the National Dementia Strategy locally. The board met quarterly and the hospital's dementia steering

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group led on improving care of patients with dementia. Staff told us that the medical division had some actions from the steering group. These included staff undergoing training in dementia care and we saw that each ward had a named dementia champion. The hospital had been rewarded grant funding to create a dementia friendly environment for patients on level 7 and work was to start in March 2014. The hospital agreed to routinely undertake memory screening of patients over the age of 75 to ensure the identification and referral of patients with dementia.

The hospital planned services to meet the needs of patients with mental health needs. An integrated psychological medicine service had been established to better meet the needs of this patient group. Consultants from this service worked as part of medical teams to deliver mental health input to patients on medical wards. As well as assessing and treating patients, the service provided education and support to enhance the psychological care given to all patients by doctors and nurses. Psychiatrists working in the team told us that this service enabled the hospital to respond to patients with mental health needs swiftly while they are treated in acute medical wards. One psychiatrist told us “patients don’t have to wait till they leave hospital to access mental health services and we can refer people more effectively to community services on discharge”.

Vulnerable patients and capacity

Patients who lacked the mental capacity to make a decision were supported in line with the principles of the Mental Capacity Act 2005 (MCA). Staff received training in the safeguarding of vulnerable adults and showed a good understanding of the MCA and Deprivation of Liberty Safeguards (DOLS). Ward sisters were responsible for completing DOLS applications and told us that the psychological medicine service provided guidance for complex applications. One patient had a representative that held the legal power to make decisions about their health and welfare. Staff understood the implications of this and explained what action they had taken to ensure the legal representative was involved in any decisions about this patient’s care. A specialist learning disability nurse was available to support people with learning disabilities.

Patients who might have fluctuating capacity were supported to manage their confusion. Patients were reassured and helped to cope in the hospital environment

so that they could better engage in decision making. Efforts were made to ensure that the impact of a patient’s confusion on other patients was minimized. Staff told us that the single-room accommodation on Adams and Bedford wards were prioritised for dementia patients that needed a quiet environment. Patients who required regular reassurance were also given rooms close to the nurses’ station so that they could be responded to swiftly. A nurse told us following input from the psychological medicine service one patient was moved further from the nurse’s station as it was felt that this person required less noise and activity around them to manage their confusion. They told us that this had worked well for this patient.

Records showed that a patient with communication difficulties had been supported to express their consent about having a PEG procedure. Nurses were not always clear who would support people with communication difficulties to make significant decisions, especially if a speech and language therapist was not available.

Confused patients at risk of falling had been assessed as needing low beds and bed rails to keep them safe when in bed. Nurses could describe the action taken to assess these patients’ capacity and how best interest decisions were made where patients had lacked capacity. Records showed that this process for gaining consent for the use of restrictive equipment had not been recorded. We were told that a new bedrail consent form was being developed to ensure consent was appropriately sought.

Access to services

Several initiatives were being piloted to ensure elderly patients and those with long term conditions could access care closer to home. These included stroke rehabilitation services in Abingdon and Witney. A joint team was also established with Oxford Health NHS and Oxfordshire County Council to speed up and rapidly implement decisions on patient discharge. Four Emergency Medical Units (EMUS) had also been created in partnership with GP’s in Abingdon, Banbury, Witney, and Oxford.

The hospital was sensitive to the support patients, who were in vulnerable circumstances, might require to access services. An equality impact analysis was undertaken for each care and treatment protocol. The equality impact analysis for the pressure ulcer prevention guideline noted that patients with learning disabilities and those who do not speak English “might need additional assistance and adjustments to enhance communication while in hospital”.

Medical care (including older people's care)

We saw that telephone and face-to-face interpreters were available. One family told us that they had declined an interpreter and preferred to interpret for their father. A text phone service was available to support deaf, hard of hearing and speech-impaired patients to make appointments. Patient transport could be arranged for patients' with disabilities.

The hospital anticipated that there would be a higher demand for medical beds during the winter. Four escalation beds were available in the Adams ward to ensure that medical patients could be treated on an appropriate ward. These beds had been filled for some months and staffing on the ward had been adjusted to manage with this increase. We attended the hospital's bed management meeting which was held twice a day. Anticipated admissions and discharges were monitored during the meeting to facilitate the flow of patients through the hospital. Due to a lack in bed capacity one medical patient had been admitted to a surgical ward. Plans were in place for them to be moved to an appropriate ward later in the day. We spoke with the clinical director for acute medicine and rehabilitation who told us that there was a high demand for beds across the hospital. They explained that the medical division had improved the management of its bed occupancy over the past 18 months. Fewer medical patients were admitted to other divisions and patients were primarily moved between wards for clinical reasons. Medical patients were assigned to a named consultant responsible for their care from admission. This meant if medical patients were admitted to other specialist wards they could be reassured that they would receive appropriate clinical input.

Patients on the stroke ward did not always have timely or ongoing access to speech and language or physiotherapy. We did not find that this resulted in unsafe care but meant that some patient's recovery or discharge could have been delayed.

Leaving hospital

Management, staff, patients, and relatives told us there were delays in discharging patients from hospital. Several patients on the medical wards were ready to be discharged. The majority of delayed discharges were due to patients waiting for appropriate community care services. The hospital was working with stakeholders to deliver the discharge improvement programme. Additional resources had been made available to the medical division to

improve internal and external discharge arrangements. This included the recruitment of discharge planners on medical wards responsible for coordinating patients' discharge. Discharge planners had started working on Wards 7C and 7D. Records showed that they planned patients' discharge from admission, ensured all relevant information was shared with social services and liaised with care agencies, and arranged transport. Attempts were made to discharge patients to community services close to home. This had not always been possible and patients refused these discharge arrangements if it did not meet their needs.

Some patients required care and rehabilitation at home once they were discharged. The trust's Supported Discharge Service supported people for the first six weeks till a care package was in place. People who no longer needed the hospital environment could be cared for at home while waiting for their care packages. Nurses had high praise for this service.

Discharge support workers had been recruited to support patients from wards to the transfer lounge. They ensured patients were dressed appropriately, provided assistance with personal care, and collected patients' take home medicine. Patients with dementia were transferred home from their ward to minimize disruption and confusion. Patients in the transfer lounge told us the wait could be long but that they were well looked after while they waited for their medication or transport. Actions were in place to improve the processing of medication for discharge.

The transfer lounge sister told us that the ward had good working relationships with care and transport providers. Nurses had been given training to identify the correct specialist transport required to take patients home. The South Central Ambulance Service liaison officer had been based on level 4 from January 2014 to help facilitate transport.

A weekly multi-agency discharge meeting took place. During this meeting all the patients reviewed by the Discharge Pathways team were monitored to ensure that appropriate arrangements were in place to meet patients' needs following discharge. The hospital audits out-of-hours discharges, and overnight discharges remain low at 0.6% of patients.

Medical care (including older people's care)

Patients and carers had been involved in designing the new patient leaflets for discharge. Several leaflets were available to patients providing information about how to plan for the discharge process, transport and information about medicines.

Learning from experiences, concerns and complaints

The medical division captured patient feedback. This included results from the "Friends and Family test", complaints and comments, Patient Advice and Liaison Service (PALS), Healthwatch Oxfordshire, National Inpatient Survey and Patients Stories. Adams ward had a low Friends and Family Test response rate in November 2013. Efforts had been made to improve the completion of the friends and family test by asking all staff including housekeeping to remind patients and relatives to complete the form. In January 2014 Adams ward aimed to achieve a 20% response rate. 24% was achieved with 100% of respondents saying that they were likely to recommend the ward to family and friends. Results of the friends and family test were displayed on wards.

Patient feedback was reviewed at monthly divisional meetings. Two patient stories relating to diabetes care were presented at trust board and quality committee meetings in February 2014. Lessons learnt from these patients' experiences were captured in an action plan which included training for staff in adhering to diabetes protocols and supporting patients to manage their anxiety. The acting divisional head of nursing and governance told us and staff confirmed that patients and relatives primarily raised concerns about communication, not receiving appropriate assistance and discharge on the medical wards. Actions were in place to address these concerns and to gain a better understanding of how concerns could be addressed swiftly on the ward.

We spoke with the sister in charge of the discharge lounge to see what action had been taken following the investigation of two complaints. Changes had been made to the cleaning of the floor to ensure that it did not pose a slip risk. Systems had been put in place to monitor patients' deterioration while waiting in the transfer lounge. Transfers would be halted by the discharge staff if they assessed patients were unfit for transfer.

Leaflets and signs were on wards to inform patients how to make a complaint, access PALS, and complete the "Friends and Family test". Patients could access the Independent Complaints Advocacy Service (ICAS) if they required support with making a complaint.

An example of the division's complaints and action taken were published in the hospital's annual Quality Account.

Are medical care services well-led?

Good 

Vision, strategy and risks

The hospital told us they were committed to "Delivering Compassionate Excellence". They described the culture and values underpinning the hospital as "learning, respect, delivery, excellence, compassion and improvement." We spoke with staff from all levels in the division. They were proud to be part of the hospital and passionately shared the vision. Staff consistently told us that it was their primary concern to ensure that the patients they cared for were treated with respect and compassion. The information noting the vision of the hospital was displayed throughout the hospital and wards to invite staff and patients to become involved in shaping future plans.

Systems were in place to ensure that risks were identified and understood on all levels. The concerns regarding recruitment and discharge shared by staff on the ward were the same as those captured at division and board level.

Governance arrangements

Clearly defined governance arrangements were in place in the division. Sisters and matrons were clear what their responsibility were in analysing and reporting on quality information. Records showed that their information were used to inform the division's monthly quality meeting and the hospital-wide clinical governance committee. Clinical governance was integrated across divisions. Risks relating to pressure ulcers and falls were assessed across the hospital. Meeting minutes showed that high quality information, from several sources, were presented to the clinical governance committee and board to inform their decision making. We saw that the board had requested clarification of information on several occasions including how the safer staffing levels in the medical wards had been determined. A detailed response had been provided.

Medical care (including older people's care)

The hospital monitored risks to the delivery of care through a risk register. The medical division's risks included the risk of not maintaining safe staffing levels as well as delayed discharges. The clinical director for acute medicine and rehabilitation owned this risk. We spoke with them and they explained what their responsibilities were in managing this risk. They understood the cause, effect, and impact of this risk as described in the risk register.

Leadership and culture

The hospital has a clear leadership development strategy developed in consultation with the workforce committee and medical division. Opportunities were available to develop leadership capabilities to solve problems, innovate, and manage change. Many staff had lead responsibilities for enhancing patient pathways on the medical wards. This included dementia, falls, consent and safeguarding champions. The sisters development programme and the new consultant development programme was available to staff. We spoke with a new consultant who told us that they had experienced strong leadership since being part of the division and had been encouraged to build co-operative relationships across the hospital. Human Resources' practices promoted a culture of compassion towards patients. The hospital used values-based interviewing to ensure that staff were recruited that prioritised high quality and compassionate care. A sister explained to us how this had been implemented in the recent recruitment of Spanish nurses to medical wards. The matron explained how the hospital's values had been incorporated in the clinical support workers academy as well as the competency bridging course for foreign workers.

Staff were complimentary of the managers and leaders. They told us they felt valued and supported. Staff were encouraged to take breaks to promote their wellbeing at work. A second annual staff recognition awards ceremony was held in November 2013. Staff who attended told us they appreciated that performance in compassionate care had also been acknowledged. Staff told us that they had received an annual appraisal. They were clear what their personal and professional development plan was following their appraisal. The matron told us that a new electronic

learning management appraisal system (ELMAS) had been introduced and several appraisals were still due. The sister on the discharge lounge explained how they had used this to record their staff appraisals.

Patient experiences, staff involvement and engagement

Staff and patient feedback is an agenda item at monthly governance and board meetings. All whistle-blowing concerns raised regarding clinical quality has to be shared with the clinical governance committee to ensure that action was taken to address these concerns. Results from the "Friends and Family test", complaints, compliments, and PALS contact were monitored at the division's monthly quality meeting. There was a shared understanding that patients and relatives concerns on the medical wards relate to communication, delayed discharge, and not always receiving the appropriate support at the right time. Action plans were in place to improve practice and patients experience. Positive feedback received from patients and relatives were displayed in wards and celebrated by staff.






The hospital continued to embed the Listening into Action (LiA) project. This empowered staff to find innovative solutions to problems they identified. The medical wards were identifying their LiA champions.

Learning, improvement, innovation and sustainability

Risk reporting systems were reviewed to ensure that they provided information that could improve performance. We spoke with the acting divisional head of nursing and governance who explained that work was underway to develop an innovative integrated risk reporting system. This risk information would follow patients through their care pathways and provide a comprehensive understanding of risk over time.

The board took time to review and improve performance. A board away day and seminar programme were held in October 2013. This day focused on understanding the challenges faced by medical wards to ensure safe staffing is provided to care for frail, elderly patients. Budget management was explored to ensure that budget adjustments were made to incorporate the increased staffing levels.

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

Information about the service

The John Radcliffe Hospital provided a range of general and specialist surgery, including trauma, vascular, cardiac, spinal, ophthalmic, neurosurgery, plastic surgery, ear nose and throat (ENT) and general surgery. Services were managed within five clinical services divisions.

We visited two trauma wards, a neurosurgery ward, and the surgical emergency unit. We also visited theatres in the main hospital and in the west wing.

We talked with 19 patients, four relatives, and 26 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, and senior management. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

There was consensus among patients, carers, and staff that staff were dedicated and provided compassionate, empathic care. However, there was frustration expressed by many staff at all levels that they were not always able to provide safe and effective care. This was due to a lack of capacity, brought about by insufficient resources and work flow.

Pressures within the wider health economy presented significant challenges in terms of demand versus capacity. There was evidence that the hospital was working with other partners to respond to this but pressures were compounded by significant and on-going staff shortage and management of resources.

There was an overwhelming sense of discontent expressed by some senior clinicians, who felt the trust board was motivated by financial, rather than by clinical motives. This was at odds with the one of the stated values of the trust; “putting patients at the heart of everything we do”. We saw evidence of strong clinical leadership at a local level but senior clinicians felt disempowered and believed they had no voice. We saw evidence of good team working at ward and departmental level but there was silo working across sites and divisions within surgery.

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Are surgery services safe?

Requires improvement 

Safety and performance

There were 206 patient safety incidents (trust-wide) reported by surgical services to the National Reporting and Learning System (NRLS) between July 2012 and July 2013, accounting for 34% of all incidents reported across all specialties. Of these, 192 were categorised moderate, 11 abuse, two severe and one death. These were within statistically acceptable limits for all notifications.

Risks to patients identified by the NHS Safety Thermometer were being managed. Records showed that national safety guidance was followed on the prevention and management of pressure sores, blood clots, falls and catheter urinary tract infections on surgical wards. There were systems in place to ensure that patients' nutritional and hydration needs were identified and met and that they were supported to eat and drink.

Between December 2012 and November 2013, 35 serious incidents were reported in surgical services trust-wide. Twenty were in ward areas, four in operating theatres, and one in a day case theatre. Of these, two were categorised as never events. A never event is classified as such because it is so serious that it should never happen. One of these never events was a surgical error which occurred in the west wing theatres at the John Radcliffe Hospital. A wrong power lens was implanted into a patient's eye.

Hospital mortality data showed that mortality rates in surgery at this hospital were not a cause for concern. The incidence of pressure ulcers, infections, venous thromboembolism (VTE), and falls on surgical wards was also within the expected range.

Staff were aware of their responsibility and the process to report untoward incidents but there was inconsistency in terms of their understanding of reporting thresholds. There was under reporting of incidents. Some staff told us they did not report incidents because they did not have time; others felt it was a pointless exercise because "nothing would change". We asked three staff if they would report that a theatre list was not supported by the recommended

number of staff. They all told us they would not. Staff on the neurosurgery ward told us planned operations were frequently cancelled due to emergency demand. They said these cancellations were not captured as incidents.

One staff member told us the trauma ward they worked on was "purpose built and fit for purpose". Bays and single rooms were spacious and allowed safe moving and handling of patients. The wards were well equipped with lifting equipment and there was ample storage. There were appropriate "anti-slip" floor finishes and hand rails to prevent falls. There were call bells in bathrooms and toilets so that people could call for help.

Concerns were expressed by staff, including senior staff and managers, about the condition of the premises in the main theatres. The trust's risk register recorded: "Cardiac theatres require complete refurbishment: Potential risk of infection as inadequate space to walk patient around when equipment laid out." The register recorded that there was "robust site surveillance" in place to mitigate this risk and there were plans to refurbish the main theatres, with work due to commence in April 2014.

There were concerns expressed by staff that trauma and spinal surgery was taking place in theatres without a laminar flow air system. This system is recommended to reduce the risks of wound infection in certain types of orthopaedic surgery. These concerns were not listed in the department's risk register but the general manager was aware of the concerns, which would be addressed by the provision of new theatres. The number of surgical site infections in the orthopaedic directorate from November 2012 to December 2013 ranged from nil to four per month, with the highest rate of four being recorded during the months of September, October and November 2013.

Staff told us that patients' operations were sometimes cancelled due to lack of capacity. Capacity was affected by lack of theatre space, suitability of premises, availability of suitable equipment and appropriately trained and skilled staff. Concerns were also expressed about efficiency. The same day cancellation rates for specialist surgery were showing an upward trend, with 4% cancelled in October 2013.

Learning and improvement

On surgical wards we saw information displayed about areas of risk, such as the incidence of pressure ulcers and falls. Staff, patients, and visitors were able to see how they

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were performing in these areas. They told us that incidents were discussed at regular ward meetings and teaching sessions had been provided by, for example, tissue viability specialists. In theatres however, staff were less well informed. Departmental governance meetings had not been taking place due to staff shortages.

We saw little evidence that staff were aware of or had learnt from serious untoward incidents, including never events. Three theatre nurses we spoke with had no knowledge of never events or serious incidents occurring in theatres.

An investigation report (December 2013), following a never event in ophthalmic surgery in August 2013, noted that a similar event (not classified as a never event) had occurred in the same clinical service in May 2013. A root cause investigation at that time had recommended a change in practice. However, when the second event occurred it was found that this new practice had not been followed. The report concluded that the recommendations had not been widely circulated. It was also found that there had been inadequate discussion by the operating team as part of the WHO safety checklist process so that there was a collective understanding of the lens to be implanted. The WHO safety checklist was developed by the World Health Organization, and requires all of the theatre team to engage and accept joint responsibility for ensuring that safety checks are undertaken at each defined stage of the surgical procedure, thereby minimising the risk of the most common and avoidable errors occurring. It was noted that the culture in the theatre at the time of the incident was such that staff did not feel able to speak up if they felt concerned.

An action plan committed to review the checking systems, to provide “human factors” training to the ophthalmology theatre team and to disseminate learning from the event to all staff working in similar areas in the trust. The action plan had not been updated to show progress against these actions. However, we were told by the general manager that “human factors” training had commenced for theatre staff. Human factors training examines the factors that can influence people’s behaviour at work.

A serious incident had taken place at the Nuffield Orthopaedic Centre in March 2013, which had resulted in the death of a diabetic patient following surgery. The investigation into this event had recommended the development of a protocol for the perioperative management of diabetic patients so that staff understood

when they should seek intervention in relation to patients’ blood glucose monitoring. On the neurosurgery ward we saw a diabetic patient who had repeated low blood glucose readings. The nurse caring for this patient had no guidance as to what action to take in the event of high or low readings. They told us they thought there was a protocol on the trust’s intranet but they had “no time to go on-line”. They were also unaware if there was a policy on the administration of insulin. We were concerned that although learning had been identified through the investigation and subsequent risk summits in the trust following this serious incident, the process of disseminating this to staff was not effective. This placed diabetic patients at risk of receiving poor or unsafe care.

Systems, processes and practices

There were systems and processes in place to keep people safe. We observed a theatre team participating in a team brief/planning meeting prior to their operating list starting. They introduced themselves, discussed the planned theatre list and equipment. We witnessed them engaging well with the WHO checklist process. Checklists had been adapted for some specialties. One staff member told us that compliance with this safety tool was “getting better”, although they said some staff found it difficult to assert themselves and sometimes the “sign out” section of the process (before the patient leaves the operating theatre) was not completed. They said this was because some staff felt intimidated by some surgeons who did not allow them time to do this. This suggested that a culture change in theatres was still required. Monthly audits of WHO checklist completion took place. Performance in the neurosciences, orthopaedics, trauma and specialist surgery ranged between 93% and 100% in the period November 2012 to December 2013.

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

There were risk assessments undertaken for each patient within six hours of admission to a ward. These included

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assessments for risk of malnutrition, developing pressure ulcers or VTE and risk of falls. On ward 2A we noted that a falls risk assessment had not been undertaken for one patient and there was no explanation for this.

