Care Quality Commission

Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital

Quality Report

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

Ratings

Urgent and emergency services	Requires improvement
Surgery	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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.

We carried out a focused unannounced inspection on 11 and 12 October 2016. We inspected the surgical service and the emergency department at this location. As part of this inspection, we returned to see if improvements were made to any concerns identified in February 2014 and March 2014 relevant to the service types inspected.

We rated the surgery service as good and urgent & emergency services as requires improvement.

- The emergency department had a consistently poorer median time to initial assessment for both adults and children than the England average. Patients arriving via ambulance did not consistently receive an assessment within 15 minutes of arrival. This in turn could impact on the timeliness of screening and the introduction of the sepsis pathway. The department performed significantly worse than the England average on the A&E four hour waiting time target, although the percentage of patients waiting four to 12 hours from decision to admit to admission was better than the national average.
- The space and layout of the main operating department and the emergency department impacted on the efficiency and flow of patients through the departments.
- Not all patients who were at risk of developing pressure ulcers in the emergency department were nursed on appropriate pressure relieving mattresses according to their assessed needs.
- Emergency equipment was available and in the majority was checked daily. The exception was the resuscitation trolley located in the cardiothoracic theatres, which had not been checked since mid-September 2016 (almost one month) and had been covered with other items of equipment.
- Staff completion of statutory and mandatory training was variable and not in line with the trust's target in some areas. This included resuscitation training, Mental Capacity Act training and conflict management practical training.
- All clinical areas were visibly clean, and we observed staff following good infection prevention and control practices to minimise the risk and spread of infection to patients.
- Staff were aware of their responsibilities and the processes to follow to protect vulnerable adults and children. However, not all staff were up to date with the required level of safeguarding training.
- Staff were confident with reporting incidents and obtained feedback. There was an emphasis on learning from incidents within departments and across the organisation. Staff were aware of the duty of candour requirements and how it applied to their practice.
- Overall, staffing levels met the planned levels. The trust achieved this using bank and agency staff for some shifts. Managers followed the trust escalation procedures when they identified staffing shortages for their department. At the time of the inspection the trust had not completed their formal review of acuity and establishment in the ED. Over a four month period, July to October 2016 over half the shifts were staffed at minimum nurse staffing levels.
- Trust wide medicines management policy and standard operating procedures were in place and monitored through audit. Medicines were stored securely in line with the trust medicines management policy. New staff were supported through a planned induction process. Training opportunities were available although staff reported the main the challenge was having time to attend training.
- Compliance with appraisal rates for medical staff was in line with the trust's target; however appraisal rates for nursing staff varied, with some low rates including 43% on the cardiothoracic ward, 61% in ED and 46% in EAU.

Summary of findings

- Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, on one ward, two patients with dementia did not have documented capacity assessments completed.
- Medical, nursing staff and support workers worked well together as a team. There was respect between a range of specialities and disciplines.However, in the ED multidisciplinary working was variable, junior medical staff found some resistance in patient transfer to the surgical emergency unit and referrals to nursing staff were impeded.
- Inpatients had plenty of a menu options and meals were said to be of sufficient portion size. Patients in the majors area of ED were offered food and drinks, however, not on a formalised basis.
- Staff assessed and managed patients' pain levels. However, in the ED not all patients had their pain managed in a timely manner.
- Care and treatment was planned and delivered in line with current evidence based guidance, standards and best practice. There was good monitoring of compliance with these standards at departmental and division level.
- In all areas, patients and relatives were positive about the caring attitude of staff, their kindness and their compassion. However, in the ED we observed occasions when patient privacy and confidentiality was not maintained.
- On the surgical wards staff took time to ensure patients, and their relatives, understood their care and treatment. Patients felt involved in their care and understood their treatment plans. Relatives in the ED did not always feel informed.
- Staff we spoke with valued and respected the needs of patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered. However in the ED patients' holistic needs were not always considered. For example, patients we spoke with said they were cold or relatives had covered the patient. The ED performed significantly worse than the national average for the percentage of patients with a total time within ED of four hours.
- Patients with mental health conditions were cared for in an environment, which was not secure and had led to absconsion from the emergency department. Although the mental health assessment room in the EAU provided a safe and suitable environment to assess patients.
- Complaints were investigated thoroughly to improve the quality of care.
- Patients had timely access to emergency surgical treatment and the trust was taking action to minimise the waiting time for elective surgery. The trust was pro-actively managing capacity for surgical patients.
- Staff took account of the needs of different people, including those with complex needs when planning and delivering services. Staff showed good understanding and made reasonable adjustments to meet patients' individual needs.
- There was an open culture within the hospital. Staff felt the leadership of the trust and within the division, directorates and at local level were visible and supportive.
- There was a governance structure to monitor the quality, risk and performance of services, which linked in with the trust's overall governance structure. However, in the ED improvements to the service with regards to service performance and patient flow through the department had not been addressed.
- The trust core values, which underpinned the trust wide vision, were embedded across the services inspected. These were further supported by the strategic objectives which were reflected in local business plans.

We saw several areas of outstanding practice including:

- Ward staff and clinical development nurses had developed safety cards. Each nurse had a pack of cards with key safety and organisation information to fit in their pocket. An example of information was where to locate pressure relieving mattresses. Clinical staff told us they were a useful reminder and were well received.
- The trust had employed a falls safe training lead and falls had reduced from three serious patient falls a month to zero falls.

Summary of findings

- The trust held a weekly serious incident requiring (SIRI) investigation forum open to all staff to discuss learning from incidents and duty of candour requirements.
- The trust had introduced a peer review programme to engage staff, encourage improvement and share learning across the different divisions.

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

Importantly, the trust must:

- Improve mandatory training levels for medical and nursing staff.
- Improve safeguarding children level 3 training for medical and nursing staff
- Improve the appraisal rates for nursing staff.
- The trust must ensure that patients receive an initial assessment by an appropriately qualified member of ED staff within 15 minutes of arrival in the ED.
- The flow of patients through the hospital must be improved to enable the emergency department to meet waiting time targets and enable patients to have timely access to specialist care and treatment.
- Provide an appropriate and safe environment for the care and treatment of detained patients.
- Review the use of both paper and electronic records in ED to ensure contemporaneous notes are maintained at all times.

In addition the trust should:

- Ensure all emergency resuscitation equipment is checked daily.
- Consider the theatre business plan to agree a way forward to address the constrained theatre environment.
- Improve patient's privacy and dignity in the theatre direct admissions (TDA) area in the main operating department.
- Ensure administrative and clerical staff receive training in how to identify and report abuse in adults.
- Ensure patients who at risk of developing pressure ulcers in the emergency department are cared for on appropriate pressure relieving mattresses according to their assessed needs.
- Continue to find solutions to ensure all clinical staff attend compulsory cardiac advance life support training.
- Ensure staff consistently follow and record the sepsis pathway.
- Consider ways to improve the arrangements for the safe care of patients at risk of absconding.
- Ensure patients' pain in ED is appropriately managed in a timely manner.
- Improve multidisciplinary working between ED, specialist services and teams to facilitate patient flow through the department.
- Consider the timeline of plans to expand the resuscitation area to determine if these could be brought forward.
- Improve the arrangements for preserving patients' privacy and confidentiality in the children's ED.
- Ensure patients within the ED are offered food and drinks where clinically safe and appropriate.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Overall we rated this service as requires improvement because: During the time of the inspection we observed crowding in the emergency department (ED), the majority of patients were not assessed within 15 minutes of arrival in the department, this included patients who arrived by ambulance. Some patients waited more than one hour before an initial assessment. This meant there was a delay to undertaking the sepsis screen. The department performed significantly worse than the England average for the four hour A&E waiting time target. At the time of the inspection the trust had not completed their formal review of acuity and establishment in the ED. Over a four month period, July to October 2016 over half the shifts were staffed at minimum nurse staffing levels. Over a four month period, July to October 2016 over half the shifts were staffed at minimum nurse staffing levels. There were five ED consultant vacancies. Consultant cover was provided by ED consultant for 16 hours daily and on call. A trauma and orthopaedic consultant provided cover for major trauma calls. The space and layout of the department significantly affected the efficiency in the department. The resuscitation area contained four bays and we observed it was often used to accommodate more than four patients. In cases when capacity did not meet demand a screened corridor, was used to accommodate up to six patients on trolleys The department was not able to provide consistently safe arrangements for the care of patients with mental health conditions or at risk of absconding. Resuscitation training and safeguarding training for medical and nursing staff was below the 90% trust target. The trust's statutory and mandatory training policy did not require administrative and clerical staff to undergo safeguarding adults training. Low numbers of medical staff were compliant with Mental Health Act and Deprivation of Liberty Safeguards training.