Care plans were developed to manage identified risks and ensure safe and appropriate care. Risk assessment documentation was standardised across all of the wards we visited; however, care planning documentation varied, as did the recording methods to demonstrate that risks were being appropriately managed. We noted on a trauma ward that a patient who was immobile had been identified as being at risk of developing pressure ulcers. In order to mitigate this risk, the patient was to be turned every three to four hours. A senior nurse told us that turn charts were not used to evidence this support but this would be recorded in the daily records completed each shift. We looked at the records and saw that there were regular references made to the condition of the patient's skin so we could see this was checked but they did not evidence that the patient had been turned as specified in their care plan.

Staffing arrangements impacted on safety. There were nursing and healthcare assistant staff shortages reported on surgical wards and in theatres. In the neurosciences, orthopaedics, trauma and specialist surgery division, the vacancy rate for nursing staff was 16.4% in December 2013. The trust told us there had been a recruitment drive and a recent cohort of registered nurses from Spain had recently begun work. Recruitment was ongoing and further recruitment drives in Scotland and Wales were also planned.

On the neurosurgery ward on one day of our unannounced visit, two beds were closed due to a shortage of staff. A patient was waiting in ITU to be transferred to the ward but there were no beds available, putting pressure on staff to discharge to create capacity. Two staff on this ward told us that there were frequently insufficient staff. The day previously they reported they had been one registered nurse short. They said that beds were frequently opened for emergency admissions, even though there were insufficient staff. Staff thought this was unsafe. The division's risk register noted "insufficient theatre capacity to manage emergency and elective workload within neurosciences. This can result in cancellation of elective cases and the ward frequently running at over 100% capacity."

In theatres the vacancy rate was of concern. The vacancy rate for the clinical support services division was 2.98% in November 2013 but in the division's January 2013 quality report it was noted that theatres was a "hotspot". At the time of our visit the operational services manager in the clinical support services division told us there was a 19% vacancy rate for nursing and medical staff. In addition there were a number of staff on long term absence. This meant there was regular and frequent use of temporary (bank and agency) staff. Staff shortage was recorded on the risk register for theatres. Some temporary staff had been employed on long term assignments to help ensure continuity. Staff told that they regularly worked long days or did overtime on the bank. However many staff were fatigued and were volunteering less. Staff reported high levels of stress and low morale due to workload. The division reported that they were investigating the reasons for staff turnover.

The senior theatres and CSSD manager told us that operating lists were cancelled about once week due to staff shortage. Theatre staff told us that sometimes theatres had only two theatre staff supporting the surgeon and anaesthetist. The Association for Perioperative Practice (AfPP) recommends that there should be three staff (three nurses or two nurses and one operating department practitioners (ODPs). Staff in the main theatres told us that they regularly had only two staff. They said this occurred approximately once a week. They said this had the potential to be unsafe.

In neurosurgery junior doctors told us that sometimes the medical staffing levels felt unsafe. Out of hours there was one junior doctor (Senior House Officer) looking after 74 inpatients, while a registrar provided emergency cover. There was no phlebotomy service, which added further to their workload. We saw this in practice during our unannounced visit.

In trauma services junior doctors felt the medical cover was safe and they felt well supported with resident registrar and consultant back up always available, including out of hours. Similarly, on the emergency surgical unit, junior staff felt well supported by senior clinicians.

Neurosurgeons told us that lack of theatre capacity meant that elective surgery was cancelled in order to accommodate emergency work. However, they also told us that there was pressure from management to meet targets for elective work and they needed to operate at night to

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complete this work. The senior theatres and CSSD manager accepted this practice was unsafe and told that it had been stopped. The trust told us that as a policy elective operations are not conducted after 8pm.

The suitability and condition of premises was varied. Surgical wards were well laid out, with provision for close observation of acutely unwell patients and barrier nursing of infectious patients. Wards were clean and there were appropriate arrangements for cleaning and the disposal of waste. There were adequate hand washing facilities and patients told us they saw staff regularly washed their hands. Staff observed the “bare below the elbow” uniform policy and wore suitable protective clothing such as gloves and aprons, which were in plentiful supply.

Each ward was equipped with an emergency resuscitation (crash) trolley. We checked this on a neurosurgery ward and found that a piece of equipment was missing. This had been identified two days earlier but had not been rectified.

However, staff expressed concerns about the condition of the main theatre suite. We were told by a senior nurse that there was a rusty sink in one theatre.

Monitoring safety and responding to risk

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

There was an infection control link nurse in the main theatres department but they did not take part in the regular “walkabouts”. We asked one of the departmental sisters if joint theatre inspections took place with estates, infection control leads, and clinical staff. They said they did not. The general manager told us that any concerns about premises would be escalated via divisional clinical governance meetings. Minutes of trust-wide clinical governance meetings did not identify any concerns of this nature.

Anticipation and planning

On surgical wards planning was done well to reduce any potential risks to patients. Staff assessed patients promptly on admission in order to identify risks. If patients required a

higher level of observation, for example, then workload was discussed at handovers and organised to facilitate the required level of support. Staff told us that they could request additional staff to facilitate intensive monitoring.

Planning for surgical procedures was not done well. Pre list briefings took place prior to each list commencing, where the whole team discussed the planned cases and discussed issues, such as equipment, timings, and individual roles. There were regular planning meetings but operating lists were open ended, which meant on the day before or the day of surgery staff were, as one staff member described it; “scrabbling around juggling cases and trying to find the appropriate number of staff.”

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

Good 

Using evidence-based guidance

Divisional quality reports showed how each division was performing in relation to guidance from the National Institute of Clinical Excellence (NICE). The trust was delivering care in line with guidance on the treatment of hip fractures but was only partially meeting guidelines in relation to pre-operative tests. There were action plans in place to show what needed to be done to ensure practice was in line with guidelines.

Performance, monitoring and improvement of outcomes

Performance on patient reported outcome measures (PROMs) was gathered from patients who had groin hernia surgery, or varicose vein surgery. Patients were asked about the effectiveness of their operation and the response data showed no evidence of risk and good outcomes for patients. The trust achieved compliance with the nine standards of care measured within the National Hip Fracture Database. The rate of unscheduled return to theatre (specialist surgery) from November 2012 to December 2013 ranged from 0% to 4%.

Staff, equipment and facilities

The senior theatres and CSSD manager told us “the infrastructure is not optimal” and described a “constant wrangle with the estates department to get basic work done”. There were regular “walkabouts” conducted by the

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theatre sisters to monitor the safety and cleanliness of premises. Identified concerns were recorded on the department's risk register. Staff told us that there was no separate scrub room which was "not ideal". Department of Health guidance (HBN 26 Facilities for surgical procedures) states: "where a scrub room is shared between theatres potential exists for the compromising of pressure gradients within and between the two theatres with possible adverse consequences for infection control." Concerns were also raised that some theatres were not large enough to accommodate necessary equipment. The trust were aware of the concerns and plans were in place to refurbish the theatres at the hospital.

The senior theatre and CSSD (central sterile services department) manager told us it was recognised that theatre utilisation had to be improved. In January 2013 it was reported in the division's quality report that the theatre utilisation rate was 75% for planned surgery and 56% for emergency surgery. It was also reported that a theatres improvement programme steering group had been set up and a new trust-wide booking process had been introduced.

We asked staff at all levels whether they felt well supported with training and supervision. Responses varied. Nursing and junior medical staff working in trauma felt well supported by their peers, senior clinicians, and managers. A newly appointed staff nurse on a trauma ward told us their ward was an amazing place to work. They told us about their in-depth induction in trauma and their ongoing support and supervision from team leaders. In neurosurgery, junior medical staff were concerned that pressure of work impacted on the time available to them for training. They told us that training and theatre time was non-existent.

Staff working on the trauma wards were positive about the layout, facilities and the way in which workload was organised on the wards, all of which they felt all contributed to effective care. There was a mixture of four bedded bays and some single rooms for patients who required barrier nursing. There were observation bays in sight of the nurses' station so that more vulnerable and dependent patients could be closely observed.

All patients were allocated a primary nurse to ensure continuity of care. At each shift change there was a whole

ward handover, followed by a one-to-one handover relating to each patient, so that staff were well informed. Primary nurses, where possible, joined ward rounds with visiting doctors so that care was co-ordinated.

Multidisciplinary working and support

We saw examples of good team working and peer support. Clinicians working in trauma surgery were proud of the multidisciplinary and integrated approach to caring for people with complex needs. As a major trauma centre, the service treated a wide range of trauma conditions. Many patients had multiple injuries and some, particularly older people, had co-existing illness and/or cognitive impairment. Two ortho-gerontologists (doctors who specialise in caring for older people with orthopaedic injuries) worked Monday to Friday on trauma wards to provide medical input and ensure an integrated approach to their care and treatment. Staff were supported to study for a diploma in gerontology and there were regular teaching sessions to help them understand the needs of older people. A locum consultant surgeon who had recently worked on the trauma wards had written to the matron saying "I believe the team working in the trauma ward is outstanding and offers the patients an unbelievable high quality of care. I had great feedback from patients in this regard."

There was a nurse consultant in trauma care. This was the first such post in the UK and was developed to facilitate and co-ordinate shared care of complex trauma cases and provide expert input into trauma care in other departments such as children's services. A grateful patient had written: "I cannot tell you how reassuring it felt to know that there was somebody who knew me. Somebody that didn't just know me for the fractures, wasn't there just for the surgery, somebody who knew about my time, not just on trauma, but on intensive care and specialist surgery wards as well." The nurse consultant had also formed links with trauma services in other district general hospitals and worked with community hospitals to develop designated beds for people with hip fractures, requiring rehabilitation.

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Are surgery services caring?

Good



Compassion, dignity and empathy

Patients on surgical wards were treated with compassion. We saw a letter written by a junior doctor to the matron, praising the “superb team of nurses” working on the trauma wards. They had witnessed a nurse on ward 3A who was looking after a very distressed, delirious, elderly patient with a fractured hip. They said on a busy night shift “[The nurse] sat with this patient for several hours, reassuring them and holding their hand with their left hand while doing their admin with their right hand.”

Patients’ privacy and dignity were respected. All of the patients we spoke with told us they were treated with courtesy and respect. We noted that curtains were drawn around patients’ beds when personal care was provided. Ward accommodation was segregated so that men and women were afforded privacy and dignity. However, this was not the case on the theatre direct admission unit, although an audit had shown that patients did not feel uncomfortable with this arrangement.

Patients told us they had enough to eat and drink and there was a plenty of choice with their meals. Most people felt that the quality of the food was adequate or good. We observed that patients had jugs of water by their beds and these were regularly topped up. Patients had access to call bells which they could use to call for assistance. We noted that these were always within easy reach. Patients told us that staff responded promptly when they called for help.

Patients and staff told us that nursing staff conducted regular ward rounds to check that people were comfortable. Patients were regularly asked about their pain levels, particularly immediately following surgery. Patients told us if they asked for pain relief this was arranged and administered promptly.

In the Patient Led Assessment of the Care Environment (PLACE) in 2013, the John Radcliffe Hospital scored over 90% for cleanliness, over 80% for facilities and privacy, dignity and wellbeing. The lowest score was for food which scored 73.4%.

Involvement in care and decision making

Patients and those close to them told us they were well informed about their medical condition, their care, and treatment. They said that nursing and medical staff had explained everything to them in a way that they could understand and they understood the risks and benefits of treatment. Consent procedures were followed and documented. On trauma ward 2A we saw a letter from a grateful patient to the trauma nurse consultant. They said: “Being in hospital is a strange experience... Throughout it all I knew I was being cared for and in the best place; everybody was kind, patient and always gave me as much information as possible as to what was happening and why”. One patient told us that each time they were given their medicines, staff explained what they were giving them and the dosage. They appreciated that while they found this tedious; it was a safe practice and one which ensured that they retained some control.

In the 2012 Adults in patient survey the trust performed better than other trusts in response to the following questions; “Did a member of staff explain the risks and benefits of the operation or procedure?” and “Were you told how you could expect to feel after you had the operation or procedure?”

Trust and communication

Patients told us that things were explained to them in a way they could understand. One patient complimented the doctor’s bedside manner. They said they were put at ease and felt able to ask questions. Another patient told us they appreciated the clarity and the openness of the medical explanations given to them. They were encouraged to ask questions if they did not understand. Patients were well informed about their medical condition and their treatment. The risks and likely outcomes of surgery had been explained to them and they had been asked for their consent. There was a range of patient literature available, both on the wards and on the trust’s website. Translation and interpreter services were available for people whose first language was not English.

Emotional support

Patients and relatives told us they received the support they needed to cope emotionally with their treatment and hospital stay. A relative who had been very anxious about

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their family member told us they had been made to feel welcome on the ward and had been supported and kept informed. There was a chaplaincy service available for people of all religious denominations.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement 

Meeting people's needs

Most patients told us that all of the staff were responsive to their needs. One patient said: "nothing is too much trouble." Most people who had used their call bells when they needed help said, staff always responded quickly. One person on a trauma ward told us that they needed pain relief in the middle of the night and this was arranged without delay. However, a patient on the neurosurgery ward told us that staff were slow to respond to calls for help and felt that staffing levels were inadequate.

The hospital worked towards achieving national targets in relation to waiting times, cancelled operations, and delayed discharges. The NHS constitution sets out that patients should not wait more than 18 weeks for treatment from the time they are referred. Overall data for the trust failed this target for patients who were admitted, achieving 88.06% against a target of 90% as at November 2013. Eleven patients waited over 52 weeks; nine patients for orthopaedic surgery, one maxilla-facial surgery and one for paediatric spinal surgery.

Department of Health guidelines state that if patients require surgery and their operation is cancelled for non-clinical reasons, their operation should be re-arranged within 28 days. The trust scored similar to expected when compared with other trusts in relation to cancelled operations. However, staff told us that operations were regularly cancelled due to lack of theatre capacity, shortage of staff or inefficient planning. Cancellation data provided by the trust showed that overall the cancellation rate was 0.63% for the period 1 April 2013 to 31 December 2013. The highest rate was categorised "unknown". This required further explanation and investigation. High rates were also recorded in cardiac surgery (5.3%) and neurosurgery (3.85%).

There were numerous comments from staff about the inefficient system for planning theatre lists and some concerns expressed about the administration of theatre lists. Several examples were described where patients did not arrive because they had not received notification of their surgery. A relative told us that their family member had received three letters inviting them for surgery which had already taken place.

A manager described the planning of theatre lists as "chaotic" which had implications for efficiency and safety. They told us lists were put together by surgical divisions and were very often unrealistic and overran. They said that non-clinical staff (secretarial) were prioritising patients and placing them on operating lists in a "disjointed way." They told us that there were "pockets" where patients were not being properly assessed prior to surgery and operations were cancelled due to the patient not being fit. A consultant surgeon told us: "Operating lists are run on goodwill, rather than good planning."

A theatre manager told us there were significant issues around the management of the 18-weeks target which led the theatre lists being over booked. If emergency cases arose, planned surgery was cancelled. We heard that that operating lists were "chopped and changed on the day" and that there was no real planning. Concerns were also raised about the inconsistency of surgeons' practices, with some starting at 9am and others starting at 11am. In the west wing theatres an anaesthetist told us that the out-of-hours emergency theatres were inefficient because the specialist theatre teams (neurosurgery, maxillofacial, ENT, paediatrics, and plastic surgery) were on call and therefore there were frequent delays. They told us that emergencies were prioritised but patients' operations were frequently delayed. We were told that recently a patient with a fractured jaw waited two days, without food each day, until they had their surgery.

A maxillofacial surgeon told us the service struggled to meet increasing demand and that access to emergency theatre was a particular problem. They told us this resulted in poor patient experience and that delays had led to some poor outcomes for patients. Delays also impacted on the 18-weeks referral to treatment target.

In neurosurgery medical staff told us that there was insufficient theatre capacity to cope with the emergency

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demand. This meant that elective surgery was often cancelled. Nursing staff told us sometimes patients were without food for up to 24 hours, because their surgery as constantly delayed.

The risk register for the trauma directorate recorded that patients with fractured femurs were failing to receive surgery within 36 hours because theatre capacity/efficiency could not accommodate peaks in demand. The quality report for the specialist surgery division showed that the target of 70% had been exceeded, with 72% of patients receiving surgery within 36 hours in the quarter ending 31 December 2013.

Theatre staff told us they had concerns about the lack of theatre capacity, the suitability of premises, and the availability of equipment. In the main theatres, capacity had been reduced recently due to the closure of two theatres.

Staff in theatre recovery reported that staff shortages on surgical wards meant that recovery nurses had to take patients back to the ward. This meant that they were sometimes away from the recovery department for 20 to 30 minutes. The impact of this was that there were sometimes delayed transfer of patients from theatre to recovery, and in turn, further delays in theatre.

Vulnerable patients and capacity

There was insufficient attention paid to the identification, assessment and planning of care needs for vulnerable people. There was recognition that a large proportion of trauma patients were older people who may have complex or special needs, including dementia. The trust was required to screen patients over 75 years of age if they were admitted as an emergency and remained in hospital for over 72 hours. The trust's performance in November 2013 was 6%. The neurosciences, trauma, orthopaedics and specialist surgery division reported in their January quality report: "there is a drive to raise the profile with dementia screening."

Some patients, who required a period of rehabilitation, continued to be cared for on acute surgical wards following the acute phase of their care pathway. This was because of a shortage of suitable placements in, for example, community hospitals. On the emergency surgical and

trauma wards there was support from physicians and doctors who specialised in the care of older people. We heard about plans to develop a 'dementia friendly' environment on some wards.

On a trauma ward we looked at two care plans for older people. One patient was recorded as having "known dementia". The second was recorded as "query dementia." In both cases there was a pre-populated, semi structured care plan for people with dementia. Prompts included: "assess patient to find out best way to communicate" and "complete 'knowing me' form." ('Knowing me' is a profile completed for people who have limited capacity or are unable to communicate their needs and is often completed by people who are close to them.) Neither of these actions had been completed for either patient, despite the fact that they had both been inpatients for over a week. We were concerned that staff, particularly temporary staff, may not have sufficient information about each of these patient's particular needs to ensure that their needs could be met. We were shown a new template for a dementia action plan which was to be introduced on the ward the following week.

On a neurosurgery ward a generic care plan had been developed for an elderly patient with dementia. There was no detailed care plan to indicate any special needs associated with their dementia. Similarly, a care plan for a patient who was being fed via a nasal gastric tube was too generic and did not contain sufficient detail to ensure that staff understood their needs.

Access to services

Access to services was variable because the hospital had a high occupancy rate (92% trust-wide between July and September 2013). There was limited access for some people who required a period of rehabilitation, to suitable placements in the community.

Leaving hospital

Department of Health guidelines state that patients should be discharged from hospital when ready and with information and support available to them to ensure they do not need to be re-admitted. Patients should have adequate notice of their discharge and it should not be delayed due to waiting for medicine, to see a doctor or for an ambulance. The clinical support service quality report reported in January 2014 that the turnaround time for pharmacy to fulfil prescriptions for patients to take home required improvement. The target was that 90% of

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prescriptions should be fulfilled in less than 90 minutes. Performance in December 2013 was 59% for weekdays and 47% for weekends. The trust was aware of this, through the internal peer review process conducted from November 2013 to January 2014. Work had commenced to resolve this issue.

In the CQC survey of adult inpatients (September 2012 to January 2013) the trust scored similar to expected when compared to other trusts in relation to these targets. However, some patients remained in acute wards for too long because suitable placements to support their rehabilitation could not be found.

Most of the patients we spoke with had been given information about their discharge from hospital and they knew when they were expected to be discharged. They had been assessed by physiotherapists and occupational therapists and asked about their home circumstances and the support available to them. Arrangements were confirmed about how they would get home. These were known as simple discharges. However, for some patients the process was more complex because care packages had to be arranged to support their rehabilitation in the community. This often led to delayed discharge which left patients feeling frustrated and anxious.

Staff told us that patients' discharge was planned as soon as they were admitted. We saw that an estimated discharge date was recorded in their notes. They told us that patients were given information about their surgical procedures before their admission and this included information about after care. This was reinforced on their discharge.

Learning from experiences, concerns and complaints

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

The wards we visited had received few complaints. We asked staff if there were any themes. Most staff could not think of any but on one ward a staff member told us the

most common complaint from patients was the cost and unreliability of the televisions provided by patients' beds. They told us they passed the information on but felt that the solution was out of their control.

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

Are surgery services well-led?

Requires improvement 

Vision, strategy and risks

There was a clear trust vision and a set of values, which were patient focused. Many staff did not know what the vision and values were but portrayed similar values and passion and motivation to provide excellent patient care.

Governance arrangements

There was a clear governance structure with reporting lines from departments through directorates and divisions, ultimately to the trust board. Although there was some evidence of cross divisional working, for example, the theatres improvement programme steering group, this was not sufficiently embedded to be effective. For example, the complex issues relating to inefficient theatre use, which involved key staff working in different directorates. Contributing factors including staffing issues, premises and administration processes but these were not yet being addressed in a joined-up way.

Leadership and culture

Many of the staff we spoke with felt well supported by their immediate managers. For example, in trauma services, a staff member described a "very well-led service with good multidisciplinary team working". There were mixed views about the provision of training, support, and supervision for staff. Staff in the trauma service felt well supported by senior clinicians and were well supported with training. The clinical director and matron sent letters of commendation to junior medical staff who had "gone the extra mile and deserved recognition".

Staff in theatres had experienced many changes in management and did not feel that the department was well led. Staff shortages meant that senior staff provided

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clinical care and could not fulfil their managerial roles. Some new interim managerial appointments had recently been made. They acknowledged the lack of senior clinical leadership had begun to engage with and support staff.

Some staff felt that the executive level management was neither visible nor accessible. We were approached prior, during and following our inspection by 21 senior clinicians (doctors and nurses) who had serious concerns about the culture of the organisation. Many of these staff were anxious that they would not be identified as whistleblowers. Some clinicians felt they were disempowered and did not have a voice. Staff talked of a leadership style which they perceived as limiting autonomy, creativity, and flexibility. This was in contrast to the views of the Chief Executive who described encouraging innovation and autonomy.

Some of the consultants described their dissatisfaction with their job plans and the process by which they were developed, saying they felt there had been little room for negotiation. Four consultants told us they had had their perioperative care time (care given before during and after surgery) cut and said they did not feel able to deliver the service safely within these constraints. Job plans are jointly agreed plans which set out a consultant's responsibilities and objectives. They set out what work is to be done, where it is to be done and the time and resources required to achieve objectives.

There had been a high turnover of senior nurses and it was felt that nursing leadership had been a factor in this. Theatre staff told us there had been five theatre managers in the last five years and the post was about to become vacant again. Some staff felt that morale was low and stress levels were high. One senior nurse told us "This has been the worst four years of my career. Care is second to none but we are stressed on a daily basis." Several senior nurses confirmed that work related stress was a major factor which led to nurses taking less senior positions, leaving the trust or the profession. This was in contrast to the improving results in the staff survey.

A junior doctor contacted us highlighting a number of concerns about the management of the anaesthetics department; in particular there were issues with communication and with staff working hard but not feeling supported. They told us there had been a succession of theatre managers in the west wing and they felt that they were not sufficiently visible or accessible.

Patient experiences, staff involvement and engagement






Patients' views and experiences were a key driver for how services were provided. There was information displayed in wards showing how the ward was performing and what the friends and family test results were telling them. Patients' views and experiences were taken into account in the planning and delivery of services.

Staff at local level staff felt involved and engaged in making things work and constantly improving standards of care. However, there was less engagement about, or understanding of, other drivers, pressures and challenges and some staff did not see opportunities to have open dialogue about problems or solutions. Many theatre staff were concerned about the condition of the premises in the main theatre suite, which were not considered to be fit for purpose. Staff talked about plans to build new theatres but even senior staff were ill informed about the timescale for this and what could be done in the meantime to address the issues of concern. They expressed frustration that they were not able to influence change.

Learning, improvement, innovation and sustainability

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

Intensive/critical care

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

Information about the service

The critical care unit at John Radcliffe hospital has 19 beds. There were arrangements to provide 24 critical care beds between the adult intensive care units at John Radcliffe hospital and Churchill Hospital. This allowed for flexibility of how many beds were available at each hospital but would not exceed a collective bed number of 24. Critical care covers both intensive care and high dependency care. These are defined as level 2 being high dependency and level 3 being intensive care beds. The critical care departments at John Radcliffe Hospital included the adult intensive therapy unit (ITU) 19 beds, the cardio thoracic critical care unit (CTCCU) 19 beds, and the neuro-critical care unit 13 beds. There were also six high dependency unit beds (HDU), which formed part of the Coronary Care Unit.

A critical care outreach service to assess patients on the wards to be admitted to the intensive therapy unit was not available. However, systems were in place to escalate patients with deteriorating health. A patient follow up system was in place to ensure patients leaving critical care and returning to the wards were well supported. There was consultant cover on all of the departments 24 hours each day.

We talked with four patients, this low number was due to the difficulties in communicating with some critically ill patients and our wish not to tire or disturb them. We spoke with six relatives visiting the adult intensive therapy department, cardio thoracic and neuro-critical care units and 23 members of staff. These included nursing staff, consultants, junior doctors, and management of the units. Before our inspection, we reviewed performance

information from, and about, the trust and listened to comments from people at our listening events. We also reviewed data from the Intensive Care National Audit & Research Centre (ICNARC) for April 2012 to March 2013.

Intensive/critical care

Summary of findings

Patients received safe and effective care. While staff recruitment and retention was recognised by the senior staff as an issue, the levels and skills of staff on a day-to-day basis were consistently managed. Clinical outcomes were monitored and demonstrated good outcomes for patients.

Patients and relatives told us the caring, consideration and compassion of staff was of a very high level. Considerable work had recently been undertaken to improve the responsiveness of the service to ensure patients were discharged when they were ready and delays were minimised. This also improved the responsiveness for pre-planned admissions following surgery to take place. The departments were well led and demonstrated a positive leadership and culture. A business case had been submitted to the trust to increase in intensive care and high dependency beds in order to improve care and meet the identified demand as the service sometimes runs at over 100% capacity.

Are intensive/critical services safe?

Good 

Safety and performance

The monitoring of safety takes place to promote patient safety. Each critical care unit used a standardised record for measuring their performance and so all safety data was comparable. This increased the learning available to each critical care unit. The areas covered included a monthly check on infection control assessments, falls, urinary tract infections, and incidents relating to pressure damage. The hospital trust contributed their data to the Intensive Care National Audit and Research Centre (ICNARC) in order that they could be evaluated against similar departments nationally. The results of this and all monitoring was reviewed and discussed at divisional meetings each month. Further data was also monitored monthly which related to the views of patients and their relatives. The comments made by patients and relatives were used when needed to change practice on the units. We saw that when an issue had been identified a response and action plan was put in place and this information was put on notice boards to inform relatives of the plans for change. Two relatives told us that at a time when they felt a loss of control they had found this openness reassuring.

Patients and their relatives felt care was safe. We observed care being given and saw staff following the safety checking policies provided by the trust to promote patient safety. These included infection control procedures such as hand hygiene and medicine management policies to reduce the risk of medicine errors.

We saw that the environment of the three units within John Radcliffe Hospital varied as the cardio thoracic and neuro-critical care units being more updated and larger clinical areas which were easier to clean and had better storage. The adult intensive care unit was less suitable for purpose. However, the staff on each unit received the same safety information and followed the same procedures to maintain safety for patients.

Learning and improvement

Staff told us and records showed they learned from untoward events.

Intensive/critical care

All serious incidents were recorded through the incident reporting system and were investigated and discussed at the divisional governance meetings. Staff told us that learning from all of the critical care units was shared to develop and improve practice. We saw that an incident had occurred during a patient transfer. As a result of the following investigation a training need had been identified and a programme to suit the needs of the trust devised and implemented. All critical care staff had received transfer training to promote the safety of patients during hospital transfers.

Systems, processes and practices

Systems for patient records were managed safely. The patient record systems in place varied between each unit. The cardiothoracic and neuro-critical care units had completely electronic records. The adult intensive care unit had a mixture of electronic and paper records. The electronic records were not all compatible with each other and none were compatible with the rest of the hospital. The trust told us there were systems in place to accommodate this.

Nurses used an electronic system for care records and information. This excluded do not attempt resuscitation records. Doctors maintained paper records. While there was a variation, staff confirmed that this did not affect the safety of patient care. All electronic stored information was backed-up and could be transferred into paper records in preparation for transfers to other wards when patients were discharged. We saw that systems relating to medicine administration had been identified on one unit as a risk. This was because the medicine charts were stored on the computer and the medicines were stored in a locked cupboard by each bed, away from the computer. New policies and procedures were being planned to inform staff how this should be managed in a procedural way to prevent medicine errors taking place. Electronic prescribing systems had been implemented and staff told us that this worked well and was effective for patients and staff.

Infection control and hygiene was monitored and the results made public on each unit. The trust's infection rates for *Clostridium Difficile* and MRSA lie within a statistically acceptable range, taking into account the trust's size and the national level of infections. On the adult intensive care unit hand hygiene was assessed at only 87% completed and cleaning at only 83%. The matron advised that ongoing works takes place to review all areas audited. We

observed good hand hygiene taking place in all areas. However, we noted that staff did not adhere strictly to the uniform policy with hair touching collars and earrings which was not in line with the trust policy.

Monitoring safety and responding to risk

Monitoring systems were used to make improvements to safety and work practice. As a result of identification of patient delays to admission and transfer, in December 2013 a programme of action had been developed to change how the units managed their admissions and discharges. Changes included a review early each morning to establish if beds would be available for the planned theatre admissions that were known to have a need for a post-surgery critical care bed. This enabled staff to communicate earlier with theatre staff to plan the theatre lists and promoted a more effective way of working.

The critical care departments recognised and understood risks. The managers for each critical care unit decided what risks were escalated to the service risk register and how they were to be managed.

All deaths on the critical care units were reviewed to inform and direct current practice. Monitoring of mortality included comparisons to other trusts. We saw that ICNARC data from first two quarters of 2012/13 showed that all three units had a Standardised Mortality Ratio (SMR) that lay comfortably on or below (better than) the mean value.

Anticipation and planning

Planning has taken place to develop the critical care and high dependency beds needed by the trust. The considered lack of high dependency beds meant that there were delays discharging to the wards from critical care units. The lack of critical care beds meant patients deteriorating on other wards did not have swift access to higher dependency beds. We were also told that a lack of high dependency beds impacted on planned surgical operations taking place and in some cases caused these operations to be cancelled. A business case had been submitted to the trust as staff had identified the demand for level 2 high dependency beds.

Further agreement had also been reached for three consultant posts to be filled to support the critical care units.

Are intensive/critical services effective?

Intensive/critical care

(for example, treatment is effective)

Good 

Using evidence-based guidance

Patients received care in line with national guidelines.

We saw that the management of skin damage by pressure or moisture damage was effective. A tissue viability nurse was available on the unit who ensured staff were kept up to date with new methods and equipment. Trolleys of dressings had been made available on the unit to enable staff to access the equipment they needed quickly and easily. Nursing staff showed us that tissue viability was included on their observation records to prompt them to seek review and records included a wound care plan if seen to be needed. All grade three damage was recorded as a notification to inform the hospitals auditing process. This was discussed at clinical governance reviews to consider if the current methods of management were effective. The tissue viability lead audited all pressure damage daily and the auditing showed a reduction in skin damage. Any learning outcomes were shared across all of the critical care units. However, it was noted that the high health risks of patients receiving critical care often meant that pressure damage could not always be avoided.

The management of deep venous thrombosis was recorded electronically and staff reviewed equipment and medication needed routinely to reduce the risks to patients of thrombosis. A warning on the electronic recording system reminded staff to complete this area or reminded them if a review was due. Staff monitored any urinary tract infections and reviewed the cause. Recording of all of these areas was open to the public as results were made available on notice boards on each unit.

Performance, monitoring and improvement of outcomes

Outcomes for patients were good.

Mortality rates, which are measured nationally, had not been raised as an area of concern at John Radcliffe

Hospital. Patient transfer to other departments and hospitals in the night had reduced and any transfers at night were reviewed and investigated. The ICNARC data for the first quarter of 2013 showed that there were delays of four hours and above for patients being discharged from

critical care units. The Matron assured us that latest data had showed this trend had slowed and was improving. Staff confirmed a significant improvement in delays of discharge.

We saw from the electronic records that recording of consent was not prompted by the electronic system. However, discussions with staff and observations of care being provided showed that while not well recorded consent was actively sought on all levels including consent to provide personal care and included consent to change position.

We reviewed records for those patients who had a decision not to be resuscitated in the event of a cardiac arrest. We saw that they had been fully completed and staff explained what action would be taken should the patient not be able to participate in the decision process. They demonstrated a good understanding of whose best interests must be served. Staff told us that at each handover the status for resuscitation was confirmed and that reviews of the decision not to resuscitate were taken before the patient left the department.

Staff, equipment and facilities

Patients told us “They [staff] have been marvellous” and “They are worth their weight in gold”.

Relatives also told us: “The care has been excellent, I know what is going on, I am kept up to date on any changes or an issue on the unit with my relative” and “staff are just fab!” Two relatives said that while they had no criticism about staff but sometimes wished there were more staff available to prevent the wait needed to turn patients to relieve skin pressure. However, they told us that at no time was the quality of care compromised.

There were sufficient medical staff and consultant staff available 24 hours per day and 7-day cover was provided on all critical care units. Medical cover was rotated every three to four weeks over the John Radcliffe and Churchill Hospital adult intensive care units. Doctors felt well supported and had unlimited access to senior medical staff.

A pharmacist was allocated to each critical care unit and reviewed all medical prescriptions daily to ensure sufficient stocks were available and they were available to advise on all areas related to medicine practice.

Intensive/critical care

Staff told us that sometimes they felt that they were very busy but staffing levels remain stable with agency and contingent workforce staff made available when needed. Staff told us there was no pressure to work extra hours. This was despite the NHS staff survey in 2012 which said that the percentage of staff working extra hours was worse than expected. The recruitment and retention of nursing staff remains a problem area for nurses due to the geographical location of the hospital. This has been raised to the divisional and directorate risk register for the trust.

The trust continues a foundation training programme for all nursing staff to ensure sufficient training in critical care. This included competence assessment and observation of care being provided. An induction programme took place for all new staff and they confirmed it was informative and sufficient at the start of their critical care role. Further specialist training packages were available to support staff. A mentorship programme by band 7 nurses provided further support to new and existing staff. An education lead nurse was available and told us that sufficient support and resources were available to ensure training and support was provided to all new staff. Weekly training sessions took place, tissue viability and moving and handling training took place during inspection, and we observed band 5 trained nurses shadowing more experienced staff to observe practice.

Staff told us that they were proud of the units they worked on and enjoyed having the time to provide the highest level of care. They told us the hospital provided them with good learning and development opportunities and that discussions with Matron were always possible to highlight any ideas they had. Staff survey results highlighted a shortage of information and support for staff to deal with difficult situations. As a result a psychologist had been visiting the units to support staff to manage challenging and emotionally difficult situations.

Staff worked between three hospitals and a system was in place whereby staff rang a taped message each morning to find which unit they were worked on that day. Staff told us that this system was not a problem to them.

Facilities in the cardio thoracic 19 beds, coronary care unit six beds and neuro-critical departments 13 beds were of a high standard. The departments were purpose-built designed with input of experienced critical care staff. Here was capacity for level two and three patients. This meant that patients who required artificial ventilation could be

cared for as well as patients with less intensive needs but still had needs which could not be met on a main ward. Staff had identified a need for further reception staff to cover the evening as this was found to be a shortfall in the "front of house" service provided.

The adult intensive care department was equipped for up to 19 patients with a flexible arrangement with Churchill Hospital to accommodate up to 24 patients between them. The trust's bed occupancy average for July to September 2013 had been higher than the England average and above the recommended rate of 85%. However, for critical care beds, the trust's occupancy rates had been lower than the England average for the period of September to November 2013. During January 2014 the adult intensive therapy unit ran in excess of the 19 beds at around the 108% capacity by creating extra bed space. This was due to the high demand for critical care and high dependency beds.

The adult intensive therapy unit was less spacious and suitable for purpose. Care was provided and the areas managed as well as staff could. However, the single rooms were noted to not all have natural light, no overhead hoist equipment and very limited space. Male and female patients were cared for in the same space; however, curtains were available around each bed for privacy and dignity.

Accommodation was available on all of the units for relatives to stay overnight. There was also a sitting room available for staff to explain to relatives what was happening and for the delivery of poor news. The adult intensive care unit facilities of these areas was of a much lower standard than the other critical care units due to the lack of purpose built accommodation.

Staff told us that they had sufficient equipment to meet the needs of the patients. We saw that equipment storage was an issue on the adult intensive care unit and areas appeared cluttered due to the lack of sufficient storage space. All equipment was maintained as needed and most equipment had self-alert indicators when there was a fault or service was needed.

Multidisciplinary working and support

Multidisciplinary working was in place to support patients across other areas of the hospital.

We saw the input of therapies on each critical care unit, including physiotherapist, dietician, and occupational therapists to promote the health and welfare of patients.

Intensive/critical care

We saw that wards and units communicated with each other to ensure effective smooth transitions of care. The “follow on team” who visited critical care patients who had improved and moved on to wards worked with ward staff to support patients and staff told us they appreciated and valued this input. The management of organ donation was managed within the critical care units and staff were aware of the procedures to follow and the access to contact information for transplant services.

Are intensive/critical services caring?

Good 

Compassion, dignity and empathy

Patients and relatives spoke in the highest terms about the staff and the care they had received. They said staff had explained to them at each stage what was happening and treated them at all times with dignity and respect. We saw staff reacting calmly to requests for information and showed the upmost kindness and compassion to patients and relatives. Relatives told us they appreciated the continuity of staff over 12 hour shifts and felt seeing the same staff again gave them confidence and support.

Patients said they felt well cared for. There was not an outreach team available in the hospital to visit and assess deteriorating patients with a view to admission to the critical care beds. There had previously been an outreach team but this had become a discharge support team to support those patients discharged to medical or general wards. A system was in place to alert staff to the level of deterioration considered to be in need of critical care. There was a system in place for ward staff to contact the critical care team to review patients whose condition had deteriorated. Staff told us that the “track and trigger” monitor in place on the wards was effective. There were systems in place to review how this alert system was undertaken and its level of success.

Involvement in care and decision making

Patients and relatives told us that they had felt as involved as they could be in the decisions about care and treatment. One relative explained how a difficult situation around sedation had been handled. They said: “The most awful situation was handled as best as it could be”. They explained that the rationale for sedation had been explained repeatedly until a clear understanding by the

patient and relative could be established. The relative told us that doctors and nurses had treated the patient “as an intelligent human being” and how this had been appreciated.

Trust and communication

Patients and their relatives said they spoke regularly with doctors and nurses about their relatives care and treatment. Two relatives told us that they had observed the nursing staff explaining to their relative, despite them not being conscious what they were doing and why. The family found this comforting. Relatives told us that they had seen a doctor soon after their relative was admitted and had been updated regularly.

Relatives told us that staff were “excellent” and “brilliant” at keeping them informed and updated.

Emotional support

Emotional support was provided both during admission and after discharge from the critical care units.

A focus group of patients had been developed to discuss issues that had arisen following discharge. Information from that was used to effect change on the units. This included an understanding of why patients remembered and suffered from bad dreams and how this could be communicated during admission to emotionally support patients while they were in hospital.

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

Good 

Meeting people’s needs

Staffing levels followed national guidelines about caring for critically ill patients. This meant that for a level three patient they received one-to-one care. For level two patients they would share one nurse between two patients. This was because they had less critical care needs.

The matron told of how improvements to practice on the critical care units had meant that patients were not as delayed to leave the units. However, the transfer of patients to wards following an improvement in condition was dependant on the availability of beds in the hospital. Delayed discharges were audited and the findings reviewed

Intensive/critical care

as part of the divisional governance meetings. ICNARC data also indicated that for the early part of 2013 there was an increased amount of delayed discharges out of critical care beds.

Significant efforts had been made to prevent out-of-hours discharges to wards or transfers to other hospitals. In the month prior to our inspection only one transfer to another hospital, out of hours had taken place. This had been a considered decision as an urgent bed was needed and the patient had been previously identified for discharge.

Once a patient was discharged to another ward the department had a follow up nurse who supported critically ill patients elsewhere in the hospital. Initially they were seen by the follow up nurse within 24 hours. After that the follow up nurse would review and assess what support the patients and nursing staff needed. We received positive information from ward staff about how they found this to be very supportive. Should a patient be transferred to the Churchill Hospital, the follow-up nurse would contact the follow-up nurse there, and ensure a continuity of care.

Vulnerable patients and capacity

Patients who lacked the mental capacity to make a decision were supported. Staff received training in the safeguarding of vulnerable adults and showed a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. For those patients who lacked the capacity temporarily to make decisions, decisions were made by medical staff in their best interest. This was recorded to include the rationale for the decision and who was involved.

The cardio thoracic critical care unit was developing dementia care practice and a lead for the role, a band 7 nurse, had received training and was cascading this awareness to other staff. Identification of the difference between patients experiencing delirium as part of their critical care and those patients with a level of dementia was being classified by the use of a flower indicator. "Forget me not" stickers for patients with dementia care needs and a daisy for those patients experiencing confusion were being used.

Visits can take place by the hospital chaplain to support the spiritual needs of patients, relatives and staff regardless of their beliefs and a 24 hour on call service is provided.

Access to services

Over 1,200 critically ill adults were admitted to the two adult intensive care units at John Radcliffe and Churchill Hospital per year. Facilities were available for relatives or carers to be able to stay close by to the critical care units. We saw that the accommodation for the cardio thoracic and neuro-critical care units were superior to that of the adult intensive care unit. However, all relatives or carers accommodation included information about what to expect from each unit, information relating to visiting times and facilities and how to raise a concern.