Summary of findings

Appraisal rates for nursing staff were significantly below the trust target of 90% at 61% in ED and 46% in EAU.
Staff did not consistently record the time of review in the patients' records. All patients' pain was not managed in a timely manner.
Multidisciplinary working was variable. For example, junior medical ED staff found that the staff in the surgical emergency unit did not always work co-operatively with them and specialist nursing staff told us referrals from the ED were impeded.
We observed occasions when patients' privacy and confidentiality was not maintained. For example, conversations held by staff at the desk in the children's department could be overheard by patients and relatives in the waiting room opposite.
The holistic needs of the patients such as the need for refreshments were not always considered in a timely way.
The ED feedback on the Friends and Family Test was worse than the England average.
There was evidence of behaviours and cultures, which affected the way patient care was managed and the patient pathway through the department.
A clear governance framework was in place, although improvements to the service with regards to service performance and patient flow through the department had not been addressed.
However:
We observed staff provided compassionate care and the department had implemented changes to support vulnerable people, for example patients living with dementia or with a learning disability.
The percentage of patients waiting four to 12 hours from decision to admit to admission was better than the England average.
Staff felt supported and displayed resilience through team working and support from their leaders. The senior management team demonstrated a clear understanding of the issues facing the department.
Plans had been approved to expand the department and double the size of the resuscitation area. Staff worked collaboratively with other teams to receive and manage adult and paediatric major trauma patients.

Summary of findings

Staff were confident to report incidents and encouraged to participate in departmental and trust wide meetings to share learning in a constructive way. The department undertook a range of clinical audits as part of the directorate clinical audit programme to show evidence of learning and service improvement.

Surgery

Good

We rated this service as good because:
There was a safe number of staff with appropriate skills, training and experience to keep patients safe. The service used agency staff who were familiar with the service and its procedures. The hospital followed the escalation policy and procedures to manage busy times.
Staff planned and delivered patients' care and treatment using evidence based guidance and audited compliance with National Institute Health and Care Excellence (NICE) guidelines.
Ward and theatre areas we visited were clean and tidy, we saw most staff following good infection prevention and control practices. Staff knew the trust's process for reporting incidents. They received timely feedback from managers regarding reported incidents the lessons learned. There was strong multidisciplinary working across teams at the hospital so patients received co-ordinated care and treatment.
Nursing staff completed timely risk assessments for patients. If a patient became unwell, there were systems for staff to escalate these concerns. The hospital provided care to inpatients seven days a week. Staff ran an on call system with access to diagnostic imaging and theatres.
We saw staff treated patients with compassion and care. They were kind and treated them with dignity, and respect. There were systems to support patients with additional or complex needs. Patients felt informed and involved in their care. Patients and families said they would recommend the service to others.
Staff followed the trust's governance processes to monitor the quality and risks of the surgical service. They completed audits and monitored patient outcomes, making changes to practice when necessary. Staff told us the leadership across the service was good and the senior team was visible

Summary of findings

and accessible. Staff had an annual appraisal and could access additional training to develop in their role. The trust had employed a falls safe training lead and falls had reduced from three serious patient falls a month to zero falls.
However:
Although we saw good practice with staff risk assessing patients at risk of developing pressure ulcers and obtaining pressure relieving mattresses, we did not see pressure relieving cushions used for identified 'at risk' patients.
The resuscitation trolley located in the cardiothoracic theatres had not been checked since mid-September 2016. This meant staff could not be assured the equipment was ready to be used and accessible
Nursing and midwifery staff did not achieve the trust 90% target in three of the six mandatory modules.
Minutes from clinical governance meeting July 2016 showed the trust was aware and was taking actions to address the concern.

John Radcliffe Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Surgery

Detailed findings

Contents

Background to John Radcliffe Hospital

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 (ED) 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.

We inspected the surgical and emergency department services provided at this location.

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC inspection manager and included three inspectors, an assistant inspector and five specialists: a theatre manager, a surgeon, a surgical nurse, an emergency department consultant nurse and divisional director of medicine.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out a focused unannounced inspection visit on 11 and 12 October 2016

Detailed findings

During this comprehensive inspection, we assessed the surgical service and the emergency department. We spoke with approximately 50 members of staff and 20 patients, observed patient care, looked at patients' care and treatment records and trust policies.

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

Facts and data about John Radcliffe Hospital

John Radcliffe Hospital had 35,082 surgical spells between April 2015 and March 2016.

Emergency spells accounted for 37.8%, 48.7% were day case spells, and the remaining 13.5% were elective.

A total of 30.9% of spells at this site were for General Surgery, 16.8% for Ophthalmology and 9.1% for Plastic Surgery with the remaining 43.2% being made up of other specialities.

Between 1 April 2015 and 31 March 2016 there were 145,604 attendees to A&E in the trust. 26.7% of attendances resulted in admission compared to an England average of 21.6%.

Between August 2015 and July 2016 the trust reported six incidents which were classified as Never Events for Surgery. All six Never Events were classified as "Surgical/ invasive procedure incident":

Between August 2015 and July 2016 the trust reported no incidents which were classified as Never Events for Urgent and Emergency Care.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust was worse than the 60 minute time to treatment standard between June 2015 and May 2016. In June 2015 the median time to treatment for this trust was 65 minutes, and in May 2016 it was 77 minutes. Between June 2015 and May 2016 performance against this standard showed a trend of decline.

Between June 2015 and May 2016 the monthly median time to initial assessment for patients arriving at this trust's urgent and emergency care services by emergency ambulance was consistently higher than the England average. In June 2015 the median time to initial assessment was 25 minutes and in May 2016 it was 29 minutes.

As at October 2016, the site reported a vacancy rate of 10.8 % in Urgent and Emergency Care.

As at September 2016, the site reported a vacancy rate of 11.97% in surgical care.

As at October 2016, the site reported an average sickness rate of 2.6% in Urgent and Emergency Care; EAU had the highest sickness rate of 4%.

As at September 2016, the site reported an average sickness rate of 4.1% in surgical care; Cranio Facial – medical had the highest sickness rate with 33.01% There were seven units which had a sickness rate of less than 1%

As at September 2016, the site reported a staff turnover rate of 12.03% in surgical care.

As at October 2016, the site reported a staff turnover rate of 19.2% in Urgent and Emergency Care; EAU has the highest turnover with 22.2% and the ED has 17.66% turnover.

Between October 2015 and September 2016, the site reported a bank and agency usage rate of 6.2% in Urgent and Emergency Care.

Between October 2015 and September 2016, the site reported an average bank and agency usage rate of 9.5% in surgical care.

Between April 2015 and March 2016 the average length of stay for surgical elective patients at the John Radcliffe Hospital site was 4.2 days, compared to 3.3 days for the England average.

For surgical non-elective patients, the average length of stay was 4.6 days, compared to 5.1 for the England average.

Average length of stay at this site was notably longer for non-elective admissions in Trauma & Orthopaedics and longer than the trust average of 10.3 days.

Detailed findings

The trust's referral to treatment time (RTT) for admitted pathways for surgical services has been consistently better than the England overall performance since July 2015.

The trust's referral to treatment time for admitted pathways for surgical services has seen a downward trend since July 2016 and in September has dropped below the England average with 74.9% of patients seen within 18 weeks.

Between 2014/15 Quarter 2 and 2016/17 Quarter 1 the trust cancelled 996 elective operations, of which 4.8% were not treated within 28 days. This was better than the England average of 6.8%.

Between 2014/15 Quarter 2 and 2016/17 Quarter 1 the trust has a consistently better rate of cancelled operations as a percentage of elective admissions than the England average.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

The John Radcliffe Hospital emergency department (ED) is the larger of two EDs of the trust in the county of Oxfordshire. The John Radcliffe Hospital ED is also a major trauma centre. It provides a 24 hour, seven days a week service to the local population. The department encompasses a children's department dealing with all emergency attendances under the age of 16 years. The ED works closely with the emergency assessment unit (EAU) where patients with medical conditions are admitted from ED or directly referred by GPs for assessment for up to 12 hours.

Between 1 April 2015 and 31 March 2016 there were 145,604 attendees to ED in the trust, 26.7% of attendances resulted in admission, higher than the England average of 21.6%. The John Radcliffe ED treats approximately 250 to 300 patients per day, of which 21% are paediatric attendances.

The hospital has a helipad and severely injured patients are received into the department via the Helicopter Emergency Medical Service or land ambulance. The majority of patients, approximately 70%, self-present to the main reception and approximately 30% arrive by ambulance.