Leaving hospital

Patients were discharged with appropriate information. It would be very rare for any patients to be discharged home from the critical care units. Patients who left the unit for other wards or hospitals had a record of their electronic notes produced to accompany them. The shift co-ordinator would check all discharge processes had been completed to ensure a satisfactory outcome for the patients. Any issues around discharge would be raised with the staff team to promote learning. The electronic systems in other parts of the hospital were not compatible with the electronic recording on the critical care units. Should the patient be sent to another hospital, sufficient information (in printed form) was provided to inform the receiving hospital.

The hospital maintained a policy that no patients would be transferred between inpatient areas for non-clinical reasons between 8pm and 8am. This included transfers from ward to ward and transfers to other health providers outside of the trust. Staff told us that every effort was made to adhere to this policy and a notification is made to record when these transfers take place. This enables an audit trail of incidents for review.

Learning from experiences, concerns and complaints

Each critical care department captured patient feedback. This included results from the "friends and family test", complaints, and comments. Each unit also requested information via their own questionnaires. We saw that all information received had been reviewed and planned actions to make changes available on notice boards. Comments had been received about noise levels at night.

Intensive/critical care

An action seen to address this problem was that ear plugs and sleep masks were made available, bins were being changed to be quiet closing, and staff were being made aware of the need to be quiet at night.

Staff told us that they received feedback from notifications, complaints and patient experience feedback.

Are intensive/critical services well-led?

Good 

Vision, strategy and risks

Staff were clear about the trust vision for the future. They explained they had been involved in the development of the vision and felt involved in the strategy and future of the trust. Some staff felt the executive board were more visible than others. Some staff did not know who their divisional lead was or who to contact with any board level questions.

Governance arrangements

The critical care departments monitored the quality of its service. The critical care leads from each department met monthly. This was an opportunity to discuss any issues and feedback from complaints, review notifications, or areas of concern. The divisional governance meetings were attended by managers from each unit and there is a plan in the future for the units to spend some of this meeting time visiting each unit to expand learning. Risks were also discussed at this time and review of critical care areas which may need escalating to the trust risk register.

Leadership and culture

Staff teams from each critical care department were well led. The matron who oversaw the critical care units was clear about the development and direction of the units. Unit managers were considered highly by the staff on each

unit who told us they felt supported by the management and able to make suggestions or raise concerns. Staff told us that they felt supported by all of the experienced staff on the units and were able to ask for support or help at any time.

Board walk-arounds took place and staff felt able to approach board members at this time to raise any questions or views. Medical staff told us that they found the board supportive to ensuring standards of care were maintained. Management staff told us they felt listened to and involved in decisions which changed the service.

Patient experiences, staff involvement and engagement

Staff felt part of the hospital and wider trust.






Complaints were managed via PALS and staff told us that there was communication with families and learning taken from outcomes of complaints.

Patient satisfaction questionnaire feedback for July to December 2013 was seen and was mostly positive. Areas covered included care, environment and discharge planning, actions were planned to address any issues raised.

Learning, improvement, innovation and sustainability

Staff we met said they felt encouraged within their department to be innovative. They were able to attend national conferences, and had training and development support. We joined a group of band 7 nurses following a training session which they were supported to have to develop and support their practice. We saw email newsletters for nurses to keep them updated and signpost them to training and policy updates.

Maternity and family planning

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

Information about the service

The John Radcliffe Hospital maternity unit serves the local population and the surrounding areas and is part of the Oxford University Hospital Trust. The maternity units across the whole trust delivered 8,777 babies in the year from 2012 to 2013 and cares for women with acute needs who may require specialist care.

The maternity service is a consultant-led unit. There is a dedicated labour suite which consists of 13 delivery rooms, one of which includes a birthing pool and two observations rooms. There are two dedicated theatres attached to the maternity department. There is contingency to open a theatre in the delivery suite should there be a requirement to close one of the permanent theatres, thereby ensuring two theatres can always be in operation. This provides care and treatment to women for elective and emergency caesarean sections. There is a 10-bedded observation area for women who are in the immediate post-caesarean section phase of their recovery as well as women who require close monitoring, including women receiving antenatal care or postnatal care with complex health needs and are of high risk and having their labour induced. There are also three wards providing both antenatal and postnatal care, and a four-bedded, midwife-led unit where antenatal, delivery and postnatal care is provided.

As part of our inspection at the John Radcliffe maternity unit, we sought the views of people using the service. We spoke with 22 patients and their relatives and 24 staff including doctors, midwives, consultants, midwifery support workers, and other allied health professionals. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for some of the patients. We gathered further

information from data we requested and received from the trust. We undertook interviews, ran focus groups, and listening events where staff and members of the public were consulted. We looked at comments cards, surveys and the process for the management of complaints by the trust. We also reviewed information regarding their internal quality assurance and compared their performance against national data. We used all the information to plan and inform our inspection.

Maternity and family planning

Summary of findings

Women received care and treatment from caring, compassionate, and skilled staff. We received positive comments from women and their families about the care and support they received.

The delivery suite had been without a manager for the 18 months prior to our inspection due difficulties in recruitment. Elements of this role were being covered by three band 7 midwives, but this did not provided consistency in the management of the delivery suite. Although the delivery suite provided women in labour with one-to-one care, staffing levels were not always sufficient to ensure women received the care and support they needed. Recruitment that had occurred was of newly qualified midwives who needed support from the experienced midwives within the department. This added further pressure to those staff. In addition newly qualified midwives reported not receiving adequate preceptorship. There were insufficient supervisors of midwives in post to meet guidance from the Nursing and Midwifery Council. There was insufficient consultant presence within the delivery suite to meet national standards, although midwifery staff reported that consultants were supportive.

Despite this the maternity service was effective. Care and treatment was mostly provided in line with national guidance, with the exception of a higher number of forceps deliveries and best practice with regards to supporting new mothers with breast-feeding was not always followed.

The patients were safeguarded from the risk of abuse. Staff had received training in safeguarding and were aware of the process to report any concerns. These ensured patients were not put at risk as appropriate safeguards were in place.

There were systems in place for the safety of the patients and staff. There was equipment for the safe management of patients which included bariatric tables in the theatres and beds in the unit. Training and support for the staff was promoted to ensure safe working practices.

Women and their partners told us they received kindness and compassionate care from staff, although

the hospital had lower than expected scores in the “Friends and Family tests”. They received sufficient information in order to make informed decisions about care.

The maternity unit was clean and staff followed the internal procedures for hand washing. Hand gels were available at different points and visitors were encouraged to use them. Staff had completed training in infection control to ensure women and babies were protected from the risk and spread of infection.

The service was responsive to women and their babies’ needs. There was cohesive multidisciplinary working; staff commented this worked well with good support from clinicians at all levels which in turn had positive impacts on patients care.

There were clinical governance strategies and regular meetings which looked at development of the service. Staff felt supported within the ward and units; however they told us they felt disconnected from the wider organisation.

Despite the absence of a manager in the delivery suite, the service was well led. Staff reported that they felt supported by their immediate line managers and there was suitable governance processes in place.

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement 

Safety and performance

Women and their babies were protected from abuse and staff were trained to deal with suspicions of abuse. Training records showed 85% of staff, were trained in safeguarding children and vulnerable adults at the appropriate level for their role in the department. Staff were aware of the signs of abuse and the appropriate actions and systems for reporting allegations of abuse. Mothers to be were assessed in the community as part of their antenatal care and information about patients who were at risk was shared with the staff in the department. A coding system was used to ensure this information was not missed and women and their babies continued to be safeguarded on admission.

Information from the risk register showed the trust had identified potential security concerns regarding newborn infants and vulnerable adults. As a result an anti-abduction policy was developed and agreed in October 2013 by the clinical governance committee.

The safety and wellbeing of patients undergoing caesarean sections was protected. The World Health Organization's (WHO) surgical safety checklist was actively used in operating theatres. The WHO safety checklist was developed by the World Health Organization, and requires all of the theatre team to engage and accept joint responsibility for ensuring that safety checks are undertaken at each defined stage of the surgical procedure, thereby minimising the risk of the most common and avoidable errors occurring. The care records for two patients showed these had been completed.

There was insufficient midwifery staff within the department to meet the needs of all patients. There were systems in place to divert midwifery staff to the delivery suite to ensure women received one-to-one care during the critical stages of labour. However, this involved moving midwives from other areas of the maternity department including areas where high-risk patients with complex health needs were situated. This left those areas short staffed and women and their babies' needs were not always met. One ward midwife said they were often left on

their own to care for up to 35 mothers and babies, when midwives were diverted to work on the delivery suite. The head of midwifery stated that in situations such another member of staff would be assigned to help (this would generally be a maternity support worker not a midwife) but the midwife would not be left on their own.

On level 7, where there were patients who needed significant emotional support as well as ongoing ante and postnatal care, there was only one midwife and one midwifery support worker at night. This was not sufficient to ensure that women and their babies received the treatment, care and support they required. For example, there was a baby who was receiving antibiotic treatment because they were at risk of developing an infection after their birth. This required the baby to have observations of their condition every six hours, including temperature monitoring to ensure that should an infection occur, it could be treated promptly. There was a form in place within the baby's notes in order that this monitoring could be documented. However, this had not been completed for over 24 hours.

There was a 10-bedded observation ward to the side of the delivery suite. This ward provided antenatal and postnatal care to high-risk patients. This included those who had severe pre-eclampsia, were having labour induced and had complex health needs, and women who were post-operative, having had their babies delivered by caesarean section or those who required surgery following their delivery. There were only two midwives providing treatment, care, and support to these patients. The hospital, in monitoring the staffing using their own acuity tool, had identified this as an area where there were not sufficient staff. Managers that we spoke with could not tell us what was being put in place to rectify this.

Although there were specialist breast feeding midwives within the hospital, we saw that women did not receive sufficient support to continue to breast feed their babies if they found it difficult. Breast feeding was started on the delivery suite by midwives. However, midwives reported that they did not have time to provide sufficient support to new mothers to continue breast feeding. This included having time to demonstrate techniques to support the baby and mother. The trust told us that maternity support workers also provided support to women with breast feeding.

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There was no manager in place for the delivery suite. This role had been vacant for about 18 months at the time of our inspection. There had been attempts made to recruit to this role. However, these had been unsuccessful. Elements of this role were being covered by three band 7 midwives, over three days a week. The trust told us in addition to this, the head of midwifery was acting down to provide additional clinical support. Prior to this arrangement two midwives had been acting up into this role in a job share arrangement. Although these arrangements were in place there was a lack of consistency in leadership within the delivery suite.

A maternity staffing paper to the trust board in May 2013 identified that the midwife to birth ratio in the hospital was 1:32–1:33 which was outside the national guidance (Safer Childbirth October 2007) which was a minimum ratio of 1:28. This resulted in midwives being moved from clinical areas into the delivery suites to ensure that there was adequate staffing to ensure safe births. The paper stated: “having considered the national guidance, the financial implications and the need to provide a safer service, the Head of Midwifery believed the service could currently be provided safely with a ratio of 1:30. However, if the activity and acuity should significantly increase beyond current levels, there would be a need to revisit the staffing requirements.” Data from January 2014 showed they were achieving a midwife to birth ratio of 1:31. An update on maternity staffing to the trust board occurred in October 2013 and staffing remains under review.

The national standard for consultant presence on the delivery suite of the size of the hospital is 168 hours per week. The hospital was achieving a level of 72 consultant hours per week dedicated to supporting the delivery suite in January 2014. Within the same Maternity staffing paper, there was an aim to increase the consultant presence to 120 hours per week which meant an increase in 3 whole time equivalent consultants. This had not changed since May 2013 when the maternity staffing paper was accepted by the trust board. There was no information about the actions being taken by the trust to rectify this other than the acknowledgement that the level of consultant presence on the delivery suite required increasing.

The maternity staffing paper also referred to a recent audit highlighting delays in the care of women undergoing Induction of Labour (IOL) and Elective Caesarean Section. This stated “Some women have to wait in excess of 17

hours within their IOL process because of the pressure within the service; this is unacceptable.” The staffing levels within the hospital have not improved significantly since this time. Where recruitment has occurred this has been of newly qualified midwives, which has placed additional pressure on existing midwives within the hospital. Newly qualified midwives reported that they had not received suitable preceptorship (specific supervision and support which is required to be provided within a nurse or midwife’s first year following qualification in order to maintain their registration and progress in their career).

There were not sufficient numbers of supervisors of midwives (SOM) within the hospital. The role of the supervisor is to protect the public through good practice. They empower midwives and student midwives to practice safely and effectively. As supervisors they provide support, advice, and guidance to individual midwives on practice issues, while ensuring they practice within the midwives rules and standards set by the NMC. Each midwife meets with her SOM at least annually. The head of midwifery reported this was a ratio of one SOM to 30 midwives (1:30). The guidance from the Nursing and Midwifery Council states that there should be no more than 15 midwives supervised by one SOM (a ratio of 1:15).

At the time of our inspection there had been no further formal staffing review of the maternity services by the hospital or the trust since October 2013.

Learning and improvement

There were effective processes in place to capture incidents. Staff were aware of how to report incidents if one occurred. These incidents were discussed at the clinical governance meetings which occurred on a quarterly basis. A quality, risk, and audit newsletter shared information with staff.

The staff on one of the wards told us about their current “topic of the month”. This followed incidents of retained swab and policies had been developed about the strict management of swabs and an action plan was developed to minimise the risk of recurrence. On the delivery suite another example of learning for incidents related to the change in practice in the drug management of women having an eclamptic fit as a result of high blood pressure.

A senior member of staff told us of specific training which was initiated for staff following increase in abruptions (a complication of pregnancy where the placenta partially or

Maternity and family planning

completely separates from the lining of the womb) which had been present during the initial assessment of the women. Consultants had run training in CTG (cardiotocograph) monitoring of fetal heart rates in order to develop staff experience in identifying complex issues which are easy to miss.

Systems, processes and practices

There were monthly clinical governance meetings within the maternity directorate, and a monthly incidents claims and complaints group. Unexpected term admissions to the neonatal unit were reviewed in multidisciplinary meetings, and unusual or complex CTG tracings were reviewed on the delivery suite. These discussed issues arising in order that action and learning could be identified.

A monthly infection control audit for hand washing was completed and the results were displayed to inform staff and visitors to the unit. There was a system for the frequency of re-auditing depending on the score achieved and this could be as soon as one week. There was clear information for the staff about infection control. This meant infection control was taken seriously and action taken to protect women and their babies.

Monitoring safety and responding to risk

The hospital had systems in place in identifying risk and ensuring patients were in the most appropriate place for their care and treatment. Women from surrounding areas including Horton General hospital were referred to the hospital for obstetric care. For example women with type one or two diabetes, or gestational diabetes were cared for here and were monitored during their pregnancy by a specialist diabetic midwife. A “silver star” team monitored all women with diabetes through the ante- and postnatal stages and on admission. This ensured they received care appropriate to their needs and specialist advice and support was provided to the midwives.

There was a system in place for the monitoring of severely ill women both during pregnancy and immediate post-delivery. This process was well established and they used the modified early obstetric warning scoring system (MEOWS). Information from the clinical negligence scheme for trusts (CNST) report from November 2013 showed these were not always consistently completed and may impact on the level of care. Action had been taken and these were complete in the records seen.

The record for a patient following a post-partum haemorrhage (PPH) showed records were not fully completed. The fluids records were completed but these were not totalled up to ensure the input and output volumes as required were clear as this formed part of the management of PPH.

Arrangements were in place for the management of medical emergencies. On each unit there was an emergency trolley appropriate to deal with babies and adult emergencies including resuscitation. The equipment and the emergency drugs were in place and daily checks were completed. A record of the checks was maintained to ensure the emergency equipment was fit for purpose. Staff received training in resuscitation (including neonatal resuscitation) and this was updated on a yearly basis as well as training in obstetric emergencies such as breech deliveries and the management of severe post-partum haemorrhages.

Anticipation and planning

The maternity unit had a comprehensive clinical governance structure in place to record and report incidents and other concerns. Maternity staffing was reviewed annually across the trust. The birth rate within Oxfordshire has risen by 18% between 2002 and 2012. The hospital used Birth Rate Plus for assessing managing the midwifery workforce levels. This is a recognised tool developed for maternity services to assess the staffing level needed. This informed the number of midwives required based on clinical needs and risk. Midwifery staffing levels were reviewed across the trust prior to our inspection and recruitment was ongoing. Despite this there were not sufficient staff to meet people’s needs.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good 

Using evidence-based guidance

There were policies and procedures in place on the trust intranet which staff confirmed they were able to access.

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The maternity services training policy was available to all staff at induction. There were also clear procedures and guidelines which were adhered to in relation to the termination of pregnancy.

The delivery of care and treatment was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). Records showed that the department followed specific care pathways to ensure the patients received care appropriate to their needs. On the maternity unit the “immediate care of the newborn guidelines” had been updated to reflect NICE guidance. The trust had introduced the newborn early warning score chart (NEWS). The NEWS observation chart was used to identify any deterioration in a baby’s condition and reported to the midwife and paediatrician caring for the baby. This meant action could be taken at an early stage and appropriate intervention put in place.

There was a variety of information based on research and NICE guidance which were available to inform mothers. These included choosing induction or waiting for labour after rupture of membrane, caesarean sections and low molecular weight heparin (LMWH) for the prevention of clot formation.

However, at times NICE guidelines were not followed. This included when using equipment, for example, forceps or ventouse cups to assist and enable delivery. Trust data showed a higher rate of forceps delivery than expected. Staff said this was due to a particular type of ventouse device being withdrawn from use by the trust and a lack of staff knowledge relating to the alternative. This had resulted in medical staff reverting to using forceps to assist delivery. The maternity dashboard showed the trust target for ventouse and forceps delivery was 10-15%. The data for January 2014 this was higher than expected in the previous quarter at 16.4%.

The staff used “fresh eyes” system for women who were having CTG recordings during labour. This involved getting a second opinion from the lead co-ordinator on the delivery suite, usually on an hourly basis, to look at the CTG interpretation and tracings. This followed good practice guidance as recommended by the NICE guidelines (2007) ensuring any changes to the fetal heart rate and pattern are not missed.

The hospital was not accredited as a “baby friendly” site through the UNICEF baby friendly initiative. This is an

initiative set up by UNICEF and the World Health Organization, designed to support breastfeeding and parent infant relationships, by working with public services to improve standards of care. This provides a framework for the implementation of best practice by NHS trusts, other health care facilities, and higher education institutions, with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. NICE guidance refers to this initiative as a minimum standard. We were told the hospital was working towards this and a working group had been set up to achieve this. However, best practice in supporting mothers with breast feeding was not always followed. Bottle feeding was offered over the use of cup feeding because staff did not have time to provide the additional assistance.

Performance, monitoring and improvement of outcomes

The maternity service had achieved CNST level 2 status in November 2013. This involved a significant number and range of audits to be carried out both locally as well as participation with national audits. We saw that the outcome of these audits were discussed at monthly meetings and action plans developed in order to improve practices.

The trust had lower rates of both emergency and elective caesarean sections when compared with other trusts in England. Similarly the trust had a lower ventouse delivery rate, but a higher forceps delivery rate. There was no evidence to demonstrate that the hospital was working to reduce the rates of forceps deliveries.

Data was collected about the effectiveness of epidural and spinal pain relief, where patients’ views were sought. This looked at the effectiveness of pain control in order to ensure care and treatment was planned according to needs. Women reported that they received effective pain relief during labour and as necessary following delivery.

There was evidence that learning from incidents was monitored. For example, information from the trust papers showed changes in practice were implemented for perineal care. This had resulted in the reduction in third and fourth degree tears for women during birth.

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Staff, equipment and facilities

The trust risk register report in November 2013 a number of CTG machines were nearing the end of their service life. A bid had been placed for their replacements. We saw there were a number of new machines in the department.

Staff told us they had adequate access to equipment and at times they did borrow some equipment from the other wards. There was equipment for the safe management of patients which included bariatric tables in the theatres and beds in the unit.

There were systems in place for monitoring the temperature at which medicines were stored, including the monitoring of fridge temperatures. Medicines were secured appropriately.

Following the introduction of newborn early warning score (NEWS); one of the wards had received new monitoring equipment to ensure these were available to babies who required them.

The staff were not aware of a policy for equipment checking. During discussions with the manager of the technical engineer department we were told there was an electronic database held of all the medical equipment used in the trust. We heard equipment was not routinely maintained or serviced according to a fixed annual schedule. An appropriate service schedule was determined for items of medical equipment at the point of entry to the trust. In some cases, the service schedule might involve no routine maintenance unless a fault was reported to the department. We reviewed the equipment on the delivery suite and on the wards. We were told equipment was sent for repair or they were replaced if they were not working. Records of maintenance and servicing were maintained on a corporate database.

The environment was clean and safe with a programme of refurbishment.

Multidisciplinary working and support

There was good multidisciplinary working across the hospital and community maternity services and within other services in the hospital. Staff felt supported by specialist midwives responsible for bereavement, breast feeding, diabetes and also by allied healthcare professionals. We noted there was a supportive and open culture and staff felt well supported by the consultants. On the delivery suite there was consultants cover on weekdays

between 8am and 9pm. At weekends they were present between 8am-2pm or 9am-3pm and also on call cover was provided. We were told there were no issues with junior doctor and registrar cover for the unit.

Access and support was also available from physiotherapists which the midwives said was very valuable teaching for mothers. We saw detailed advice and guidance leaflets were available in relation to exercise, driving following caesarean section and general post-natal health and wellbeing.

Are maternity and family planning services caring?

Good 

Compassion, dignity and empathy

Women and their families were positive about the care and treatment they had received. They described staff as knowledgeable and compassionate. Some of the comments included: “the staff are excellent and caring”. We were told the staff were welcoming and addressed patients by their name. We saw consent was sought prior to an intervention.

We observed women’s privacy and dignity being maintained within the maternity unit. On the labour ward doors were kept shut and we saw staff knocking prior to entering. On the wards the privacy curtains were used and patients commented “the staff always make sure the curtains are closed.” Another patient told us “having privacy is not a problem as you can pull the curtains.”

Involvement in care and decision making

Women were informed and involved in the decision about their care. Records showed women were involved in making decisions about their care and consent was sought. Women and their partners were involved in their care through ongoing consultation. This started at the antenatal stage and continued throughout their care. Decisions about tests for fetal abnormalities and the options available to the patients were fully discussed. This included a patient who had elected to have a termination of pregnancy after the diagnosis of a severe fetal abnormality had been made, following discussion and advice from staff in order to assist them to make an informed choice.

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There was inclusive discussion between midwives, doctors, women and their partners about treatment. This included discussing the pros and cons of treatment and the provision of verbal and written information to assist women to make informed choices and decisions. Women also told us they were fully informed and consulted about the birth plan including plans about elective and emergency caesarean sections. Comments included 'it was all discussed at the clinic about my options to have caesarean section' and 'I was reassured about having an epidural when I saw the anaesthetist.' Women were well informed about the possibility the birth plan may not be followed if they required emergency intervention.

Trust and communication

Communication between the midwives, women and their families was good. Women and their partners were supported and able to ask questions. Women said the midwives were very good at listening and provided support. They felt they had confidence in staff and trust and communication was good. We observed advice given over the phone to women and partners, was clear and provided reassurance.

Staff used a recognised communication tool when taking a woman to the delivery suite from the wards. This ensured the communication included the situation; background; assessment and response required were recorded and shared in the interests of the patient.

Women and their partners described their experience of care as positive and were complimentary about the care and support they received. Throughout the inspection we observed staff discussing care, support and changes which occurred in relation to the women and their babies. These ensured women and babies continued to receive appropriate and effective support and care according to their needs.

There was a variety of information and leaflets appropriate to the maternity unit. There was also a breast feeding café which had been well received by new parents. Advice and guidance was provided on family planning to women on the postnatal ward and followed up by midwives during the postnatal visits in the community.

The friends and family test showed 85% of women would recommend their postnatal community service to friends and family.

Emotional support

Arrangements were in place to provide emotional support to patients and their family in a sensitive manner. There was a bereavement specialist midwife and pastoral care service available to support women, partners and their families if they chose. There was a separate bereavement suite facility to provide privacy and support at such difficult times. This ensured women, their partners and their children had the opportunity to have private time.

Advice and support for antenatal complications and termination of pregnancy for fetal abnormality was managed sensitively and staff told us a counselling service was available and shared with patients.

Women and their partners were positive about the emotional support they received from midwives and support staff. A patient commented they had received "excellent support when I needed help with breast feeding". Another comment was "the staff are marvellous and they are there for you." A breast feeding specialist midwife was available to women to offer practical and emotional support. The trust target for initiating breast feeding was over 78% and they had achieved 79.7% in the last quarter.

One of the wards had received a grant from the Department of Health to develop two new family rooms to support women with mental health problems. This would ensure these patients receive care and support in appropriate surrounding to meet their needs.

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

Good 

Meeting people's needs

The needs of the women were assessed and birth plans were developed to meet those needs. There was an observation ward adjacent to the delivery suite where women were admitted for closer monitoring. Two patients who had been receiving care in the observation unit said "the care was very good" and "they kept a close eye on you". One person was kept informed of the frequency of blood tests they needed as they were receiving insulin infusion and the dosage was titrated according to their blood sugar levels.

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Staff were able to monitor the fetus in labour via telemetry. This meant women could be mobile and active in labour and where desired, could still access the birthing pool while continuous fetal monitoring continued. This meant higher risk women for example those wishing for VBAC (vaginal birth after caesarean section) were not automatically excluded from using the pool.

Specialist midwives were employed to provide support for the patients and staff. These included staff with leads roles in diabetes management in pregnancy, breast feeding, drug and alcohol problems and teenage mothers. Post natal advice and support was available to assist mothers with incontinence and bowel problems.

Translation services were available. Information and contact details were provided for patients who needed an interpreter. Information was also available in other formats such as braille, large print, audio version and in languages other than English.

Staff said delays in getting a translator could impact on women's care particularly regarding pain management. A process was in place to ensure that information regarding the need for a translator to be gathered and recorded during antenatal visits. This would ensure early booking for this service was initiated.

Care plans were detailed and contained information including fetal and maternal well-being, diet, hydration, pain control, and mobility. All women had a venous thromboembolism (VTE) assessment to assess their risk for blood clots. Where risks were identified, treatment plans were in place which included anti-embolic stockings.

There was no facility for women to administer their own medicines. Staff told us this was due to medication errors and decision was taken at trust level to remove this facility. The patients we spoke with were not aware they could take their own medicines. We received positive feedbacks regarding support and availability of pain control.

Vulnerable patients and capacity

There were policies and procedures in place regarding the Mental Capacity Act 2005. Staff were knowledgeable about these processes. All staff had received training in safeguarding adults and children.

Patients who were at risk of domestic violence were supported and advice was available to them. Staff followed

the care pathway for patients with mental health problems and were able to access support from external professionals to help and support these patients. A mental health assessment was completed as required.

There were neonatal abstinence procedures for treatment for babies born to mothers who had used drugs. There were clear guidance on the monitoring process for these babies and their management.

For mental health patients, the trust had introduced new stickers to act as a reminder for midwives to follow at 28, 32 and 40 weeks. This ensured patients were tracked and strategies put in place to meet their needs.

Access to services

Information indicated access arrangements were adequate and there were no issues with access to care. Staff, women and their partners, confirmed this. Patients told us they felt the service was good and served the community well. Patients told us they came out of the county and made positive choices to use the service at the John Radcliffe Hospital. The trust had specialist teams of midwives such as drug and alcohol support and teenage pregnancy midwives which ensured care and support was available to wider community and those hard to reach. They held clinics to provide support and advice to effect maternal and child wellbeing. There was also a good support from the community midwives team which ensured women continue to receive continuity in their care.

Leaving hospital

There were appropriate arrangements to ensure safe discharge planning were followed for women and babies. Some patients told us their discharge was planned during antenatal visits. We observed the discharge process for patients on different wards and found staff followed processes. For patients who lived within the Oxford catchment areas, the discharge information were faxed to women's GPs and the community midwives at the time of them leaving hospital. This ensured information was shared appropriately and follow up appointments were not missed.

For patients who came from outside the county, the midwives initiated a phone discharge process and followed these by letters sent by post. At weekends staff telephoned the community teams to ensure they were aware of patients who had been discharged. Patients were also advised to ring the maternity unit if they did not receive a

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visit from their midwives within a specific timeframe following discharge. This ensured mothers and their babies were seen by their community midwives at the appropriate times and continued to receive care and treatment/support as needed. Take home medicines were dispensed from the pharmacy and staff said this at times did cause delays on discharge. Other advice such as wound care and perineal care and “your recovery after childbirth” were issued to the patients.

Learning from experiences, concerns and complaints

Concerns and complaints were discussed monthly at the women’s services clinical governance meeting and also reviewed by the risk manager. We received positive feedback from patients about the care and treatment they were receiving. They were aware of the procedure to raise a concern. Staff told us they would speak with their immediate managers if they had a complaint or concern, but said they would not raise concerns at trust level.

There were clear policies and procedures available to women and their partners about how to raise their concern. We saw leaflets were also available in different areas of the wards and delivery suite. Patients could also contact the Patient Advice and Liaison Service (PALS) if they needed support about raising concerns. This information was displayed and available in different formats and languages which supported patients’ diverse needs.

Complaints were collated on a quarterly basis and looked at any recurrent themes and root causes. This was presented at the maternity quality meeting and women’s services clinical governance meeting. Changes were introduced which included appointing a breast feeding specialist midwife.

Are maternity and family planning services well-led?

Good 

Vision, strategy and risks

The trust newsletter for January 2014, described the development of a teenage and pregnant parent (TAP) service to provide support to women under 20 years of age.

This service was aimed at teenagers to provide information and guidance on pregnancy, birth and antenatal checks were also provided. This initiative was to encourage them to use the service and support this age group.

There was effective teamwork in the department, and staff were considerate there was effective communication between all grades of staff. There was a process of looking at risks and these were discussed at the monthly clinical governance meetings. These were multidisciplinary team meetings and actions on risks were discussed from previous month and were either closed or taken forward for further reviews. New risks were discussed and designated staff were allocated to take action within a set timescale and feedback at the next meeting and added to the risk register. Progress against actions was reported. They also considered how these risks may impact on other departments.

The clinical governance lead and risk manager met on a weekly basis to review unplanned neonatal admissions and admission to intensive care unit. They monitored any trends such as the increase of grade 2 pressure ulcers for women following caesarean sections. Actions plans were developed including review of mattresses and position of women in recovery. There was a strategy in place for escalation of risks and staff felt confident in raising them.

Governance arrangements

Governance arrangements ensured that responsibilities were clear. Quality and performance were regularly reviewed and any concerns or problems identified were discussed and strategies developed to address them. There was a system of learning from incidents. There were ongoing audits including the “maternity dashboard”. This was a system of monitoring and reporting on the quality, safety, and key performance indicators within the maternity unit. This formed part of their monthly risk strategy meeting where this was discussed and action plan developed.

This included sharing of good practice and learning from adverse events and occurrences which was shared among a multidisciplinary team. The maternity unit was represented at governance meetings and feedback to staff was provided.

Leadership and culture

Decisions about care and treatment were taken at the appropriate level. There was a lead co-ordinator on each



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ward who was available to co-ordinate the overall management of the unit. While the delivery suite did not have a manager, they had a midwife who undertook a co-ordinating role for each shift.

The staff said there were good working relationships between the medical staff, midwives, and other professionals. Staff received good support from their immediate manager and were comfortable to raise their concerns at local level. Senior management and other staff we spoke with were clear about the trust vision and values. Staff told us they were satisfied with the local management arrangements, but they felt disconnected from the organisation and trust board. Comments from staff included “[we are] all looking out for each other”. The staff were confident in calling out the on-call consultant and said they always received a positive response.

Patient experiences, staff involvement and engagement

Staff were positive about working in the maternity unit and said they were proud to be working there. They said there was excellent team working and felt well supported by colleagues and their immediate managers.

Women said they found the staff at the maternity unit very good or excellent. They felt the staff engaged with them positively and provided care and support according to their needs. However, the friends and family test scores were quite low: Only 34% would recommend the hospital antenatal service to friends and family and 64% would recommend the post natal care. The highest score was for the labour ward/birthing unit where 68% of patients said they were extremely likely to recommend the service to friends and family if they needed similar care.

Staff had regular staff meetings and received information from newsletter which were sent out quarterly. The ward meeting minutes from February 2014 provided staff with updates on care and changes in practices and e-learning to be completed. Staff commented the meetings were good and they were able to raise any issue such as staffing.






Learning, improvement, innovation and sustainability

Staff received regular appraisals and this was an opportunity to discuss their personal development. The appraisal rate in maternity was 92.3%. All midwives received resuscitation training and were reminded they needed to complete the e-learning part of this prior to attending the training. This included basic life support for the midwife support workers. In addition, midwives and doctors all received training in the management of obstetric emergencies.

Staff were involved and contributed to various studies with Oxford University which included fetal growth, eclampsia and vitamin D studies which would have a direct impact on future management of patients.

The trust quality and risk audit highlighted the current problem with providing tongue tie service for babies. This was currently provided by the paediatric service with a prolonged waiting time which impacted on the babies. The trust was looking at strategy of training midwives to carry out this service as an extended role.

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

Information about the service

Children's services in Oxford are based at the children's hospital on the John Radcliffe site. This is a purpose-built environment. The hospital provides care for children from birth to 16 years of age. There is dedicated children's outpatients department although some clinics do take place in other areas of the hospital such as the ear nose and throat (ENT) department. Services provided include cardiorespiratory, gastroenterology, acute medicine, haematology, oncology, neurosciences, specialist surgery, general surgery and neonatal surgery. There is also a paediatric intensive care unit (PICU), paediatric high dependency unit (PHDU) and a neonatal intensive care unit (NICU). Adolescents are catered for within their own dedicated ward. There is also a ward which is dedicated to providing care to adolescents. The hospital has play areas and a school to cater for all children's needs. The children's hospital also has facilities for families.

Summary of findings

We visited all the wards in the children hospital including the PICU, the PHDU and the NICU. We spoke to 45 members of staff. This included health care assistants (HCAs), student nurses, staff nurses, midwives, senior nursing staff, doctors, registrars, consultant, and anaesthetists, operating department practitioners, nurse practitioners, administration staff, physiotherapists, and play specialists. We also spoke to 14 parents and relatives, three children and two young people.

Parents, children, and young people were positive about the care and support they received. They told us they were kept informed and involved in making decisions. Staffing levels were considered when managing the number of beds available to be used. The trust was aware of areas where additional staff were required and they were actively recruiting to these areas. Staff told us they felt supported and the children's hospital was a good place to work. There were systems in place to ensure children at risk of harm or considered to be of concerns were identified and protected if seen in the hospital. Staff were aware of how to report incidents and this information was monitored, reviewed and learning shared with the staff. There was an established governance system in place that included monitoring complaints, incidents, outcomes from audits and the adherence to national guidelines. Young people's opinions and input was actively sought through the Young People's Executive.

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Are children's care services safe?

Good 

Safety and performance

Systems were in place to ensure the safety of the children on the wards. For example, areas were secured with swipe card access for staff and an intercom system for others. We observed staff confirming the identification of people at the door and checking with them the purpose of their visit. All staff were wearing picture identification. Children had two identification wrist bands in place. We witnessed staff checking the child's identification before the administration of medication and on transfer to theatre to ensure the right child was receiving the treatment. We observed check lists being completed before and during the transfer of patients to the operating theatre, into recovery and back to the ward. The purpose of these checks being to ensure the correct person received the correct procedure.

All the staff we spoke with were clear about their role in reporting accidents and incidents. There were 54 incidents in the children's hospital three considered to have caused harm but were not serious. The staff survey in the children's and women's division showed one percent reporting they had witnessed an error that could cause harm which was not reported. Ninety eight percent of staff who responded to the survey said they were encouraged to report errors. There was an established system in place to provide feedback to staff about incidents. These including internal emails at ward levels which identified trends and actions. Incidents were also discussed at the children directorate governance meetings. This was evident in the minutes from these meetings that we reviewed. One member of staff on the NICU told us about changes made to the way one type of antibiotic was administered following an incident. They confirmed that they had learned about the change through emails and that as a result of the incident there had been a change in policy on the unit.

There had been a recent incident when the number of patients on the PICU was above capacity for the staffing levels. The increased number of patients on the PICU had been reported using the Datix reporting system. We reviewed the information and found the correct escalation procedure had been followed. A team approach had been

taken to address the issue. A review of occupancy within the children's hospital was undertaken, patients that could be, were discharged home which freed beds on the wards. This meant children from PHDU could be transferred to the ward, and patients from the PICU could be moved to the PHDU. By the end of the day the situation had been resolved and there was additional bed capacity within the children's hospital.

Systems, processes and practices

There was good oversight of bed capacity in the children's hospital. The bed manager undertook regular rounds to check bed capacity and staffing levels. It was clear from discussion with staff that the number of staff was considered when establishing the number of beds available. At the time of our visit four wards were running at reduced capacity due to staffing levels.

Steps had been taken to help control the risk of the spread of infection. All areas we visited were found to be clean. Personal protective equipment, such as gloves and aprons, was available and staff were using these to help prevent the risk of the spread of infection. We observed there were hand-washing facilities available and accessible as was hand gel. All the staff were observing the hospital's "bare below the elbow" policy. We observed staff cleaning equipment and saw that clean equipment was labelled to identify it as ready for use. Side rooms were available in all areas to prevent the spread of infections. A parent whose child had an infection told us toys were provided which were washed before being given to other children. Staff told us that cleaning staff were available 24 hours a day to deep clean side rooms if there were concerns about the risk of infection.

There were systems in place to safeguard children. A training programme was in place with three levels of training which reflected staff roles in the hospital. Information for the trust showed that as of November 2013, 85% of staff had completed level 1 training, 80% level 2 and 76% level 3, plus 69% in midwifery. This was below the trust's target of 95% compliance. All the staff we spoke to were aware of their responsibilities to safeguard children and had completed training at the appropriate level.

There was a lead nurse and a named nurse for children's safeguarding. There was also a named midwife and named doctors for children's safeguarding at the hospital. Staff confirmed they were available to support them. There was an established system for identifying children on the at risk

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register or of concern on the hospital's electronic records system. We saw this included information about the social services team working with the family. We were told this was accessible throughout the trust and this was confirmed by staff on the wards. A printed copy of this information was also sent to the emergency department. There was a monthly safeguarding children's forum where cases were discussed to ensure learning. Any learning was further cascaded using a document called "at a glance".

Learning and improvement

The trust had taken action to reduce the risk of harm from tissue extravasation incidents. This is when fluid from an intravenous infusion leaks into the surrounding tissue. We saw that infusion sites were checked to ensure early detection of any extravasation. We saw that where extravasation injury occurred an investigation was undertaken. The aim was to review the care given and to establish if any changes in care practises were required to reduce the risk of these incidences happening again.

Minutes from the children's directorate quality committee meeting showed that complaints, critical incidents, "Doctor Fosters" alerts, mortality, outcomes from audits and national guidelines were discussed and the risk register reviewed. These discussions included information on learning and action taken.

Monitoring safety and responding to risk

The 2013 to 2014 NHS standard contract for paediatric intensive care states "children requiring continuous nursing supervision, and who may need ventilator support (including CPAP) or support of two or more organs systems require 1:1 nursing". We were told that the PICU was funded for eight beds. The children's critical care workforce plan for 2013 to 2014 showed nine registered nurses per shift which included one shift co-ordinator. We reviewed the staffing rota and allocation diary for the PICU for the 36 days prior to our inspection. While during that period there was only one occasion when the occupancy level went up to and above eight patients, at no time was there enough staff on duty to open all eight beds for patients requiring one to one support. The bed manager told us that to manage this, the unit was only open to provide care in six beds.

The trust had acknowledged that there were challenges with staffing both the PICU and the NICU. Information provided by the trust showed that the NICU had a budget for 169 staff although there were only 127 in post, with 25 members of staff either on maternity leave, about to start

maternity leave or on sick leave. In addition there were 34 vacancies for nursing staff and health care assistants. The aim was to staff the unit areas (low dependency, high dependency and intensive care) in line with national guidance. When we reviewed the staffing rota for the NICU for the five days prior to our inspection we saw that agency staff were regularly used and some staff worked overtime in order to staff the unit. On occasions staff from in different areas of the NICU would support each other and some staff from the PICU and PHDU would also be flexible and move between units. The trust was actively undertaking a focused recruitment drive for the NICU in an effort to increase their staffing levels. In the meantime action was being taken to maintain safe staffing levels.

On the wards staff told us they had enough staff and when there were issues with the staffing levels or staffing skill mix there was an escalation policy to follow. We were told that beds could be closed if extra staff could not be located.

Information provided by the trust indicated that consultants were employed to fill existing posts in all areas of the children's services. Although a business case had been submitted for two to three more general paediatricians. The PICU was covered by three locums and three full-time consultants. Middle-grade medical posts were filled by specialist trainees and grid trainees in most specialties though we were told there were some gaps in middle-grade doctor appointments. There was no evidence that this was a concern or impacting on outcomes.

An orthopaedic consultant told us that they had no concerns about the number of nursing staff or the skill mix. A senior staff nurse on the paediatric surgical ward told us that they were confident that the ward was safe with senior staff acting as coordinators on shifts.

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

Good 

Using evidence-based guidance

We saw that guidance, policies and procedures were in place and were regularly reviewed to ensure they remained in line with current best practice. We reviewed the policies and procedures for the paediatric medical department and those on the NICU and found this to be the case.

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There were two sets of guidance relating to the care of the critically ill child for the PICU and there was some confusion as to which was the correct set to be used. One set had been developed with the Southampton Hospital as part the Southampton/Oxford Retrieval Team agreement. These were found to be current and in date. We were told that these were the ones that should be used and that the others would be removed.