The department consists of a majors area including a four bed resuscitation area, minors area and a separate children's department with its own waiting area.

The ED is part of the directorate of acute medicine and rehabilitation in the division of medicine, rehabilitation and cardiac services.

During our inspection, we visited the department over one and half days including evening and early morning. We spoke with approximately 10 patients and 20 staff including medical, nursing, administrative staff, occupational therapist and pharmacist. We spoke with senior ED staff including consultants, matron, directorate and divisional staff. We reviewed patient records and information about the service including performance information provided by the trust.

Urgent and emergency services

Summary of findings

Overall we rated this service as requires improvement because:

- During the time of the inspection we observed crowding in the emergency department (ED), the majority of patients were not assessed within 15 minutes of arrival in the department, this included patients who arrived by ambulance. Some patients waited more than one hour before an initial assessment. This meant there was a delay to undertaking the sepsis screen.
- The department performed significantly worse than the England average for the four hour A&E waiting time target.
- At the time of the inspection the trust had not completed their formal review of acuity and establishment in the ED. Over a four month period, July to October 2016 over half the shifts were staffed at minimum nurse staffing levels. Over a four month period, July to October 2016 over half the shifts were staffed at minimum nurse staffing levels. There were five ED consultant vacancies. Consultant cover was provided by ED consultant for 16 hours daily and on call. A trauma and orthopaedic consultant provided cover for major trauma calls.
- The space and layout of the department significantly affected the efficiency in the department. The resuscitation area contained four bays and we observed it was often used to accommodate more than four patients. In cases when capacity did not meet demand a screened corridor, was used to accommodate up to six patients on trolleys
- The department was not able to provide consistently safe arrangements for the care of patients with mental health conditions or at risk of absconding.
- Resuscitation training and safeguarding training for medical and nursing staff was below the 90% trust target. Administrative staff had not completed safeguarding adults training as this was not considered by the trust to be part of their statutory and mandatory training. Low numbers of medical staff were compliant with Mental Health Act and Deprivation of Liberty Safeguards training.
- Appraisal rates for nursing staff were significantly below the trust target of 90% at 61% in ED and 46% in EAU.
- Staff did not consistently record the time of review in the patients' records. All patients' pain was not managed in a timely manner.
- Multidisciplinary working was variable. For example, junior medical ED staff found that the staff in the surgical emergency unit did not always work co-operatively with them and specialist nursing staff told us referrals from the ED were impeded.
- We observed occasions when patients' privacy and confidentiality was not maintained. For example, conversations held by staff at the desk in the children's department could be overheard by patients and relatives in the waiting room opposite.
- The holistic needs of the patients such as the need for refreshments were not always considered in a timely way.
- The ED feedback on the Friends and Family Test was worse than the England average.
- There was evidence of behaviours and cultures, which affected the way patient care was managed and the patient pathway through the department.
- A clear governance framework was in place, although improvements to the service with regards to service performance and patient flow through the department had not been addressed.

However:

- We observed staff provided compassionate care and the department had implemented changes to support vulnerable people, for example patients living with dementia or with a learning disability.
- The percentage of patients waiting four to 12 hours from decision to admit to admission was better than the England average.
- Staff felt supported and displayed resilience through team working and support from their leaders. The senior management team demonstrated a clear understanding of the issues facing the department.

Urgent and emergency services

- Plans had been approved to expand the department and double the size of the resuscitation area. Staff worked collaboratively with other teams to receive and manage adult and paediatric major trauma patients.
- Staff were confident to report incidents and encouraged to participate in departmental and trust wide meetings to share learning in a constructive way. The department undertook a range of clinical audits as part of the directorate clinical audit programme to show evidence of learning and service improvement.

Are urgent and emergency services safe?

Requires improvement

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

We rated safe as requires improvement because:

- The department had a consistently poorer median time to initial assessment than the England average, for both adults and children.
- Patients arriving via ambulance did not consistently receive an assessment within 15 minutes of arrival which was not in line with Royal College of Emergency Medicine (RCEM) guidance. We observed some patients waited more than one hour before an initial assessment. This meant there was a delay to undertaking the sepsis screen.
- Not all patients who were at risk of developing pressure ulcers were nursed on appropriate pressure relieving mattresses according to their assessed needs.
- Hand hygiene audit results were significantly below the trust target.
- At the time of the inspection the trust had not complete their formal review of acuity and establishment in the ED. Between July to October 2016 over half the shifts were staffed at minimum nurse staffing levels.
- The ED consultants worked across the two hospital trust EDs. There were five ED consultant vacancies. In order to meet the requirements for consultant cover for major trauma centres consultant cover was provided by ED consultant for 16 hours daily and on call, a trauma and orthopaedic consultant provided cover for major trauma calls.
- Resuscitation training and safeguarding training for medical and nursing staff was below the 90% trust target. The trust's statutory and mandatory training policy did not require administrative and clerical staff to undergo safeguarding adults training.

- The space and layout of the department significantly impacted the efficiency in the department and flow through of patients. The resuscitation area contained four bays and we observed it was often used to accommodate more than four patients

However:

- Staff reported incidents and obtained feedback. There was an emphasis on learning from incidents within the department and across the organisation. Staff were aware of the duty of candour requirements and how it applied to their practice.
- All clinical areas were visibly clean and we observed staff followed good infection prevention and control practices, to minimise the risk and spread of infection to patients.
- The mental health assessment room in the EAU provided a safe and suitable environment to assess patients.
- Staff we spoke with were aware of their responsibilities and the processes to follow to protect vulnerable adults and children.
- Medicines were handled safely in accordance with the trust's medicines management policies.

Incidents

- Staff we spoke with were aware how to report incidents using the trust electronic incident reporting system. The ED matron told us they reviewed all incident reports. Serious incidents were shared with all staff for discussion at the trust's weekly serious incident requiring investigation forum (SIRI forum).
- The trust did not report any never events for the emergency department between August 2015 and July 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- During the same period the department reported one serious incident (SI) which met the serious incident framework reporting criteria set by NHS England. The type of incident reported was a treatment delay meeting SI criteria.
- Between June 2016 and September 2016, ED data showed 176 incidents were reported: 152 were categorised as no harm and 24 of minor injury. The highest category: 63 incidents were related to pressure ulcers and skin integrity.
- Data from the NHS safety thermometer showed that there were no pressure ulcers, falls with harm or catheter urinary tract infections between July 2015 and July 2016.
- We attended two clinical governance meetings; emergency department (ED) and children's department. We observed the meetings included review of mortality and morbidity cases. There was an open discussion with constructive challenge and no blame approach to facilitate learning, improve the service and reduce risks.
- There was a process in place for the management of incidents that included the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of the duties required by the duty of candour. The ED matron said duty of candour was allocated to senior staff to ensure actions were taken. We saw one example where a patient's fall had triggered the duty of candour and the patient had been provided a copy of the investigation report.
- We reviewed the notes of the SIRI forums (22 September 2016 and 29 September 2016), these were led by the trust's deputy medical director and they demonstrated a wide multidisciplinary staff attendance. Serious incidents from the previous week were discussed to share learning and the status of incidents where duty of candour was triggered was highlighted.
- Reception staff we spoke with said they did not report incidents, as they had not historically received feedback on incidents they had previously reported and therefore did not see "the point".
- The trust clinical governance and risk practitioners (CGRP) trained staff on incident investigations and

ensured appropriate individuals were involved. They had oversight of incidents reported and they were alerted to all incidents graded as moderate or serious incidents via the electronic reporting system. They monitored incidents for trends and produced directorate and divisional monthly trend reports.

Cleanliness, infection control and hygiene

- We observed the department was visibly clean. Equipment was clean and labelled as ready for use and stored appropriately.
- Hand sanitiser gel and personal protective (PPE) equipment, such as gloves and aprons were available for staff to use. We observed that staff took measures to reduce the risk of infection such as they were bare below the elbow, used hand sanitiser gel and wore PPE.
- We reviewed the validation audit against hand hygiene compliance 2015/2016. This identified 84% (53 out of 63) clinical areas reported at or below 80% hand hygiene compliance. The majors department achieved the lowest score of 26%, minors area was 45% and the emergency assessment unit (EAU) was 57%.
- The report recommendations included the action that daily hand hygiene audits to be conducted in areas which scored less than 80%. We saw two daily hand hygiene reports for the previous two months, both of which reported below 80% scores: 75% and 50.3%. The service reported they had taken measures to improve hand hygiene compliance by continued monitoring and feedback to staff, increased staff awareness through display of hand hygiene posters, reminders to staff at hand overs and staff encouraged to carry alcohol gel on a toggle for easy access.
- Reception staff told us they would immediately alert cleaning staff if they were made aware of any blood or body fluid spillage in the waiting area. Reception staff had cleaning signs they could position to alert patients to the infection hazard.
- The cleanliness score for John Radcliffe ED 2016 patient led assessments of the care environment (PLACE) was on average 98% compared to the overall trust score of 97%.
- The divisional report showed MRSA screening compliance for EAU between April 2016 and August 2016 varied 38% (April 2016) to 72% (May 2016), this achievement was consistently below the target of 90%.
- The ED had an isolation room, however, staff told us it was rarely used for isolation purposes, as dedicated isolation facilities were available at one of the trust's other hospital sites.