There was an established system to review and monitor compliance with National Institute for Health and Care Excellence (NICE) guidance. We reviewed the results of a review of compliance with the use of sedation in children which had been conducted by the trust. Areas of non-compliance had been identified, action plans put in place, monitored and a re-audit conducted which had shown improvements. The children's and women's divisional quality report for December 2013 indicated that 10 sets of guidance had been reviewed and the trust was compliant with all bar one. This related to epilepsy in children and young people. A paper had been drawn up to address these issues.

Children and their families told us that their pain was assessed and they received timely pain relief. A mother of a baby on the surgical ward said "there was excellent pain relief when needed." A young person told us there were no problems with getting pain relief. Patient records showed that a pain score chart, devised specifically for use with children, was being used. We saw in one child's records, that following surgery their pain was assessed and monitored in the recovery area and then on return to the ward.

There was a system in place to support staff in identifying when a child's condition was starting to deteriorate to enable early intervention to ensure that care needs could be effectively managed. This included transfer to the critical care facility if required. Records showed that a paediatric early warning scoring system (PEWS) was in use. However, there was no paediatric critical care outreach team to support staff in the management of deteriorating children. We were told a paediatric critical care outreach team had been a piloted. As a result of this it was established that the current PEWS tool was not ideal for all settings and patient groups. Therefore, two further projects had been commissioned: one was to explore unplanned admissions to PICU/HDU to review the notes and PEWS to see if deteriorating children requiring critical care were

identified appropriately. The second project was to trial a range of PEWS tools to assess their suitability. There was no time frame for these projects to be completed. This demonstrated that the trust was reviewing the use of nationally-recognised tools to ensure that were meeting the purpose for which they were designed. In the interim staff on the PHDU told us that they responded to requests from the ward staff for advice.

Play specialist were involved in ensuring that child understood what was happening and why. This process included the use of toys, models of equipment and pictures. A young person told us that they had been fully informed and involved in making decision about their care including consenting for their operation.

Multidisciplinary working and support

In all areas we found that multidisciplinary team working was effective. For example the physiotherapist on the PICU told us that cover was available 24 hours a day. They said that there was good communication via the multidisciplinary meeting held each morning. A mother was complimentary about staff and their liaison with the home care team. We observed good multidisciplinary working with the anaesthetist, operating department practitioner and nurse practitioner working together to calm and prepare a child for theatre. There was a relaxed approach with the child involved in the discussion. This had a positive outcome with the child laughing when transferred to the anaesthetic room.

The handovers that we observed were multidisciplinary with staff listening to each other. For example, on the NICU we saw an open discussion with everyone involved. Nursing staff were involved in the handovers and ward rounds although we did not see any nurse on the medical ward handover.

There was multidisciplinary working to safeguard children in the hospital and in the community. Data and information was shared with the paediatric liaison health visitor in the community, link social workers and school nurses.

Staff, equipment and facilities

All new members of nursing and administration staff attended a trust induction and an induction to their main area of work. How this was managed varied from department to department. On the NICU there was an established pattern with staff working in the different nurseries, completing competencies and progressing to the

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next nursery at a pace agreed by them and their mentor. This meant their skills and knowledge were considered as part of the allocation of work. One experienced more senior member of staff felt that their induction had not met their needs, although they had received some support from the unit educational lead. A new staff nurse on the PICU said they had felt well supported and had had a good mentor. An administrator told us that their induction had including training on the use of the IT system which was key to their role.

Staff were clear about the trust expectation for them to complete mandatory training. Many staff told us that they did this at home in their own time. On two wards we were told by staff if they produced evidence that they had completed all their mandatory training during their annual appraisal they were then given time back. Nursing staff told us that they were further supported with developmental days either as teams or according to their grade or role. Staff were trained in either basic or intermediate children's life support, with medical staff and staff in the intensive care areas receiving European paediatric advanced life support training.

Medical staff confirmed they had an educational supervisor and clinical skills supervisor. A Registrar told us that they felt well supported.

Staff told us that generally equipment was available when they required it. We reviewed a selection of equipment and found that electrical equipment testing dates varied, according to the labels on the equipment, with the oldest being 2002 and the most recent being January 2014. It was not clear when equipment had last been serviced although equipment was labelled with barcodes. Monitors in the PICU were on the risk register as they were no longer manufactured and if they broke would need to be replaced. We checked the emergency equipment on three wards and found that it had been checked and all equipment was available according to trust policy.

Are children's care services caring?

Good 

Compassion, dignity and empathy

All the parents we spoke to were positive about the caring and supportive nature of the staff. They said the whole

family was well cared for and they were kept informed of and involved in making decisions. In the NICU one mum said "they have encouraged me to help with [my child's] care and they are thoughtful ensuring that my dignity and privacy is considered when we are having 'skin to skin' time." We observed caring interaction between patients and staff and parents and staff. A parent on Robins ward said they received an excellent service from the team. A second parent was equally as positive saying they had brilliant care. A third parent told us that they felt communication was very good with the medical and the nursing teams.

Staff told us there was a very good chaplaincy team who offered support to both families and staff where hard to hear news was given and or a child died. Information from the mortality and management meetings showed that families were involved in making choices and difficult decisions. They also demonstrated staff showed a caring approach with staff being complimented for their approach in sensitive and difficult situations.

Involvement in care and decision making

We followed a child and parent through from the ward to theatres and back to the wards. The parents were enabled to be with their child until they were asleep. We saw that good humour was used to relieve the child's anxiety and the while process was smooth and completed without incident. The parent was also able to meet their child in the recovery area.

We reviewed a sample of responses to surveys for Kamrans ward and the PICU. Results demonstrated that parents felt that they were given enough information to understand what was happening and felt that they were involved in making decisions.

Emotional support

Play specialists were available in all areas although they were not available all of the time. One play specialist told us that they worked with the psychologist, teachers and nurses to ensure that distraction and developmental play was prioritised. We saw that play was used to help children understand their treatment and to prepare them for investigative procedures and operations. Parents were positive about the support and input from the play specialist.

A mother on the PICU told us they were involved as much as they wanted to be in their child's care. Over the four

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weeks prior to our inspection they had felt supported. Another mother, on the surgical ward, who had some health challenges of her own, told us the staff were careful about considering her needs as well as those of her child. She commented that she was very happy with the surgeon, who explained everything well and would not hesitate to recommend the ward to others.

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

Good 

Meeting people's needs

A hospital school supported children to continue their education when in they were hospital. This was seen to be particularly important to the young people on the adolescent unit.

The adolescent unit, a facility designed to meet their needs; it was managed inclusively and provided care and treatment for young people from all specialities. Nursing staff were clear that they could not be an expert in all areas and actively sort guidance and advice from their colleagues.

In response to an increased demand on beds the trust had looked at other ways of ensuring that children received their treatment. For example, the trust had arranged for children who were well but required physiotherapy, to stay at a local hotel rather than using a bed in the children's hospital.

In the months prior to our inspection, the children's clinical decision unit had moved to be closer to the A&E department. We were told this enabled an "ambulatory care approach" for children booked to return for a follow up to their attendance at the children's emergency department. The unit also provided 24-hour observation for some children. The move had also opened up more space on one of the wards, which after the recruitment of new staff would be utilised for paediatric medical patients.

Parents were positive about the facilities available to them including accommodation for them to stay and access to parking, although it was acknowledged this was a finite facility.

Access to services

Some parents expressed concerned about the number of different days they had to attend the hospital to see different specialists and said this was not co-ordinated. One family had faced some difficulties when they returned home to another county with no after care arranged. While parents were positive about their outpatient department experiences and the care they received they raised concerns about the time they had to wait.

There was a clear policy in place for the escalation of concerns relating to staffing levels. We saw from records seen that this system had been implemented.

Learning from experiences, concerns and complaints

The trust monitored and analysed complaints from patients in children's services. Information indicated 0.08% of patients who used women and children's services across the trust complained in the year prior to our inspection.

We reviewed information relating to six complaints which were included in the divisional quality report for children's services. Where the complaint had been up held action taken to prevent re-occurrence was included in the report. This demonstrated that complaints were taken seriously investigated and when required action was taken. In one instance, where a child's surgery had been cancelled, an apology was sent along with a new date for the operation.

We saw from the records of meetings that the loss of a child was discussed at multidisciplinary meetings including any learning from the events.

Are children's care services well-led?

Good 

Vision, strategy and risks

Staff throughout the children's hospital were clear about the trust's values and vision. New members of staff told us that this was included in their induction. Staff felt that the values were demonstrated in the work they did every day. Staff at all grades told us the appraisal system was in the process of being amended and rolled out and this was to be more values based. Staff involved in interviews were aware the trust had implemented a values based interview to recruit new staff.

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Risks inherent in the delivery of safe care for children were clearly identified on the hospitals risk registers. On the division risk register for children's and women, there was an entry about the 24-hour management of paediatric airways during paediatric resuscitations and paediatric trauma. This was because of a reduction in the number of medical staff confident in dealing with children's airway problems when children were admitted to areas outside of the children's directorate. The airway pager holder may be with an anaesthetised patient in theatre and unable to attend. We saw that a clear algorithm had been created and circulated which identified who should attend in these situations and the escalation process if the pager holder was unable to attend.

Governance arrangements

There was a system in place for the monitoring of performance and risk. We reviewed the children's and women's divisional quality report for December 2013. This stated that the report sought to enable the clinical governance committee to monitor the implementation of clinical governance activities within the division. The paper was relevant to two strategic objectives. Firstly, to provide high quality, efficient and innovative core services that meet the needs of the local patients and the challenges of the local health community. Secondly, to provide demonstrably excellent clinical outcomes and indicators of patient safety. Information included in the report related to patient experience; where positive feedback was shared. It also included information about incidents and complaints. There was additional information on compliance with NICE guidance, safeguarding, medicines audits, and staffing.

Leadership and culture

Staff told us that they felt supported by more senior staff. One of the registrars said that they felt well supported, with good relationships between trainees and consultants and between specialists. A consultant told us they felt there was good team work between specialities. They also said that they felt the directorate and the division was responsive and that the department was well led.

Newly appointed nursing staff and health care assistants told us that they felt well supported, received training to undertake their role and that supervision was available. A student nurse on the day care unit said that mentorship was good and supervision consistent with all staff willing to

answer questions. A staff nurse on the NICU told us that "generally the relationship amounts the staff is brilliant, everyone is supportive of each other, and they would recommend it as a place to work."

Patient experiences, staff involvement and engagement

Children and young people were involved in decisions and their views obtained through the hospital's Young People's Executive (YiPpEe). The trust had actively engaged with children, young people and their parents and carers. For example, A set of posters were created by the YiPpEe, to raise awareness of the standards of care and values, pertinent to younger patients. These were created using images created captions also written by the young people. Records of meetings also showed that members had been involved in obtaining feedback from their peers and in a review of the menu.






We saw from questionnaires that feedback was sought from families using the children's hospital about the care they had received; the information they had been provided with; the way they were treated and the environment. Those we reviewed were generally positive. Where improvement could be made these had been acknowledged for example one comment was "internet and phone connection would be helpful."

The staff survey from the children's and women's division showed that staff felt the service was well led: 67% of staff who responded to the survey felt that managers acted on their feedback and 66% said that team members met to discuss the team's effectiveness.

Learning, improvement, innovation and sustainability

We were told that all staff required an annual appraisal. Survey results showed that 71% of staff in the children's and women's directorate had received an appraisal. All the staff, who we asked, bar one, confirmed they had received an annual appraisal. Staff were positive about this and told us that their appraisal included a discussion about development and learning needs. A staff nurse on NICU was particularly positive of her experience and as a result was undertaking a neonatal course with support from staff on the unit. A new administrator told us that she was working her probationary period and would have a review at three and then six months.

End of life care

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

Information about the service

End of life care services were provided by the hospital based specialist palliative care team which included a specialist consultant and specialist nurse practitioners. This team were available to provide face to face support and advice to hospital staff from Monday to Friday during working hours. Out-of-hours, 24-hour telephone support was available from specialist palliative care staff based at the Michael Sobell House Hospice. The hospice is located at the Trust's Churchill Hospital site.

The wider specialist team included allied health professionals, a psychiatrist, bereavement and chaplaincy services. The specialist team provided support with end of life care in 30% of the 2,300 deaths per annum at the hospital. Patients were seen by the specialist palliative care team when they were already known to palliative care services or when they were referred to the service by ward based doctors or nurses. A palliative care link nurse system was in place which linked identified ward nurses to the specialist teams.

We visited five ward areas where patients regularly received end of life care including the Emergency Assessment Unit, and four medical wards, including two short stay wards. We spoke with 17 members of staff in a range of roles from clinical support worker and junior doctor to lead members of the specialist palliative care team. We spoke with four patients and relatives, observed care and treatment being given to people and looked at four care records. We also received comments from people at our listening events. End of life care for children was inspected under children's services.

Summary of findings

Patients received safe and effective end of life care based on evidence based guidelines, national standards, and protocols. Staff were caring and motivated. They demonstrated commitment to meeting patients' end of life needs and to supporting patients' relatives at this time. A specialist palliative care team was based in the hospital and provided advice, training and support to hospital staff from Monday to Friday. 24-hour specialist advice was provided by staff at Michael Sobell House hospice, based at the trust's Churchill Hospital. The hospital palliative care team were part of a wider specialist team who worked collaboratively across the Trust's four hospital sites and in the local community. A member of the team was the National Director for End of Life Care and chair of the Leadership Alliance for the Care of Dying People.

Feedback from patients receiving end of life care, and their relatives, was positive. They were well informed, had been asked what was important to them, and were involved in decision making. They told us that staff were sensitive to their needs and treated them as a whole person.

End of life care

Are end of life care services safe?

Good 

Safety and performance

The trust participated in a large national audit of end of life care in acute hospital trusts in May 2013 which included audit of recognition of the dying patient, patient records, and people's experience of the service. The results of this audit which would provide external comparative data and benchmarking information were awaited by the trust. No performance data regarding end of life care at the John Radcliffe Hospital was available at the time of the inspection.

Learning and improvement

All staff said they were able to report concerns and incidents, most said they would escalate these directly to their line manager. More senior staff told us how they used the Trust's incident reporting system to capture risks and escalate concerns. Staff were not aware of written guidance from the trust about incident reporting requirements, or of any reporting requirements that were specific to end of life care. Staff decided which incidents they reported, sometimes with guidance from a more senior staff member. We found that lack of specific reporting requirements for end of life care meant that opportunities for learning and improving standards in this area may be lost.

During the inspection we learned of an incident which occurred on a medical ward at the hospital in 2013, where the prescribed medication for a person receiving end of life care had not been given due to a syringe driver failure. Staff told us that syringe drivers used for pain and other symptom control during end of life care were routinely checked every four hours. On this occasion the staff member was alerted to the patient's distress by family members and "as required" pain relief was administered. Staff administering the "as required" medication failed to check that the syringe driver was working as expected at this time and this was not noted until later. The patient's safety had not been compromised in this case but it was a concern that "as required" medication was administered without first establishing what medication the patient had already received.

The incident had been escalated to the matron by the ward sister and was addressed on the ward concerned, but was not entered into the Datix reporting system. This incident involved a newly qualified staff member and an experienced staff member. The staff involved received feedback about the incident and learning was shared with the ward team. As this incident had not been reported on Datix, or escalated beyond the ward matron, the opportunity to identify wider learning needs and to review the effectiveness of syringe driver safety checks had been lost to the wider organisation.

Once in the incident reporting system, incidents were escalated according to their impact and level of risk. This meant that unless a major incident occurred the response to the incident would be managed within the directorate it originated from. The Datix system could be interrogated to identify trends, which could then be reported on. Wider learning in the trust was communicated in the team brief which is an internal briefing for staff. Staff told us about changes to pressure area care that had been communicated via the team brief but did not have any examples of improvements that were specific to end of life care.

As responses to complaints and incidents were generally managed within directorates this meant that common themes relating to safety and quality of end of life care across the trust may not be identified. Senior members of the specialist palliative care team did not know the scale or nature of complaints/ incidents relating to end of life care across the hospital or the trust. The specialist palliative care team were located in the surgery and oncology division and were not informed of incidents or complaints involving end of life care in other divisions. This was significant as this team provided all teaching in end of life care to the ward-based palliative care link nurses and junior doctors across the trust. Training in end of life care was not mandatory for nurses or support staff, but learning was disseminated through the link nurse role. This included updates to equipment used, including syringe drivers.

Staff told us that there was good team support on the ward areas after patients had died. This included discussion of learning points such as response to emergencies. Staff

End of life care

expressed no concerns about patient safety in relation to end of life care as they felt supported by the palliative care team and had good access to specialist advice. They felt that this support had a positive impact on end of life care.

Systems, processes and practices

Standard operating procedures that reflect national and professional guidance had been established for the specialist palliative care multidisciplinary team. The hospital specialist palliative care team were based on site and supported staff in providing end of life care from Monday to Friday during working hours. Staff knew about the team and how to contact them and information about the service was displayed on posters in ward areas. Out of hours specialist support was always available by telephone.

Staff had access to clear information that enabled them to do their job effectively. Specific guidance for end of life care was accessible via the trust intranet. This included detailed guidance and documents to support advance care planning, discharge home for end of life care, pain and other symptom management. This was backed up by end of life resource packs containing hard copies of these documents, available on each ward and by support from the palliative care team. This resource pack was not available on all wards we visited. This meant that guidance and policies may be difficult for new or temporary staff to locate and refer to as they may not have intranet access.

Staff had received appropriate mandatory safeguarding training and demonstrated awareness of their role in reporting concerns and protecting people. Senior staff were aware of the systems in place to protect people within the hospital and how to access these. We heard an example of how a former patient with a learning disability had been protected. Requirements around resuscitation training and practice were clearly set out in the trust resuscitation policy. This included appropriate arrangements for Do Not Attempt Resuscitation (DNAR) decisions.

Monitoring safety and responding to risk

Four-hourly checks were carried out by nurses when syringe drivers were being used to administer medication to patients. This included checking the dose delivered against the dose remaining in the syringe and checking the battery life of the syringe driver. Nurses described verbal and non-verbal cues they used and feedback they sought from patients and/or their families, to assess the impact of medication on the patient. An early warning system, known

as “track and trigger” was used to identify deterioration in an individual patient’s condition. (Early warning systems use vital signs including pulse, blood pressure, respiratory rate and temperature to assign a risk score to the patient’s condition so that changes and risks can be readily identified and acted upon). Nurses told us that this system worked well as everyone understood the significance of the scores obtained. Guidance in the use of the early warning system was available on the trust intranet under the policy for identifying and responding to acutely ill inpatients.

Individual patient risks were assessed in advance of treatment. Nursing and medical staff in ward areas met each morning to discuss each patient and their plan of care. This meant they had regular opportunities to discuss concerns, or changes to the patients’ needs and to review these against the agreed plan. This could result in a referral being made to the specialist palliative care team or a change to discharge plans. One ward sister told us they were able to flex staffing levels if needed to support end of life care. Ward staff were happy with staffing levels which they told us had improved. Patients and relatives praised the level of care they had received and told us they had regular contact with the medical team.

The same approach was not possible in the Emergency Assessment Unit (EAU) as the number of admissions to the unit could not be controlled and patient’s needs were not predictable. In this unit patients were often admitted from home via their GP and were seen by a doctor with half an hour of their admission. Specialist staff were regularly called to see patients on the unit staff and senior staff were always available to support less experienced staff. Staff worked closely with the bed management team to ensure that patients were cared for in the most appropriate place within the hospital.

The hospital specialist palliative care team met weekly to discuss complex cases and participated in daily triage meetings to review and prioritise all new referrals.

Anticipation and planning

Where a Do Not Attempt Resuscitation (DNAR) decision had been made, this was clearly visible in patient’s records. The nine forms we saw had been completed appropriately and in line with the trust’s resuscitation policy. When patients were admitted from the community with a DNAR decision in place this was noted. Discussions with the patient or their family (as appropriate) had been documented.

End of life care

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

Good 

Using evidence-based guidance

End of life care was delivered in line with relevant legislation, current and new best practice and evidence based guidelines and standards. National reports and guidance following review of the Liverpool Care Pathway (LCP) were available for staff to access via the trust intranet. Staff worked in accordance with guidance issued by the Leadership Alliance for the Care of Dying People, as agreed by the trust Board in 2013. The trust was one of 69 trusts who had signed up to the “Transforming End of Life Care in Acute Hospitals” initiative, which was due to be implemented at the trust. This initiative provides a comprehensive service improvement framework and includes use of the AMBER care bundle which assists clinicians to identify and work with patients who are nearing the end of life.

Staff worked in line with the trust’s resuscitation policy which referred to European Resuscitation Council and the Resuscitation Council (UK) protocols.

Performance, monitoring and improvement of outcomes

The organisation participates in national clinical audit, reviews of services, benchmarking and clinical service accreditation. Mortality rates for the trust were within expected limits; a breakdown of mortality rates by hospital site was not available. The trust took part in the National Care of the Dying Audit in May 2013, the results of which were awaited at the time of our inspection. A recent audit of GPs showed that the trust specialist palliative care team provided timely and useful support to GPs providing palliative care in the community. This meant that patients were able to be better supported to receive end of life care in their own homes.

A business case had recently been submitted with the aim of improving standards in end of life care at the John Radcliffe Hospital in high-pressure/turnaround areas including the Emergency Assessment Unit, accident and emergency and medical wards. These areas were in the top 10 highest mortality spots within the hospital. We did not

see patient feedback or audits specific to end of life care in these areas but received mixed feedback from staff. This indicated that patients may benefit from additional end of life support in these areas.

Staff, equipment and facilities

The facilities and equipment in use reflected best practice and had a positive impact on patient outcomes. Staff were able to access the equipment they needed including syringe drivers, via the hospital equipment library. Switchover from Graseby to McKinley syringe drivers was included in the educational activity action plan for 2014. This change was being implemented in line with the Medicines and Healthcare Regulatory Agency (MHRA) requirements for infusion devices. Requirements for checking resuscitation equipment were set out in the resuscitation policy and compliance with these requirements was audited annually.

Wherever possible patients were offered side rooms to enable privacy and dignity at the end of life. Staff in the EAU told us they received effective support from the operational team, which enabled them to prioritise end of life patients to be admitted to wards and side room facilities.

Hospital palliative care team nurses received individual training to ensure they were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. End of life training for non-specialist staff was provided by members of the specialist palliative care team. As e-learning was not available, capacity for training staff in end of life care was limited. Two study days per year were available to palliative care link-nurses who disseminated learning to others on their ward. Additionally, 100 nurses, allied care professionals and 45 clinical support workers and housekeepers from across the trust’s hospitals had attended study days in palliative care in 2013. These sessions were fully subscribed. The specialist team also provided training to junior doctors and medical students as part of their education and induction programmes and some ward based sessions.

Two link nurses for palliative care had been identified on each ward we visited. We found that one of the three link nurses we spoke with had not completed any study days in palliative care but they were aware of the palliative care link group page on the intranet. Responsibility for identifying link nurses and making sure they attended study days lay with individual wards. Uptake of the role was not monitored centrally, so it was not clear if all wards had

End of life care

identified link nurses in place. These study days were well attended but staff were sometimes pulled off courses at short notice to meet staffing needs in their ward areas. This was significant as it meant equipment updates or new initiatives may not be communicated to staff on all wards. A ward sister told us that it could be difficult for nurses to find time to carry out link roles.

Multidisciplinary working and support

A multidisciplinary collaborative approach to care and treatment involved a range of providers across health and social care systems. An integrated advance care planning document produced jointly with the Oxford Health NHS Foundation Trust had been in use at the hospital since 2012. This was completed by the patient either with their GP or in hospital and was shared with ambulance services and uploaded to the trust's patient record systems. The specialist palliative care team ran a community based service, with nurses linked to GP practices across Oxfordshire. Telephone triage and day care services were provided from the Churchill hospital site.

Treatment plans for patients were determined with multidisciplinary involvement as well as the involvement of patients and those close to them (this includes proactive discharge planning, referral to other organisations and transitional arrangements). Multidisciplinary and hospital team meetings were held regularly to discuss treatment plans, including admission or referral to hospice or community based services. An end of life discharge planning checklist was used by staff to ensure that the right services and equipment were in place for patients on discharge. The fast track continuing healthcare pathway was used to support patients whose condition was deteriorating rapidly and wished to go home to die. The hospital's bereavement and chaplaincy services worked with community-based organisations to ensure that patients' religious needs were met and families were supported to make appropriate arrangements after their relative's death.

Are end of life care services caring?

Good 

Compassion, dignity and empathy

Staff demonstrated commitment to providing good end of life care which met individual patient's needs. They told us

how they 'pulled out all the stops' to make sure patients got home to die when this was what the patient wanted. Staff on the Emergency Assessment Unit (EAU) expressed regret and frustration regarding patients admitted to the unit from nursing homes for end of life care as the EAU environment was often busy, noisy and had limited private spaces. They worked with operational staff to make sure that wherever possible patients were admitted to a side room or ward where they could have privacy and dignity at the end of life. Despite the fact that this was not always possible, staff felt they made a positive difference for patients and their relatives.

Patients and their relatives on the medical wards told us that staff were very caring, kind, considerate and sensitive to their needs. They had been given options to keep them comfortable, they felt safe, they got what they needed, and nothing was too much trouble. Staff treated them as a whole person.

Involvement in care and decision making

Patients were able to refer themselves to the specialist palliative care team and could "just ask" when they wanted to speak with a member of the hospital team. They had regular contact with the doctors responsible for their care and were asked how they felt and what they thought. Patients were involved in discussions about their discharge and treatment plans and were informed about the progress of their illness. When they declined specific treatment options this was respected. Discussions with patients and/or their relatives around Do Not Attempt Resuscitation (DNAR) decisions were recorded in patient's records.

Written information for patients described the services and support available and gave contact information for the organisations concerned.

Trust and communication

Staff developed positive relationships with patients using the service and those close to them. Some patients got to know staff over the course of their illness, through repeated admissions or use of hospice services. When this happened, patients regularly chose the ward or hospice they attended as the place they wanted to die. We observed that staff communicated with patients in a respectful way. Patients and their relatives said communication was excellent and staff made sure they understood the explanations given. Staff had time for patients and were happy to repeat any information and answer questions.

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Staff respected the patient's right to confidentiality and used quiet rooms where possible when discussing options with patients. When the patient did not want their diagnosis shared with their relatives this was respected.

Emotional support

Patients were supported by trained staff to cope emotionally with their treatment and care during their stay in hospital. The Trust had recently established a psychological medicine service which was integrated with the hospital palliative care team. In addition to assessing and treating patients this service supported hospital staff to enhance the psychological care they gave to patients. Hospital palliative care nurses completed a course in advanced communication skills.

Hospital chaplains were available to provide pastoral support to patients and their families at all times. Chaplains ensured that patients' religious needs were met by arranging for a representative from their faith /religion to visit them if this was wanted. When issues were raised to them they signposted patients to the Patient Advice and Liaison Service (PALS) and when agreed reported issues in 'real time' to relevant staff members. This meant that any issues could be addressed directly in order to improve the outcome and experience for the patient.

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

Good 

Meeting people's needs

The trust actively engaged and worked with local commissioners of services, the local authority, other providers, GPs, patients and those close to them to co-ordinate and integrate pathways of care that met the health needs of the local population. The specialist palliative care team were part of the Oxfordshire End of Life Care Reference Group which worked strategically to ensure that the services commissioned in Oxfordshire met local need. The team had recently set out a commissioning proposal to improve palliative care services in the John Radcliffe hospital on weekends. If approved this would mean patients would have access to a member of the

specialist team seven days a week and specialist nurses would be on site to assist and support staff every day. The hospital team aimed to see all patients as frequently as the patient needed them.

Staff in the Emergency Assessment Unit (EAU) also told us that side (single) rooms not always available to patients for end of life care. This was due to having four side rooms in the unit and needing to manage competing priorities such as infection control risks. Due to the nature of EAU, this meant that end of life care was sometimes provided in a busy and noisy environment where conversations and actions could be overheard. Senior staff told us that EAU was due to be reconfigured to add more side rooms. The Trust reported on a survey of how side rooms were used in their 2012/13 Quality Account. This demonstrated that side rooms were offered to patients for end of life care where they were available. New builds included more side rooms. Facilities for relatives had been reviewed and priorities identified.

Vulnerable patients and capacity

The provider had a process in place to decide if a patient has capacity to consent and, where a patient did lack capacity, made sure that their best interests were assessed and recorded. The provider ensured that the needs and wishes of people with a learning disability or of people who lack capacity are assessed and monitored appropriately. Staff demonstrated understanding of the requirements of the Mental Capacity Act (2005) and told us how the requirements were met in their ward areas. Advance Care Planning discussions were captured on an integrated document which included reference to Advance Decision to Refuse Treatment/Living Will documents and Do Not Attempt Resuscitation (DNAR) decisions. This proactive approach meant that people with life-limiting conditions could record their wishes so they could be taken into account if they lost capacity to make decisions when the time came. We saw evidence that capacity assessment was undertaken appropriately and any best interest decisions were recorded. Guidance and policy documents contained appropriate and timely reminders to assist staff in ensuring requirements were met.

Access to services

The provider was proactive in taking action to remove barriers that people face in accessing or using the service e.g. making reasonable adjustments for disabled people and homeless people. Staff worked with County Council

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social workers to meet the needs of homeless people. This included referral to Michael Sobell House hospice for end of life care. Translators were available on the same day. In an emergency or with short notice a telephone-based service was available.

The chaplaincy team were mostly Christian with one Muslim part-time chaplain in the team of six who covered the Trust's four hospital sites. The team made sure patients received the support they needed by facilitating visits from an appropriate member of the patient's religious community, with whom the hospital had voluntary contracts. Chaplaincy services aimed to see all patients referred to them within half an hour and this was achieved in 90% of cases including times of high demand. Nurses had close working relationships with chaplaincy services who they described as "very responsive". The hospital had a small multi-faith prayer room which was accessed by an average of 250 people per day. Funding was in place to improve this room to enable it to be used more effectively by different faith communities.

Leaving hospital

Staff made sure that arrangements to discharge or transfer a patient met their needs and happened at the right time in their care or treatment programme. Options for care were discussed with patients and their views were sought. Patients told us they felt involved in discharge planning. They told us about decisions they had made, or options available and when these would be discussed. When patients expressed a wish to return home for end of life care they were referred to an occupational therapist early in the process, to assess their need for a care package including equipment or home adaptations.

Staff found that getting patients home for end of life care quickly could be a challenge but they were highly committed to making this happen and to ensuring patient's wishes were met. The average time to "fast track" a patient was 48 hours. Nurses on one ward described how the whole team worked together to get patients home, they often achieved this within 24 hours. Staff understood what services were available in the community and knew who they needed to involve. Staff also used the trust's Supported Hospital Discharge Service (SHDS) to facilitate timely discharge. This service provided home care for patients which meant that the hospital was less reliant on

other agencies to put services in place, so patients could be discharged more quickly. This initiative meant patients were not delayed in hospital unnecessarily when they were ready to return home.

Learning from experiences, concerns and complaints

The provider ensured that both its complaints procedure and ways to give feedback were easy to use. Services encouraged patients, their relatives and those close to them to provide feedback about their care. Patients told us they would speak to a nurse or staff member in charge if they had a complaint or concern to raise. Three complaints regarding end of life care at the John Radcliffe hospital had been logged in 2013 and one in February 2014. Investigations had been completed for two of these and these complaints had been partially upheld. One of these cases had been referred to the clinical governance team to make sure that a similar incident was avoided in the future.

The chaplaincy service signposted patients to the Patient Advice and Liaison Service (PALS) and reported any complaints or concerns to the medical or nursing team concerned to address in real time. Feedback was recorded in the chaplaincy service database, but this was not shared more widely to contribute to service improvement. This meant opportunities for resolving common, potentially more minor issues which negatively impacted on patient experience may be lost. In one of the four complaints received the complainant had not received a response from PALS.

The trust was piloting a real-time patient feedback system for end of life care at the Churchill Hospital and Michael Sobell House. The aim was to introduce a real-time feedback system across the trust's hospital sites.

Are end of life care services well-led?

Good 

Vision, strategy and risks

Improving end of life care was a quality priority for the trust in the 2012 to 2013 financial year and progress was reported in the trust's Quality Account for that year. Four key areas for improvement had been identified and these remained as key objectives for end of life care. A local tool had been developed and piloted to assist clinical staff to

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identify when patients were reaching the end of life. The trust decided not to pursue use of the local tool but signed up to the “Transforming End of Life Care in Acute Hospitals” initiative, which was due to be implemented. This initiative provides a comprehensive service improvement framework and includes use of the AMBER care bundle which assists clinicians to identify and work with patients who are nearing the end of life. A clear position had been agreed on use of Liverpool Care Pathway (LCP) and a discharge checklist had been developed and implemented to facilitate patient discharge home for end of life care. No risks had been identified in relation to achieving these objectives.

Governance arrangements

The trust committed to developing and implementing an annual audit programme in 2013 to 2014. The trust took part in the National Care of the Dying Audit in May 2013, the results of which were awaited at the time of our inspection. This was a robust audit involving over 200 hours of work to complete and would be expected to identify areas of good practice and areas where improvement was needed to meet national standards. A business case had been submitted by the specialist palliative care team with support of a board member, which included an administrative post to audit of end of life care. A local audit programme would provide timely feedback and assurance that local strategic objectives had been met. This was indicated as some risks identified on the trust risk registers may impact on achieving trust objectives. In particular, increased use of locum and agency staff to address achieve adequate medical and nursing cover.

Responsibilities for governance of end of life care were not clearly defined and understood by staff. Members of the specialist palliative care team did not have a clear reporting pathway through which issues or concerns about end of life care could be escalated to the trust board. They also did not know which board director has strategic responsibility for end of life services. The specialist team was located in the surgery and oncology division and worked in an advisory capacity to support other clinicians. This meant they did not have oversight of complaints and incidents relating to end of life care across the hospital and they had limited influence to drive improvement through all hospital divisions.

Leadership and culture

Staff demonstrated the values underpinning the trust’s “Delivering Compassionate Excellence” vision. Members of the specialist palliative care team and palliative care link nurses were especially well informed, highly motivated, keen to learn and contribute to improving end of life care. They were committed and passionate about getting end of life care right for patients. They were motivated to affect improvement and share their knowledge and expertise with their colleagues.

The specialist palliative care team provided leadership in end of life care. They worked strategically as part of Oxfordshire End of Life Care Reference Group, including submitting commissioning proposals to ensure that local needs were met. A member of the team was chair of the national Leadership Alliance for the Care of Dying People and National Clinical Director for End of Life Care. This meant initiatives and proposals made by the team were consistent with national priorities and quality standards. The team had submitted a business case to fund appointment of a second specialist palliative care consultant and two additional specialist nurses at the John Radcliffe hospital. The aim of this was to improve end of life care from the time of admission, particularly in short stay, high-pressure areas where there were many competing priorities.

Patient experiences, staff involvement and engagement

The trust was piloting a real time patient feedback system for end of life care at the Churchill Hospital and Michael Sobell House hospice. If successful the system would be rolled-out to the John Radcliffe hospital. The Friends and Family Test was used to collect comments from in-patients at the hospital and Patient Stories were used at the Quality Board meetings to address issues and share good practice. The trust held public meetings to hear people’s views in March and October 2013. These trust-wide initiatives covered all areas of patient care and were not specific to end of life care.

Staff who did not have an extended or specialist role in palliative care felt supported by their senior colleagues and through access to advice from the specialist palliative care team.

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Learning, improvement, innovation and sustainability

Senior staff demonstrated a positive attitude toward complaints and audit and described how they worked to support junior colleagues. This included coming in early or staying late on allocated administration days, to ensure they were available to staff on night shifts. They told us that issues raised by staff were taken forward. Senior nurses supported junior doctors to obtain appropriate guidance when prescribing pain relief as due to their inexperience in palliative care medicine they may prescribe less than was needed. Senior nurses felt supported by their line

managers and told us their concerns would be listened to. Staff in the Emergency Assessment Unit (EAU) told us that members of the board regularly visited the unit and they would be happy to raise any concerns directly to them.

The hospital specialist palliative care team were supported by the wider palliative care team. The team's operating policy included training and supervisory arrangements and expectations for team members. The team were part of the Thames Valley Strategic Cancer Network and contributed to training in the network, at Michael Sobell House and across the Trust.

Outpatients

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

Information about the service

The John Radcliffe Hospital provided 364,572 outpatient consultations in 2012/13, which accounted for 42% of the total trust-wide activity. The hospital provides outpatient services for general surgery, vascular surgery, cardiology, gastroenterology, trauma, neurosciences and specialist surgery. This included including Ear, Nose and Throat (ENT), ophthalmology, plastics, oral and maxillo-facial surgery. Outpatients for maternity and children's services were inspected as part of these services and are reported on under the relevant sections of our report.

Patients and commissioners raised concerns about delays in getting appointments and the potential poor impact this had on people's health and wellbeing. We were told that some clinics were overbooked, which meant some patients experienced long waiting times in clinics, particularly in ophthalmology. Healthwatch told us that long clinic waits impacted on volunteer drivers, as updates about waiting times in clinics were not always provided. In our survey in February 2014, people expressed frustration with the appointment administration system and told us that reception staff could be cold and unhelpful, offering no explanation or apology for delays. The Trust told us that outpatient administration was an area of significant challenge for them in ensuring quality of care and patient safety. This included access to appointments via the Choose and Book system and some people waiting longer for an appointment than the national standard.

We visited general surgery, vascular surgery, cardiology, gastrology, ENT, ophthalmology, oral and maxillo-facial surgery clinics. We spoke with 18 patients and 40 members of staff and observed staff interactions with patients.

Summary of findings

Patients received safe care because risks to patients were understood and were being managed. Hospital policies were based on national standards and evidence-based guidelines and adherence with these was monitored. An uncommissioned 10% rise in demand for outpatient appointments over the past year meant the Trust struggled to meet national standards for referral to treatment time (RTT) for patients. The Trust agreed to fail RTT targets for January, February, and March 2014 with the NHS Trust Development Authority, who provide oversight and governance for all NHS Trusts, to enable patients who had been waiting longest to be prioritised. This meant that patient safety was prioritised over meeting targets.

Patients were unable to book into appointments using the Choose and Book system on 50% of attempts as this could not be done online and there were not enough administrative staff available to answer calls and make bookings. This resulted in poor experiences for some patients when trying to book appointments, to make queries or change appointments. The way clinics were set up in booking systems did not make the best use of clinic facilities available, which meant that patients sometimes faced unnecessarily long waits to be seen in clinic. In order to address capacity issues, a trust-wide project was in progress to increase the number of appointments available and to ensure that clinic facilities were used more efficiently. This project was on schedule and was due to be rolled-out to clinics in May/June 2014.

Clinics and waiting areas were clean and well maintained but space was limited, which meant waiting

Outpatients

areas were often overcrowded. Initiatives were in place to improve the experience for patients and keep them informed of waiting times but these were not used consistently in all clinics.

Despite administrative challenges, patients were highly complimentary about the clinical care they received. Staff were appropriately trained, motivated, and worked well together to ensure that outcomes for patients were good.

Are outpatients services safe?

Good 

Safety and performance

There were effective arrangements in place for reporting patient/staff safety incidents and allegations of abuse, which are in line with national guidance. There are clear accountabilities for incident reporting and staff at all levels can describe their role in the reporting process, are encouraged to report, are treated fairly when they do, and get feedback on what has happened as a result. A trust-wide incident reporting system (Datix) in place, this was accessible to all staff and a password was not required, which meant incidents could be reported by any member of staff. We saw that outpatient clinics had a positive reporting culture, which meant staff were more likely to over-report than under-report concerns. Incidents were escalated to appropriate staff for investigation and agreed time limits for responses were adhered to.

The organisation understood internal/external performance indicators and reviewed performance alongside other information, for example, patient feedback and staffing levels. Concerns had been raised about patients having timely access to the Age related Macular Degeneration (AMD) service after sight deterioration was reported for three patients where access to care was delayed. This occurred following a change to National Institute for Health and Care Excellence (NICE) guidelines, which resulted in increased unanticipated demand on ophthalmology services. This was recorded on the Trust risk register which demonstrated the action had been taken to mitigate this risk.

Referral to Treatment (RTT) targets were not being met by the trust, this included delays in accessing specialist surgery, neurosciences, cardiology, endoscopy and spinal surgery. Despite these delays no other patient safety incidents had been reported in relation to waiting times or outpatient clinics. Staff said that despite being very busy at times, outpatient services were safe.

Learning and improvement

Incidents were categorised according to the level of risk/concern and were escalated accordingly for action and investigation. Root cause analysis was undertaken in relation to high-risk/major incidents which were captured

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on directorate or divisional risk registers. A review of the AMD service was carried out by the Clinical Director and additional clinics were run to reduce the waiting list in the special surgery directorate by December 2013.

A trust-wide initiative to increase the number of appointments available, and reduce waiting times was in place. This work had been in progress since May 2013 and was on schedule. The Trust agreed to fail RTT targets for January, February and March 2014 with the NHS Trust Development Authority (TDA). (The NHS Trust Development Authority provides oversight and governance for all NHS Trusts.) This was to enable the Trust to manage the backlog of patients waiting to be seen. This approach and agreement meant that patient safety was prioritised over meeting targets.

Systems, processes and practices

A programme of risk-based audit was carried out to monitor adherence with the standard operating procedures. Action was taken as a result of findings. Audits were carried out to check compliance with infection control procedures and cleanliness of the environment. These were reported back to staff teams and monitored through divisional quality reporting. Results for ENT/ophthalmology outpatients for February 2014 were displayed in the waiting area. 100% compliance had been achieved with hand hygiene and the area had scored 85% for environmental cleaning. The environment was modern and clean, hand hygiene facilities were available, toilets were clean, and bins were emptied. We saw that emergency equipment was available and appropriate checks had been carried out. An equipment checking schedule was in place and details were held and monitored on a database.