Environment and equipment

- The department received more patients than it was safely able to accommodate. For example, we observed patients on trolleys transferred by ambulance often waited at the entrance to the majors area causing an obstruction to one entrance to the resuscitation area and the corridor to the EAU.
- The ambulatory area consisted of a large waiting area, one screening room located in the corner of the waiting room and a treatment area of four beds and five chairs.
- The ambulance entrance was controlled by key pad entry. A small majors waiting area was located to one end of the majors assessment area opposite the ED staff station. However, the majors treatment area was not visible from the assessment area but was staffed when in use. The majors treatment area consisted of ten bays, which included two cubicles.
- The emergency assessment unit (EAU) was located adjacent to the ED. ED transferred patients to EAU who were expected to be discharged within 12 hours.
- The resuscitation area had four bays; one bay was prioritised for trauma patients and one was suitably decorated for children. Staff we spoke with told us the bays in the resuscitation area were often 'doubled up' due to lack of bed space and also meant there were issues with availability of equipment. Screens were used to separate patients and we observed this situation during the inspection visits. However, there was sufficient oxygen and suction equipment available to meet the needs of all patients in the resuscitation room.
- The risk register showed the lack of space in the resuscitation area was recorded as a risk and the

actions taken to mitigate the risk. A business case had been approved to expand the resuscitation area into an eight bed area and was planned for completion in 2018/19.

- Records for the last month and our spot check of equipment showed the resuscitation equipment had been checked daily and was in order.
- The condition, appearance and maintenance score for John Radcliffe ED 2016 patient led assessments of the care environment (PLACE) was on average 92% compared to the overall trust score of 97%.
- The children's emergency department had separate controlled entry for staff and visitors. It was secure from the adult area. The department consisted of areas for children to wait with age appropriate toys and also allowed observation of children with head injury. The treatment area contained seven bed spaces which included four cubicles.
- Staff in the adult ED and children's department did not report any issues with availability of equipment or delays in equipment repairs. We saw the up to date log of works for the ED department equipment which showed repairs and maintenance service checks on equipment had been carried out in a timely manner.
- All trolleys within the emergency department had pressure relieving mattresses and staff had access to hospital beds with alternating air mattresses to allow patients who were at risk of pressure ulcers to be nursed appropriately. However, staff said patients were risk assessed and transferred to an appropriate mattress, such as alternating air mattress after 12 hours if needed.

Medicines

- A trust wide medicines management policy and standard operating procedures were in place and monitored through audit. We reviewed medicines storage in the minors area, major area and resuscitation area. Medicines were stored securely in line with the trust medicines management policy.
- Controlled drugs (CD) were stored securely and appropriately. CD cupboards were checked daily and CCTV overlooked the cupboard in the majors as an additional security measure.
- A review of the controlled drugs register for the last month found medicines administered had been correctly completed and reconciled daily with the stock level.
- We reviewed the ED's results of the safe and secure storage of medicines audit conducted in December 2015 which showed a small number of areas of non-compliance. Pharmacy staff had also carried out CD audits in May and August 2016 which identified areas for improvement in different areas of the ED, which were notified to the nurse in charge.
- Secure refrigerators in the resuscitation area, minors and children's emergency department stored medicines which required storage at low temperatures. Daily minimum and maximum temperature recordings of medicines refrigerators were carried out to provide assurance of the integrity of stored medicines. Records for the last month for the resuscitation area and children's emergency department showed readings were in the expected ranges. However, concerns regarding the accuracy of the thermometer reading of the fridge in the resuscitation area had been escalated to the pharmacy department. Staff told us they were investigating the purchase of a replacement thermometer. The records for monitoring the temperature of the medicines fridge in the minors area showed daily recording for September 2016 and October 2016, however, prior to that daily readings were not recorded. In the months of June to August 2016 there were between 10 and 20 missed readings each month. On one occasion where the reading had been higher than the expected range, there was a note that the issue had been escalated.
- Medicines stored in the medicines cupboard in the minors area were regularly restocked and checked. We spot checked seven medicines which were all in date except for one medicine which had expired in January 2016 and was removed by the nurse in charge.
- The prescription charts we reviewed showed patient allergies were recorded.
- We spoke with the pharmacist on EAU which had a ward based service. They told us pharmacy provided support to ED although there was not a clinical pharmacy service to ED. However, the pharmacist and

ED matron met every two to three months to discuss issues such as CDs and packs of discharge medicines. Senior ED staff we spoke with said the department would benefit from a clinical pharmacy service to improve medicines management and support staff.

Records

- The trust used an electronic patient record (EPR) system. We observed staff recorded patient details on the EPR at registration or details were handed over to ED staff by ambulance crews. The department also used paper records. In our review of seven records we saw two instances when the time of initial medical review was not recorded.
- Records were a mix of paper and electronic systems. We found it was difficult to follow the patients' journeys when some of the documentation was on paper and some electronic.
- The time to initial assessment was also not clear for example, two out of seven records showed the time to assessment preceded the time the patient attended the department.
- Computer systems in the department were protected by password to prevent unauthorised persons accessing patient information. We saw computers timed out after a short period and staff also logged out to reduce the risk of unauthorised access.
- A trust wide health records audit was carried out in 2016. However, patient records in ED were not included in the scope of the audit.
- Data for the department showed venous thromboembolism (VTE) screening compliance was above 95% for the period August 2015 to August 2016.

Safeguarding

- Nursing staff we spoke with were aware of how to make a referral to the trust safeguarding team and the trust procedures to follow. Staff were aware of the trust safeguarding lead named nurse and told us the named nurse or paediatric registrar were accessible for immediate concerns.
- Staff were aware that there was a statutory reporting process in cases of female genital mutilation and could find this information on the hospital intranet if required. We observed safeguarding contact numbers on display in the different areas of the department.
- Staff told us they received regular teaching sessions from the named nurse, on for example, female genital mutilation and child sexual exploitation. A department domestic abuse champion also provided support and advice to staff if needed.
- Reception staff at the point of registration identified parental responsibility. If appropriate they also completed the patient injury form before directing patients to the children's ED. Children's safeguarding and child protection arrangements were appropriate.
- The electronic patient record used across the department provided a template for staff to follow and record responses. The electronic patient record (EPR) system had an alert system for safeguarding adults and children if certain criteria were fulfilled.
- The health visiting team were informed of all patients under one year and all under-fives if specific criteria was fulfilled. Staff used the EPR to trigger a safeguarding alert which alerted the liaison team for follow up.
- In the children's department information posters were on display and leaflets provided to parents/ carers to make them aware of procedures followed if children presented with suspected non accidental injuries.
- Safeguarding adult and safeguarding children training was a core mandatory training requirement for nursing and medical staff. However, not all staff groups in the emergency department had achieved the 90% mandatory training target set by the trust for all the modules. September 2016 data showed 89% of eligible staff had completed safeguarding adults training.
- For safeguarding children level 2, 90% of staff had completed the training. However, for safeguarding children level 3, only 74.5% staff had completed the training, and only 40.6% of medical and dental staff had completed the training.
- Safeguarding children level 1 training had been completed by 93.4% of administrative and clerical

staff. However, this group of staff had not completed safeguarding adults training.The trust's statutory and mandatory training policy did not require administrative and clerical staff to undergo safeguarding adults training.

- Staff told us the trust learning disability specialist nurse supported staff to care for patients with a learning disability. Electronic alerts flagged patients with a learning disability on the electronic patient record. Data showed 31 patients recorded as being seen in ED with a total of 36 attendances (four people attended more than once).
- Adults living in Oxfordshire who had a diagnosis of a learning disability and consented (or best interest decision) were flagged on the electronic patient record system. Under 18's were flagged on the system if they come into contact with the learning disability liaison nurse. The system supported the trust to monitor vulnerable patients who received care and treatment.

Mandatory training

- Core mandatory training included health and safety, infection control and equality and diversity. Additional mandatory training was specified for certain staff groups. For example, nursing staff required venous thromboembolism (VTE) prevention training and medical and nursing staff required resuscitation training. The trust monitored staff uptake of mandatory training, this was reported on the monthly unit dashboard against a target of 90%.
- September 2016 data showed medical and dental staff in urgent and emergency care had only achieved the target for conflict theory, only two members of staff were eligible for this module. Completion percentage for the remaining modules varied from 75%, for electronic patient record, and 45%, for conflict practical. Only 41 (51.3%) out of 80 medical and dental staff had completed resuscitation training.
- Mandatory training uptake for nursing and midwifery staff in urgent and emergency care showed the service had achieved the 90% target for conflict theory, equality and diversity and health and safety. However, completion percentage for the remaining three modules was 88% in infection control -clinical, 78% in information governance and 62% in conflict practical. The uptake for resuscitation training was 76% for nursing and midwifery staff.

Assessing and responding to patient risk

- All emergency departments in England are expected to receive and assess ambulance patients within 15 minutes of arrival. During our inspection we observed some patients waited more than one hour before ED staff carried out a clinical assessment. Between May 2016 and October 2016, each month approximately 2500 (70%) patients who attended the majors department waited more than 15 minutes to be assessed; on average 29 minutes compared to the England average of under 10 minutes.
- The ambulance service records any delays in patient handover of more than one hour (known as black breaches). Between July 2015 and June 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In July 2015 21% of ambulance journeys had turnaround times over 30 minutes; in June 2016 the figure was 26%. Performance had been consistent between July 2015 and January 2016. There was then a peak in the percentage of turnaround times over 30 minutes in February 2016 and March 2016 where it increased to over 30%. The England average for percentage of journeys with turnaround times of more than 30 minutes in October 2016 was 53% and for journeys more than 60 minutes was 6.9%. For John Radcliffe hospital it was comparatively better at 30.7% and 1.6% respectively.
- All ambulatory patients who attended the ED were directed to the main reception desk in the minors/ ambulatory department. Reception staff we spoke with were clear their role was to register patients and ask for presenting information and not to triage. If they were concerned about a patient for example, in cases of chest pain they would alert the minors streaming nurse to prioritise a patient by using a flag on the electronic record. In cases where the streaming nurse and minors staff were unavailable the reception staff would ask majors staff to see the patient. Children under the age of 16 years were directed to the children's section of the ED and the separate waiting area.

- Reception staff said they would “Watch the waiting room” to spot cases when a patient had collapsed or bled and use the panic button to summon help if needed.
- The minors streaming nurse was situated adjacent to the ambulatory waiting area and aimed to carry out a brief clinical assessment within 15 minutes of arrival. The streaming nurse directed patients to the major treatment area if they felt this was clinically indicated. Otherwise patients were asked to return and wait in the minors waiting area until they were called for by minors' treatment staff.
- The ED was an accredited major trauma centre, during the inspection we saw occasions when the trauma team were activated to receive adult and paediatric patients. We observed two major trauma cases were prioritised and immediate action taken to assess the patients’ needs in line with emergency trauma activation and major haemorrhage emergency protocols. We observed the management of trauma patients diverted staff and resources from the continuous management of patients presenting to the majors department.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust performed worse than the 60 minute time to treatment standard between June 2015 and May 2016. In June 2015 the average time to treatment for this trust was 65 minutes, and in May 2016 it was 77 minutes, which meant there was a decline in performance against this standard.
- The ED had initiated a medical rapid nursing assessment (MRNA) in majors. The intention was for this to be undertaken within 15 minutes of the patient arrival in the department. However, data between May 2016 and October 2016 showed for approximately 70% of patients this did not take place within 15 minutes.
- During the inspection, we observed delays to MRNA taking place; the assessment took more than 15 minutes to complete. Our observations and review of 15 records showed one patient was assessed within 15 minutes and five patients waited more than 60 minutes. We observed one patient who had been waiting to be assessed for 38 minutes; the patient was identified by one of the ED consultants who then immediately initiated the sepsis pathway.
- We identified delays in initial medical reviews and senior medical reviews of patients. For example, an elderly patient who arrived late afternoon and was in ED overnight, there was no record of senior medical review in the patient’s notes.
- A second patient who presented with urinary sepsis on admission had no medical review or follow up in the notes and no sepsis bundle recorded. A third patient with palpitations was first reviewed by a doctor three hours later. No sepsis bundle had been commenced.
- Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings (National Institute for Health and Care Excellence, Clinical Guidance 50, 2007). The trust used the track and trigger system, a local alternative to the national early warning score. However, we observed the sepsis bundle was not always followed.
- Nursing staff we spoke with explained the nurse assessment process involved a question with respect to sepsis or other worries about the patient’s clinical condition. If positive, this triggered a red symbol against the patient’s name for it to be prioritised for the doctor’s attention. However, we identified patients with a query of sepsis who did not have a sepsis proforma in their notes. We observed sepsis was not always considered until the medical review took place.
- We reviewed the quarterly sepsis update (October 2016) to the trust clinical governance committee which reported more than 90% of emergency admissions through the ED had been screened for sepsis using the electronic sepsis screening tool since May 2016.
- However, our observations during the inspection indicated a delay to the sepsis screen and no clear paper or electronic evidence that the sepsis pathway was consistently followed. We raised our concerns with the trust. They reported that in May 2016 the trust had introduced an electronic sepsis screening tool for acute admissions. This triggered a flag for sepsis if there was evidence of infection at the patient’s initial assessment. Following the inspection the trust

reported all copies of the paper sepsis pathway had been removed from the ED and a reminder issued to staff which reinforced the use of the electronic sepsis toolkit.

- The trust carried out a continuing audit of the deteriorating patient as part of its audit programme. Results showed compliance for the areas measured except for the percentage of patients for whom there is evidence of increased frequency of monitoring in response to the detection of abnormal physiology. Compliance levels had fallen between March 2015 and March 2016 from 87% to 74%.
- We reviewed the system for electronic notification and data (SEND) data for the ED department for July 2016 to September 2016, this showed 50% or less of patients with a track and trigger score of 3 or more did not have hourly observations recorded. We asked the trust what actions had been taken in response to these findings. They reported that they had identified some of the compliance data from SEND was inaccurate and the system was under development to increase accuracy; a further review of ED data was being undertaken to improve performance.
- We reviewed records for paediatric patients. The paediatric early warning score (PEWS) and sepsis pathway was not recorded for all children. A PEWS chart was generated when regular observations were to be recorded and this was determined by the nurse in charge of the children's department.
- We observed some vulnerable patients, for example, a patient with mental health needs and a patient with learning disability were assessed within 15 minutes and also had a timely medical review or psychiatric review.
- All trolleys within the emergency department had pressure relieving mattresses and staff had access to hospital beds with alternating air mattresses to allow patients who were at risk of pressure ulcers to be nursed appropriately. However, staff said patients were risk assessed and transferred to an appropriate mattress, such as alternating air mattress after 12 hours if needed. We observed one elderly patient who had pressure sores recorded in their notes was cared for on a trolley. At the time we reviewed the patient's notes they had been in majors on a trolley for 10 hours and was waiting to be admitted.

Nursing staffing

- The trust informed us the department had reviewed the draft National Institute for Health and Clinical Excellence (NICE) guidance on safe staffing for nursing as part of its work within a network of trusts. However, at the time of the inspection they had not completed a formal review of acuity and establishment in the ED. Following the inspection the trust informed us they were undertaking an in depth review but no outcomes were available.
- Staffing levels for the day for ED were 14 registered nurses (RN) and two health care assistants (HCA) and 13 RNs at night and two HCAs at night. We reviewed the shift staffing levels for ED for July to October 2016 which showed each month, on average less than half (40%) of shifts were at agreed staffing levels and 60% were at minimum staffing levels to ensure a safe service.
- Staff we spoke with of different grades said the most 'challenging' part of the job was staffing levels in the department. Some staff expressed concern that in the month of October they were working at full capacity and winter, "Had not hit yet."
- As of October 2016, the site reported a nursing staff vacancy rate of 10.8 % in urgent and emergency care and a turnover rate of 19.2%. Between October 2015 and September 2016, the bank and agency usage rate was 6.2% in urgent and emergency care. Senior ED staff told us it was difficult to recruit agency staff to cover ED, if needed bank staff were employed. The department was also supported by military nurses who worked as supernumerary on shifts.
- There were two allocated RNs for four beds in the resuscitation area. The ED coordinator confirmed staff worked flexibly across the different sections of the ED and EAU to ensure a safe service and patients' needs were met. For example, staff would be redeployed to the resuscitation area if needed. Although some staff we spoke with said adequate staffing levels in the resuscitation area were not always maintained.