In oral/maxillo-facial outpatients a risk assessment had been completed for one treatment room where x-ray equipment required replacement and the room needed refurbishment.

Problems had been experienced in ensuring that patient notes were available for outpatient consultations. This stemmed back to implementation of the Electronic Patient Record (EPR) system across the Trust in 2011 and was compounded by shortage of administrative staff. Some areas experienced delays in patients' medical notes arriving within the department, which meant they had limited time to locate any missing records. An unexplained error in the EPR system resulted in some appointments being cancelled where patients were not informed, or not

informed in a timely manner. This meant their notes were not available. This was happening in one to two cases a week in the specialist surgery division, but was a trust-wide problem being monitored on the Trust risk register.

When records could not be located, temporary notes were created by pulling off information stored in the EPR, which meant patient's full medical histories were not always available. Delays in merging temporary and original notes had also occurred which had potential to impact on follow-up treatment. The proportion of missing notes in clinics was variable. We saw that staff reported issues with notes via Datix, this included when paper notes were in poor condition. It was not clear that all staff were as vigilant in reporting as incidents were logged at the discretion of individual staff members. We did not see evidence of completed audits to establish the extent or impact of the problem.

Staff had access to clear information that enabled them to do their job effectively. Guidance and policies could be accessed via the Trust intranet and all new staff were provided with electronic copies of policies relevant to their job role when they started working for the Trust. Outpatient teams met regularly which gave them opportunities to share learning and discuss areas where improvement was needed. We did not see any minutes from these meetings. Some staff in ophthalmology felt that more could be done to disseminate learning from incident and complaints. A team strategy meeting for ophthalmology was planned for 17 March 2014 where "improving learning and embedding changes" was on the agenda.

Monitoring safety and responding to risk

No concerns were raised by staff about staffing levels or skill mix in outpatients. One staff member said they thought outpatients tended to be better staffed than the wards, others told us they could be stretched to their limits and sometimes stayed late. We saw that staffing levels were monitored and expected staffing levels versus actual staffing levels for nurses and Clinical Support Workers (CSW) were displayed in the ENT/ophthalmology waiting area. Minutes from the Outpatient Steering Group for January 2014 showed that a staffing review was planned for all outpatient areas across the Trust. This was necessary and timely in response to the trust-wide re-profiling of outpatient clinics, which was in progress. This means that the demand for services was being accessed and decisions

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made on the numbers of clinics needed to meet that demand. One consultant told us they were working 11 sessions plus additional clinics to address the appointment backlog, which was unsustainable for them.

Staff were aware of any outstanding training requirements they needed to fulfil. One staff member told us they were three months overdue for resuscitation training, as they were needed to cover clinic on the day their training was booked. They said there was a lack of capacity for resuscitation training which made it difficult to book on to. Another staff member told us resuscitation training had to be booked well in advance. While visiting maxillo-facial clinic the emergency buzzer sounded, staff responded appropriately to this. Staff demonstrated appropriate knowledge about how to recognise and respond to safeguarding concerns. When entered in the Datix system, safeguarding concerns were automatically escalated to the Trust safeguarding lead.

The Outpatient Steering Group was working to standardise approaches to outpatient service improvement across the Trust. New standards had been agreed which were to be reported on monthly. The metrics included meant that quality issues raised through concerns, complaints and national standards could be monitored and benchmarked across outpatient services.

Anticipation and planning

Changes to outpatient services were being managed through the outpatient re-profiling project. This project was established in response to the need to improve efficiency and effectiveness, to meet national standards for waiting times (RTT) and Choose and Book requirements. There had been an unpredicted rise in demand for outpatient services in the past year and the Trust was working with the Clinical Commissioning Group (CCG) to manage this. This project was due to complete in May/June 2014. We were concerned that when the new booking system had been rolled-out (implemented) in ENT clinics in Autumn 2013 the system had contributed to RTT issues and had been withdrawn. Changes were made to the new ENT clinic profiles but it was not clear how the lessons learnt were being taken forward as the action plan was under development at the time of our inspection.

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

Not sufficient evidence to rate

Using evidence-based guidance

The Trust Access Policy was based on NHS England's performance measures for hospital trusts and individual patient rights set out in the NHS Constitution 2013. The policy had been updated in August 2013.

Staff were able to access trust policies and guidance via the intranet. Staff told us trust policies they worked to were based on Royal College, BASO (The Association for Cancer Surgery) and NICE guidelines and standards. The Trust's Resuscitation Policy referred to European Resuscitation Council and the Resuscitation Council (UK) protocols.

Performance, monitoring and improvement of outcomes

Adherence to NICE guidelines was monitored and was reported in some divisional quality reports. As treatment generally extended past outpatient services it was not possible to assess outcomes for patients in outpatient clinics separately.

Clinical audit was carried out by senior nurses and individual consultants. Team/departmental governance meetings were held, typically every three months, to discuss clinical governance issues and complaints.

Staff, equipment and facilities

Staff demonstrated knowledge of evidence-based standards in our discussions with them. Staff had e-learning accounts from which they could book training or access e-learning. Nurses told us they undertook competency-based assessments, based on clinical policies. A clinical support worker (CSW) told us about their positive experience of the Trust's CSW academy. The academy provided induction training for them over a period of one to two weeks when they moved into their new role in outpatients at the John Radcliffe. This training was competency based and involved orientation to each area the staff member worked in. Another staff member told us they were able to access e-learning and work email from home which they found useful.

A specialist nurse practitioner told us how emergency, everyday, and specialist equipment was checked and maintained within their clinical specialty. Patients were complementary about the care they received from clinic staff, which they described as professional.

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Customer service training was available to receptionists and peer review processes had been introduced for some staff groups. Staff told us they felt well supported by senior colleagues.

Multidisciplinary working and support

Staff were highly complimentary about their colleagues, describing them as “fantastic” and “fabulous”. It was evident that clinic staff worked as teams and understood each other’s role and contribution to the effective running of the service. Regular team meetings were held which were attended by all members of the multidisciplinary team.

Are outpatients services caring?

Good 

Compassion, dignity and empathy

Staff in all roles put significant effort into treating patients with dignity and patients feel well cared for as a result. We observed members of staff from all staff groups while they interacted with patients and their relatives. We saw that reception staff sometimes worked under considerable pressure. We saw one receptionist managing misdirected calls, long queues and a less than polite patient alone as their colleague had been delayed in a traffic incident. Despite this, they politely signposted the disgruntled patient to the correct area for their appointment and suggested that another patient who arrived early went to get refreshments and return later. The receptionists we observed were calm and friendly throughout.

A senior staff member in another area told us that receptionists were a “mixed bag”; they had recently reported concerns about a staff member’s approach to patients to the matron for the service. Matron had already been aware of the issue and the staff member had attended customer service training. Clinical staff were friendly and approachable. In the consultation we observed, the patient was welcomed by name, the consultant introduced themselves and others in the room and ensured the patient and their relative were comfortably seated.

Involvement in care and decision making

Patients, relatives/carers, and advocates described feeling involved in planning their care and making decisions about

the choices available in their care and treatment. Patients told us that nurses and consultants listened to them and they had been given opportunities to ask questions during their appointment. Patients in oral/maxillo-facial outpatients told us they had agreed to future surgery. In the consultation we observed, the patient was asked about how specific treatment options had previously affected an unrelated condition they had. The consultant checked the patient’s understanding and adjusted the explanations they gave to make them easier for the patient to follow. A treatment plan was agreed between the patient and consultant.

Trust and communication

Staff developed positive relationships with patients who used the service and those close to them. Patients valued their relationships with staff and could identify the staff who cared for them and their role and responsibility. Information about staff and their roles and a list of clinics and what they did was visible in the ENT/ophthalmology waiting area. Patients were positive about their interactions with staff in all clinic areas we visited. Some patients praised individual consultants for the way they had managed their care. Another patient told us how a specialist nurse had identified clinical changes that required treatment and ongoing follow-up when they attended eye outpatients for an unrelated emergency. They had since attended the outpatient service for four years and described the staff member as, “Brilliant”.

Emotional support

We did not observe any instances where emotional support was needed but saw that patients were treated in a caring manner.

Are outpatients services responsive to people’s needs? (for example, to feedback?)

Requires improvement 

Meeting people’s needs

The provider actively engaged and worked with local commissioners of services, the local authority, other providers, GPs, patients and those close to them to co-ordinate and integrate pathways of care that met the health needs of the local population. GPs and the hospital’s

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A&E department referred patients to emergency clinics in ophthalmology and ENT to manage acute pain and removal of foreign bodies. The Trust was working with the Clinical Commissioning Group (CCG) to predict and plan to meet future demand for outpatient services. An audit of two-week wait referrals by GPs was planned to ensure that the two-week wait care pathway was being used appropriately for patients who needed to be seen urgently. Recent high discharge rates from these clinics suggested GP training may be required.

A loop hearing system was in place in ENT and big letters were used on signs to assist visually impaired patients in ophthalmology. The facilities were clean and well set out but clinic and waiting area space was very limited in all areas we visited. Space limitations were compounded as clinics were overbooked and patients often waited long past their given appointment time. During our visit an announcement was made in ophthalmology asking people waiting with patients to give up their seats.

Verbal and written information that enabled patients to understand their care was available to patients and their relatives in ways that meet their communication needs, including the provision of information in different accessible formats and interpreting services. Leaflets were available in all waiting areas, including how to raise a concern or complaint. This leaflet included information in a variety of languages. Other leaflets included a telephone number and email address for assistance from an interpreter or alternative formats. Interpreter services were available and these were booked by staff when screening patient notes before clinic. This was usually done the day before clinic, but was not possible if notes were late arriving in the department or were unavailable. A three-way interpreter telephone service was available at any time. Healthwatch informed us that patients who were deaf had not always had a positive experience as interpretation services at their appointment had been poor. A befriending/ advisory service for blind and partially sighted people was also located in the ophthalmology/ENT waiting area.

Vulnerable patients and capacity

No special arrangements were in place in clinics to meet the needs of patients with learning disability or dementia. Staff were aware that patients with these conditions may find the busy clinic environment difficult to cope with and told us they would try to identify patients when they

screened their notes before clinic. If possible the patient would be offered a quiet area to wait in. Staff were aware of “hospital passports” used by people with learning disability to assist them to communicate, but did not see many of these in brought in with patients. A nurse told us that meeting the needs of patients with dementia could be challenging. Arrangements were in place to assess people’s capacity to consent to care when this was in question. The new core standards for outpatients included monitoring use of a yellow sticker to identify patients with additional needs including those who required disabled access or hearing support.

Access to services

The Trust were not meeting national standards for referral to treatment (RTT) times at the time of our inspection. An agreement was in place with the NHS Trust Development Authority (TDA) for the Trust to fail RTT targets for January, February, and March 2014. (The NHS Trust Development Authority provides oversight and governance for all NHS Trusts.) This had been agreed to ensure that a backlog patients who had been waiting longer than agreed standards would be prioritised. Additional clinics were being run to clear the backlog of appointments within these agreed timescales.

The Trust was not meeting standards for the Choose and Book service, with an average 50% failed booking rate trust-wide. An online service was not available which meant that all bookings were made by telephone. Booking patients into an appointment using Choose and Book took about eight minutes, this and introduction of the Trusts Electronic Patient Record (EPR) system in 2011 had a significant impact on administrative staff time. This impact had not been quantified or anticipated and administrative staff were struggling to meet demand. This resulted in poor experiences for some patients when trying to book appointments, to make queries or change appointments.

Not enough outpatient appointments were available to meet demand. Clinic “templates” set out how many appointments were available and the length of appointment slots in each clinic. The templates in use no longer reflected demand for appointments which had risen year on year. With the existing templates staff were able to “force book” additional patients into clinics, causing overbooking which contributed to long waiting times in clinics. This also meant that waiting lists were more difficult to manage and some appointments needed to be

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cancelled at short notice. When patients were booked into clinics they were triaged by consultants to ensure they were booked into the right service, this meant the appointment may be changed. Each time an appointment was booked or cancelled a letter was generated and sent to the patient. The impact of these systems on patients was that they may experience late cancellations or multiple letters which left them confused. One patient showed us five letters they received changing their appointments and another told us they had travelled from Bristol to learn their appointment had been cancelled. Some patients had not experienced any issues with their bookings. In response to these issues and concerns raised by patients and the CCG a trust-wide initiative to increase the number of appointments available, and reduce waiting times was in place. This work, to re-profile (redesign) clinic templates had been in progress since May 2013 and was on schedule.

We found that whiteboards to inform patients of waiting times were used inconsistently. In the oral/maxillo facial clinic staff were waiting for the whiteboard to be put up. In cardiac and vascular clinics waiting times were not filled in when we arrived on one of the two days we visited, as staff told us they had been too busy. Staff did not inform patients of delays verbally and did not apologise for the delay when calling patients. Reception staff generally did not know how late clinics were running and relied on nursing staff to update patient information boards. Waiting times were displayed in ENT and ophthalmology, staff made verbal announcements to inform patients and a "pager call" system was in use to allow patients to leave the department while waiting. Feedback from patients in these clinics was generally complementary.

Our observations were consistent with what patients and their representatives told us. We were contacted by a relative who told us they had recently waited for four and a half hours for a cardiac appointment, where no delay was shown on the whiteboard and staff did not communicate any delay. When they made a verbal complaint to they were advised to complain to the doctor. The whiteboard had not been updated when they left the clinic. Waiting times and parking issues were consistent themes in patient surveys and complaints. Patients shared concerns about difficulty parking, distances from the car park to clinics and penalty fines for overstaying due to unanticipated delays in being seen.

Leaving hospital

We observed that ongoing care was discussed with patients during their consultation. The patient we observed left clinic with a letter for another consultant they were booked to see at the Churchill hospital the following week. In oral/maxillofacial outpatients, patients who would be returning for surgery had some pre-operative checks carried out at the same time as their first consultation. This meant they would not need to return to do this at a later date. They also knew when they were likely to be admitted for surgery.

When people with dementia attended using patient transport, staff tried to book a "wait and return" service to ensure the person was not waiting unnecessarily for their transport to arrive.

Learning from experiences, concerns and complaints

The provider was open and transparent about how dealt with complaints and concerns. Feedback from patient surveys was available to patients in ENT/ophthalmology waiting areas. This included the Matron's response to concerns raised and the action they had taken. Staff were very well informed about patient complaints and knew what the main issues were.

A senior nursing and governance lead told us how they looked for trends from patient complaints and incidents reported on the Datix system to improve safety and patient experience. This informed quality priority setting for the coming year. They identified that complaints often stemmed from poor communication with patients, who had not always been informed of what to expect when attending their appointment.

Are outpatients services well-led?

Good 

Vision, strategy and risks

Trust-wide vision and strategy was set out in the trust's Quality Account. A clear vision for outpatient services was set out in the trust's Access Policy this encompassed key elements of the NHS constitution including patient safety, choice and experience. The board was aware of potential and actual risks to quality and safety. Risks at team, directorate and organisation level were identified and

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captured. There was alignment between the risks on the risk register and what staff told us they were concerned about. The outpatients steering group met monthly to ensure a consistent approach to improvement in outpatients was achieved trust-wide.

Governance arrangements

It was unclear how administrative shortfalls were being addressed to improve patients' experience of the service. Patient feedback on NHS Choices website for February 2014 showed that difficulties getting through to arrange appointments by telephone was an ongoing source of concern and frustration for some patients. Similarly, when a patient had cancelled their appointment, clinic staff were not always informed and said this made running clinics more difficult. Staff experienced improvements in relation to missing patient records in some clinics over the past three to four months.

Management of waiting lists was being monitored through weekly meetings. Choose and Book and patient record issues were tracked through monthly meetings and were reported in divisional Assurance, Quality and Performance (AQP) reviews.

Performance information was not always available to senior clinical staff and some said they wanted more information. Outpatient core standards and quality metrics had been agreed by the outpatients steering group. These were to be reported on monthly and would enable performance benchmarking of outpatient services across the Trust. These included national standards for access to care, availability of notes and limits on waiting times in clinics. An education pack was being drawn up to prepare staff before the quality monitoring metrics were introduced. An outcome measures dashboard was being developed as part of the re-profiling project. This would allow RTT standards and Choose and Book success rates to be tracked.

Leadership and culture

Leadership was generally good in outpatients. Some departments and individuals stood out as they were working more openly with patients and had implemented technology to improve patient experience. Plans were in place to review strategic approaches to problem solving a local level.

There was strong team based working characterised by a cooperative, inter-disciplinary, cross-boundary approach to delivering care in which decisions are made by teams. Teams had clearly defined tasks, membership, roles, objectives, and communication processes. Nursing and medical staff reported being well supported by their senior colleagues. They were confident that concerns were addressed effectively and assistance was available to them to manage more complex clinical cases. Multidisciplinary team meetings had been held quarterly, these were moving to monthly in ENT and ophthalmology to ensure the team was prepared for roll out of the revised clinic templates. Staff felt able to approach their line manager and senior staff. Non-executive directors had a high profile in outpatients and one in particular was described as very approachable.

Patient experiences, staff involvement and engagement

Staff felt valued and supported in their work place. Despite clinics being very busy at times and staff working at their limits on occasion they enjoyed their jobs and were enthusiastic about the development opportunities open to them. They demonstrated commitment to improving the service and readiness to learn. Staff spoke highly of each other and the way the teams worked together. They valued the contributions their team members made.

Several ways of obtaining patient feedback had been used. These included patient surveys and complaint monitoring. Special kiosks had been ordered to capture patient feedback electronically in real time. These were in use in clinics in other hospitals in the Trust. An open day had been held in an outpatient unit over a weekend, this gave patients an opportunity to ask questions and share their views. Patient pathways through ophthalmology clinic had been plotted, to show times required for different steps in the process. This had been shared with the patient involvement group through a focus group.

Learning, Improvement, innovation and sustainability

Improvement initiatives and good practice were shared through the outpatient steering group. This group enabled managers and nursing staff to share their experience and learning and to support each other to implement changes.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and outpatient care to meet their needs and ensure their welfare and safety.</p> <p>This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>The accident and emergency department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively.</p> <p>The outpatient department was failing to provide an effective booking service, failing to meet national standards for timely referral to treatment and failing to provide suitable information.</p> <p>In some surgical specialties waiting times for surgery were too long and operations were cancelled too often.</p> <p>There was not suitable attention paid to the identification, assessment and planning of care needs for vulnerable people, particularly those with dementia in surgery and A&E.</p>
Regulated activity	Regulation
Surgical procedures	<p>The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and outpatient care to meet their needs and ensure their welfare and safety.</p> <p>This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p>

This section is primarily information for the provider

Compliance actions

The accident and emergency department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively.

The outpatient department was failing to provide an effective booking service, failing to meet national standards for timely referral to treatment and failing to provide suitable information.

In some surgical specialties waiting times for surgery were too long and operations were cancelled too often.

There was not suitable attention paid to the identification, assessment and planning of care needs for vulnerable people, particularly those with dementia in surgery and A&E.

Regulated activity

Regulation

Treatment of disease, disorder or injury

The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the maternity department and on surgical wards and in operating theatres.

Regulated activity

Regulation

Surgical procedures

The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Compliance actions

There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the maternity department and on surgical wards and in operating theatres.

Regulated activity

Regulation

Family planning

The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the maternity department and on surgical wards and in operating theatres.

Regulated activity

Regulation

Maternity and midwifery services

The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the maternity department and on surgical wards and in operating theatres.

Regulated activity

Regulation

Compliance actions

Termination of pregnancies

The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the maternity department and on surgical wards and in operating theatres.

Regulated activity

Regulation

Treatment of disease, disorder or injury

The provider had failed at times to deliver care to patients that ensured their privacy, dignity and human rights were respected.

This is a breach of Regulation 17(1)(a) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The use of the accident and emergency triage room, the atrium area, and layout of the reception did not give patients privacy and dignity.

Regulated activity

Regulation

Treatment of disease, disorder or injury

The provider did not have suitable arrangements in place in order to ensure that all staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard through receiving appropriate training, professional development and supervision.

This is a breach of Regulation 23(1)(a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some of the new nursing staff coming to work at the hospital did not have sufficient induction into the A&E

Compliance actions

department. Newly qualified midwives did not always receive adequate preceptorship. Not all nurses qualified overseas working in A&E and newly qualified midwives were appropriately supervised to ensure they were competent and trained to deliver all care and treatment procedures to the appropriate standard.

Regulated activity

Maternity and midwifery services

Regulation

The provider did not have suitable arrangements in place in order to ensure that all staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard through receiving appropriate training, professional development and supervision.

This is a breach of Regulation 23(1)(a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some of the new nursing staff coming to work at the hospital did not have sufficient induction into the A&E department. Newly qualified midwives did not always receive adequate preceptorship. Not all nurses qualified overseas working in A&E and newly qualified midwives were appropriately supervised to ensure they were competent and trained to deliver all care and treatment procedures to the appropriate standard.