- Staffing levels were on the ED risk register, specifically, the resuscitation area and mitigating actions taken to ensure appropriate staffing levels to accommodate up to eight patients in a four bed facility.
- Although there was not always a band 7 nurse in charge of the department in accordance with national guidance. The trust provided assurance that on occasions when a band 6 nurse was in charge they had completed the nursing and AHP trauma competencies to operate as the nurse in charge and they were supported by an on call senior sister for advice if needed.
- Emergency nurse practitioners (ENP) worked with medical staff in the minors area. Staffing consisted of one ENP 7.15am to 7.45pm, one at 10am to 10.30pm and one at 1pm to 1.30am. The trust reported if an ENP shift was not filled it remained vacant.
- We observed handovers during our visit which ensured staff on duty were aware of the needs of patients in the department.
- The children's ED was not a standalone unit; it was part of the mixed ED and part of the joint nursing establishment. It was staffed daily by three registered nurses and a maximum of three children's nurses during the day and a minimum of two children's nurses and two registered nurses on at night and a play specialist, four days a week. We were told by senior staff the flexible staffing across the whole ED meant they were able to maintain the skill mix in the children's area.

Medical staffing

- The ED had 13.5 whole time equivalent (WTE) consultants across the two hospital trust sites; there were five ED consultant vacancies. Consultant cover consisted of two consultants from 8am to 6pm, one consultant from 3pm to 11.30pm and sometimes an extra consultant from 1.30pm to 10.30pm. There was an emergency medicine consultant on call from home from 11.30pm. However, consultants told us that often they were not able to leave promptly at the end of their shift due to the department needs. Two middle grade doctors were on duty overnight most nights.
- The middle grades doctors were three registrars, four trust doctors and two internal trust locums.
- There was consultant cover in the department for more than 16 hours per day; an ED consultant covered for 16 hours daily and on call. A trauma and orthopaedic consultant provided cover for major trauma calls to meet the requirements for consultant cover for major trauma centres.
- The proportion of consultants and junior doctors reported to be working at the trust were about the same as the England average. However, the department had a lower percentage of consultants compared to other EDs with major trauma centres. It also had the joint highest percentage of junior doctors and a similar percentage of middle career positions.
- The vacancy rate for medical staff was minus 4.18% in urgent and emergency care. This negative figure meant that there was more medical staff in the ED than originally budgeted for. Between October 2015 and September 2016, the site reported an average bank and locum usage rate of 15.4% in urgent and emergency care, there was an increase in locum usage between October 2015 and June 2016. Since then there had been a decrease, in September 2016 there was a 5.7% locum usage.
- Two new paediatric emergency medicine (PEM) consultants had been appointed recently to bring the establishment up to four PEMS and this was positive for the department. One paediatric registrar was based in ED overnight.
- The department had 2.4 WTE Band 6 occupational therapy staff supporting ED/EAU. If the department was busy additional staff were redeployed from other clinical areas. In addition 1.4 WTE Band 4 occupational therapy assistants also support the department.
- We observed medical handover during the inspection. This gave an overview of activity within the department. All adult and children's department patients were discussed at length including ED patients on EAU to ensure staff were aware of the needs and plans for patients in the department.

Major incident awareness and training

- There were security staff in the department 24 hours. These staff had received training in conflict resolution and physical restraint.

Urgent and emergency services

- There was a trust wide major incident policy (July 2016) which aimed to enable the trust to provide an effective response to any major incident and resume normal services as quickly as possible. Associated action cards contained information to ensure staff were able to fulfil their roles.
- The Oxfordshire emergency treatment centre protocol identified the John Radcliffe hospital as one of the designated emergency treatment centres in the case of a mass casualties incident. It included the department's response to incidents involving hazardous materials and chemical, biological, radiological, nuclear explosive.

- During the course of the inspection we witnessed ED staff in a planned major incident exercise with the ambulance trust and other partners to test the preparedness of the plan.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

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

We rated effective as requires improvement because:

- Appraisal rates for nursing staff were significantly below the trust target of 90%.
- Low numbers of medical and dental staff were compliant with Mental Health Act and Deprivation of Liberty Safeguards (DOLS) training.
- Multidisciplinary working and relationship with teams was variable. For example, junior medical ED staff encountered delays in obtaining a response from the surgical emergency unit and specialist nursing staff told us referrals from the ED were " Slow".
- There had been work undertaken to improve some of the patient pathways for example, direct admission rights from ED into the surgical emergency unit (SEU), which fostered effective multidisciplinary working. However, implementation of the pathway had been impeded and junior medical ED staff encountered delays in patient transfer from ED to SEU.
- All patients' pain was not managed in a timely manner.

However:

- The trust utilised a range of policies and guidelines which were based on for example, national guidance and best practice. Staff were aware of these guidelines and had access to them.
- Nursing and medical staff were supported by senior staff and formal and informal training opportunities to undertake their roles.
- The department undertook a range of clinical audits throughout the year and could show evidence of learning and improvement following these audits.
- The trust's unplanned re-attendance rate was better than the England average, although worse than the standard.
- Staff worked collaboratively with other teams to receive and manage adult and paediatric major trauma patients.

Evidence-based care and treatment

- ED staff used a wide range of clinical guidelines based on, for example, on the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) to ensure care and treatment was evidence based.
- Compliance with NICE guidance and implementation of new NICE guidance and clinical policies/procedures was an agenda at the ED monthly clinical governance meetings. The divisional quality report monitored directorate and service level NICE guidance compliance; the August 2016 report showed there were no issues with compliance identified for ED.
- Staff were emailed policy updates and we saw staff had access to up to date policies on the trust intranet. Staff followed clinical pathways such as treatment of strokes, asthma, chest pain, feverish children and multiple trauma, stroke and fractured neck of femur.
- Our discussion with the trust clinical governance risk practitioner demonstrated there was a clear process for the review and monitoring of compliance with national

guidance. There was a rolling program of review that included an assessment of compliance, action planning to make changes where required and the recording of rationale where practises deviated from the guidance
- The emergency medicine clinical audit programme 2015/2017 was part of the divisional audit programme. The ED participated in a number of national audits, including those specified by the Royal College of Emergency Medicine (RCEM).

Pain relief

- In the CQC A&E Survey 2014, the trust scored 5.58 for the question "How many minutes after you requested pain relief medication did it take before you got it? The score was about the same as for other trusts. The trust scored 7.17 for the question "Do you think the hospital staff did everything they could to help control your pain?" The score was about the same as other trusts.
- During our inspection we observed timely pain relief was administered to children. The results of the pain relief were monitored and additional treatment given if necessary.
- Patients we spoke with in the minors area told us they had been offered and received pain relief if needed.
- The ED lead consultant informed us as part of the initial assessment of any patient, pain assessment was recorded as part of the track and trigger score on the electronic patient record. The trust used the World Health Organisation 0 to 3 pain scoring system, as oppose to the 0 to 10 scoring identified in the College of Emergency Medicine guidance on management of pain in adults (December 2014). However, we noted on the ED risk register (October 2016) pain scoring methodologies and recording was a concern which could result in 'a failure to adequately monitor pain'; no comments on mitigating actions were recorded. The service confirmed no audits of pain control had been conducted for patients cared for in the ED.
- Staff assessed and managed patients' pain levels. However, in the ED not all patients had their pain managed in a timely manner. During the inspection we observed an elderly patient who appeared in discomfort and had not received timely intervention or review. They had sustained an arm fracture and were in a box splint (a padded firm structure to keep a limb immobilised) for eight hours over night. We raised our concerns with staff, approximately one hour later a plaster cast was applied.
- Staff told us they worked closely with the trust pain team particularly for patients who were identified for palliative care.

Nutrition and hydration

- We observed following assessments, patients were prescribed and administered intravenous fluids for hydration when clinically indicated.

Patient outcomes

- The emergency medicine clinical audit programme 2015/2017 showed the ED participated in six Royal College of Emergency Medicine (RCEM) audits over the two years and one audit to measure compliance against NICE quality standard. There were also six local audits, three of which related to service evaluations. The trust informed us all national clinical audits were reported and monitored by the trust's clinical effectiveness committee and action plans were in place in relation to all reports
- We reviewed the audit results for 2015/16. The audit results of procedural sedation in adults (2016) showed the John Radcliffe (JR) hospital performed in line with or better than the national average in all standards except one. The associated action plan highlighted areas for improvement across both trust ED departments.
- The vital signs in children (2016) audit showed the JR performance was in line with the national average for all standards. The venous thromboembolism risk in lower limb immobilisation in plaster cast (2016) audit showed the JR performed better than the national average in all the standards measured.
- We reviewed the results of the January 2015 RCEM audits: For asthma in children the department performed in the upper quartile for one measure, between upper and lower quartile for seven measures and in the lower quartile for one measure. For assessing cognitive impairment in older people, it performed in the upper quartile for three measures, between upper and lower quartiles for two measures and lower quartile for one measure.
- For the audit for initial management of the fitting child, the service performed between the upper and lower quartiles for three measures and in the lower quartile for two measures. For the audit for mental

health in the ED, the service performed in the upper quartile for three measures, between upper and lower quartile for two measures and in the lower quartile for three measures.

- The ED is a designated major trauma centre and benchmarks itself against other trauma centres through the trauma audit and research network (TARN). We reviewed the unit's dashboard for January to June 2016. It performed worse than expected for 1 out of 3 evidence based measures and 4 out of 7 system measures, three of which related to the lack of consultant led care on arrival or within 30 minutes of arrival. However, for the children's trauma centre provision, performance was better or in line with other children's trauma centres for all the standards measured.
- The TARN clinical report (October 2016) to the trust clinical effectiveness committee and due to be presented at the Thames Valley trauma network board, identified good practice and made recommendations including for improved consultant cover in ED.
- Between June 2015 and May 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average. In the latest period, trust performance was 5.5% compared to an England average of 8.5%. Since May 2016 the trust's re-attendance rate had slightly increased although it remained better than the England average but worse than the standard.
- Emergency nurse practitioners (ENP) we spoke with said new pathways had been developed for specific types of fractures to reduce patients' re-attendance at the fracture clinic. Notes of clinical governance minutes showed a review of the new pathways was planned to assess the impact.

Competent staff

- Appraisals of both medical and nursing staff were undertaken and staff spoke positively about the process. September 2016 data showed for medical and dental staff the appraisal uptake for the directorate of acute medicine and rehabilitation was 94%. However, for nursing and midwifery staff uptake was significantly lower at 61% in ED and 46% in EAU.
- Data showed all the senior nursing staff: band 7 nurses and all except two band 6 nurses had current certification on the advanced trauma nursing course (ATNC). The department aimed to support three nurses each year for the ATNC certification. ED nursing staff said educational opportunities were available which included competency assessment, so that nurses and their managers knew when they were ready for increased levels of responsibility.
- We spoke with junior doctors. They told us that they received regular supervision from the emergency department consultants, as well as twice weekly teaching sessions.
- We spoke with emergency nurse practitioners (ENP) in the minors department. They were very positive about the educational opportunities. Staff had been supported by the trust to undertake a master's degree. They described good access to the nurse consultant who undertook their appraisals. ENP staff said they worked on rotation in different departments to keep their skills up to date.
- Medical staff were provided a new doctors handbook (August 2016) which included an extensive range of operational policies, references, clinical protocols and guidelines.
- The trust's responsible officer annual revalidation report (September 2016) demonstrated the trust's performance and compliance with the Licence to Practise and Revalidation regulations.

Multidisciplinary working

- We observed medical, nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- Staff spoke about an effective working relationship with the trust's safeguarding teams.
- The ED department worked collaboratively with others in the trust to receive adult and paediatric trauma patients. For example, we observed an ITU consultant, nurse and anaesthetist were ready to receive a trauma patient. On another occasion the paediatric team had contacted the critical care outreach nurse to attend and receive a sick infant into the paediatric resuscitation bay.

- The ED worked closely with the ED psychiatric service (EDPS) to support patients with mental health conditions.
- Specialist staff we spoke with, for example, stroke nurse specialist, cardiac outreach nurse and therapy staff told us the ED were generally slow and unreliable at referrals. Specialist staff had to 'search for patients' either by attending the ED or conducting an electronic search of patient records.
  - Data from the directorate performance report (September 2016) showed stroke metrics were not met for two out of the six indicators measured: direct admission of patients to the hyper acute stroke unit / acute stroke unit within four hours of hospital arrival and percentage of applicable patients who were given a swallow screen within four hours of hospital arrival. The report concluded a factor in the underachievement was delays in the patients' medical assessment in ED.
  - The notes of the ED clinical governance meeting (August 2016) identified patients with a diagnosis of stroke who had breached the target to arrive on a stroke ward within four hours in July 2016. Actions in response to improve care of patients and reduce breaches were highlighted. The service was aware of some of the issues we identified and had an action plan in place to address them.
  - Senior ED staff including the ED lead consultant, informed us there had been improvements to pathways, for example, direct admission rights from ED into the surgical emergency unit (SEU), which fostered effective multidisciplinary working. However, staff also informed us implementation of the pathway had been slow and junior medical ED staff encountered delays in patient transfer from ED to SEU due to obtaining support from the team.

Seven-day services

- Emergency department consultant cover was provided 24 hours a day, 7 days a week (24/7), either by an ED consultant or trauma consultant. A registrar was resident overnight in hospital and a consultant on call at home.
- Radiology service and support was available 24/7; x-ray and computerised tomography (CT) scanning was located adjacent to the ED with access to the radiographer.
- An on-call pharmacy service was available outside of normal working hours.
- Occupational therapy provision was available, 12 hours a day during week days, and 8am to 4pm at weekends.

Access to information

- Information needed to deliver effective care and treatment was organised and accessible. This included test results. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- There were electronic information screens in the majors area which identified when patients were due to arrive in the department. This helped to allocate resources to ensure staff were available to receive patients.
- The electronic information system alerted staff when vulnerable children or adults arrived in the department. It also provided up-to-date information about patients' flow through the department, investigations and length of stay.
- Staff provided patients' discharge information, for example, head injury, back pain and asthma.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained patient consent where possible, before undertaking procedures. Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found any decisions made were appropriately recorded within the medical records.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity and knew when formal mental capacity assessments needed to be carried out.
- Trust wide data for October 2016 showed 90% of nurses and midwifery staff had received DOLS and Mental Health Act training but only 40% medical and dental staff were compliant.

Urgent and emergency services

Are urgent and emergency services caring?

Good

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

We rated caring as good because:

- We observed ED staff provided compassionate care and were sensitive and empathetic in their interactions with patients.
- Patients spoke positively about the care they received and the attitude of caring and considerate staff.

However:

- We observed occasions when patients' privacy and confidentiality was not maintained. For example, assessment room doors were not always shut.
- Not all patients and relatives we spoke with felt they were fully informed about their plan of care and treatment

Compassionate care

- All the patients we spoke with described the care they received as good. Comments included, "Staff were lovely" and "Friendly."
- We observed staff speak with patients in a calm and empathic manner to reduce patients' and relatives' anxiety.
- Patients were treated with dignity and respect, where possible staff tried to maintain confidentiality of conversations by speaking discreetly.The A&E survey results from 2014 in response to the question about privacy and dignity, rated the department about the same as other trusts'. The results of the CQC A&E survey 2014 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.
- The privacy score for John Radcliffe ED 2016 patient led assessments of the care environment (PLACE) was on average 88% and specifically 83% in majors and 100% in the children's ED compared to the overall trust score of 87%. Although we saw patients were doubled up in the resuscitation area, we observed staff took care to preserve patients' privacy dignity and staff were caring and sensitive to patients and family members.

Understanding and involvement of patients and those close to them

- We observed staff conveyed information in a way that patients were able to understand and checked understanding. One patient we spoke with said "Once I was seen it was good and the doctor was thorough, it was the waiting which was not good".
- Relatives we spoke with said the care had been "Excellent" but they felt they had not been kept informed of the progress of care/ treatment of the patient.
- The CQC A&E survey 2014 showed that the trust performed similar to other trusts for the question about how long it took for a patient to speak to a nurse or doctor.

Emotional support

- Clinical nurse specialists attended the department from various teams within the hospital. We saw supportive interaction with patients from nurse specialists in the palliative care team.
- The A&E survey results for the question about staff responding to patients being distressed rated the department about the same as other trusts.
- Matron said they were concerned if a patient was end of life as the ED could not always accommodate them in a quiet space to be cared for.
- We observed three occasions when the door to the nurse assessment room in the minors area was open while a patient was being assessed by a nurse. This compromised patient privacy as people passing by were able to observe and hear the consultation.
- The paediatric waiting room was located opposite the nurse station. This was not conducive to staff preserving confidential information about individual patients as we observed patients and families could overhear conversations.
- The trust urgent and emergency care friends and family test (FFT) performance was generally worse

than the England average between July 2015 and June 2016. In the latest period, October 2016 trust performance was 78% compared to an England average of 86%. There had been an overall decline to the proportion of patients who recommended the service between July 2015 and June 2016.

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

Requires improvement

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

We rated responsive as requires improvement because:

- The department performed significantly worse than the England average for the four hour A&E waiting time target.
- The majority of patients waited more than 15 minutes for assessment
- In cases where capacity did not meet demand a screened corridor, was used to accommodate up to six patients on trolleys
- The department was not always able to provide appropriate arrangements for the care of patients with mental health conditions or at risk of absconding.
- Patients who had been in the ED over four hours were not routinely offered refreshments.

However:

- The percentage of patients waiting four to 12 hours from decision to admit to admission was better than the England average.
- The trust had approved a bid to expand the resuscitation area of the department.
- The department had implemented changes to support vulnerable people, for example patients living with dementia and a learning disability.
- The department investigated complaints and made changes to improve the service

Service planning and delivery to meet the needs of local people

- The John Radcliffe (JR) Hospital and another hospital in the trust provided emergency department care for the local populations. The JR ED is also a designated regional major trauma centre.
- The ED was separated into three areas: major receiving and treatment area (majors), the minors or ambulatory reception and treatment area and the children's department. The resuscitation area was located in the majors area. Radiology services were accessible adjacent to the department.
- The majors area consisted of five majors assessment cubicles, 10 majors treatment beds and four resuscitation beds. The ratio of the resuscitation beds to majors cubicles was lower (approximately half) compared to other units it benchmarked itself against.
- The directorate leadership team recognised the ED at JR was relatively small to fulfil the role of a major trauma centre, particularly the number of beds in the resuscitation area. However, a business case had been approved to provide capital development. The time scales were yet to be confirmed.
- Senior staff had reviewed the patient journey/flows through the ED and considered the different ways of utilising the space effectively or alternative models they could use. However, the constraints of the current physical space meant any changes were dependent on the department expansion.
- The trust had implemented an urgent care improvement plan to reduce overcrowding and improve patient flow within the department. For example, the provision of an ambulatory assessment unit for GP referrals and a surgical emergency unit to accommodate direct referrals from GPs. The aim was to divert patients from the ED.
- During our visit we observed the minors waiting area had sufficient seating capacity for the people waiting. There was a separate waiting area for children in the children's department and a small waiting area for patients able to sit in the majors area.
- The trust had also worked closely with other providers, the commissioners and local authority to reduce delayed transfers of care in the county. The trust had been successful in its bid for the contracts for the hospital discharge and community reablement service which involved the merger of four existing services into

the home assessment and reablement team (HART) from 1 October 2016.Staff spoke of initial operational problems with the merger which potentially compromised patient flow. However, the new team was expected to rapidly improve discharges from the hospital and patient flow based on the success of one of the trust's predecessor teams.

Meeting people's individual needs

- Ambulance staff transferred patients from the ambulance in wheelchairs, rather than trolleys, if it was appropriate to do so to encourage patients' independence.
- The ED matron told us there had been improvements in the way vulnerable patients were cared for through the resources available and staff training. For example, measures included, a short cognitive assessment tool for patients admitted over the age of 70 years which resulted in patients being issued a green wrist band if they scored below a certain level. Staff had a choice of curtains and a different coloured privacy curtains were used for patients with dementia in the majors area as an easy visual prompt for staff and reminiscent aids for patients were available.
- There were two relative's rooms in the department that could be used for family members of critically ill patients or for recently bereaved relatives.
- The disability score for ED 2016 patient led assessments of the care environment (PLACE) was on average 70%.
- We spoke with two relatives of patients with a learning disability who were positive about the care received. Staff said particular attention was paid to patients with a learning disability, for example, patients were cared for in a cubicle if possible, to reduce noise and patient's anxiety. We saw an example of this during the inspection.
- The trust had a learning disability specialist nurse who supported staff and the electronic patient record system flagged patients with a learning disability to notify staff if they had been in contact with the trust and gave their consent. Patients under the age of 18 were flagged on the electronic system if they come into contact with the learning disability liaison nurse.
- Nurses had received training in the care of people with a learning disability. They were able to speak confidently about the differing needs of people with learning disabilities and prioritised their care where possible. For example, we saw patients with were seen promptly for a medical review.
- Patients with mental health conditions were referred to the emergency department psychiatric service (EDPS). Data showed there had been on average 183 referrals per month for the last 6 months to the EDPS. The EDPS service was provided by another trust. ED staff we spoke with said patients with mental health conditions often stayed in EAU for three to four days although the environment was not secure for mental health patients.
- Incident data showed 12 reports of patient absconsions between January 2016 and November 2016. None of the absconsions resulted in actual harm. One was a patient detained under Section 2 of the Mental Health Act and one was waiting to be transferred to a mental health ward. The other incidents involved patients who were not formally detained but may not have had capacity at the time of presentation. We saw the management of mental health patients was recorded as a risk on the ED risk register. Mitigating actions were limited to monitoring of the service requirement, a standard operating procedure to deal with patient absconsions and a monthly meeting with EDPS.
- The emergency department psychiatric service provided a 24 hours a day, 7 days a week service to assess and provide a safe discharge plan to all patients presenting with mental disorder in the emergency department. The new assessment room in EAU provided a safe and comfortable environment for patient, carer and staff.
- We spoke with a community safety practitioner who supported vulnerable patients, for example patients with drug and alcohol problems and homeless patients. The practitioner worked with other services to ensure the patient was linked in to the right support networks. For example, with the EDPS to contribute to joint management plans
- Staff had access to interpreting services but they told us in practice, often relatives or staff who could speak the patient's language were used if it was safe and appropriate to do so.
- We observed occasions when patients' holistic needs were not considered. For example, patients we spoke with said they were cold or relatives had covered the patient with their coats; these were patients on trolleys

in the entrance to the majors area. Staff told us patients cared for in the majors areas were offered food, including hot meals and drink during their stay. However, during the inspection, except for two occasions when we saw patients eating sandwiches, we did not observe any meal rounds, snack or drinks offered to patients. We spoke with patients who told us they had not been offered food or drink and had been in majors for more than four hours. We saw elderly patients who asked for something to eat.

- A drinks trolley was available near the majors assessment area but we did not see patients or visitors helping themselves to drinks or being offered them. We highlighted our observations to senior trust staff. In response the trust informed us they planned immediate changes to the food offered to patients in ED so that patients who could eat would be offered breakfast, lunch and dinner as standard.

Access and flow

- The Department of Health's standard for emergency departments is to admit, transfer or discharge 95% patients within four hours of arrival. The trust performed worse than the England average for the four hour A&E waiting time target between July 2015 and June 2016. In July 2015 the trust's performance was better than both the England average and the standard however it had a rapid decline over the winter period and by February 2016 the percentage of patients seen within four hours dropped to 78%. It increased since then although, remained below the England average. The figure for October 2016 was 73.9% compared to the England average of 89%.

- The ED received approximately 11000 attendances each month, over 75% patients conveyed themselves to the ED and presented at the minor reception desk. Patients registered at the reception desk. Approximately 500 (4.4%) attendances each month were attributed to patients who were not registered with a GP. Reception staff said patients, for example, foreign visitors or students, who were not registered with a GP, took longer to register. In addition they may have presented to A&E as they were not aware of alternative sources of healthcare treatment or advice.

- Between July 2015 and June 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was similar to the England average. The trust achieved its lowest percentage of patients waiting between four and 12 hours from the decision to admit until being admitted in July 2016 with 4%. Since then it increased month on month and in September 2016 it was at 8.8%, better than the England average of 10.3%.

- Between July 2015 and June 2016 the monthly median percentage of patients who left the trust's urgent and emergency care services before being seen for treatment was similar to the England average. Since June 2016 the trust has seen the percentage of patients leaving the department before being seen had followed the trend of the England average but remained slightly higher than the England average of 3.2% (September 2016).

- Between June 2015 and May 2016 the trust's monthly median total time in A&E for all patients was consistently higher than the England average. In July 2015 median total time in A&E was at 164 minutes. Since then it had increased and reached a peak median time in February 2016 of 203 minutes and had been fluctuating around 190 minutes up to September 2016.

- Ambulance turnaround time of more than 60 minutes (black breaches) since January 2016 were: nine in February and March, three in May and June and none since June 2016 up to October 2016.

- We observed ambulance crews conveyed patients in wheelchairs or trolleys to the majors entrance where ambulance staff transferred patients to the ED nurse in charge. Patients waited in wheelchairs in the majors waiting area before being assessed in one of the five majors assessment cubicles. Patients on trolleys were transferred to an assessment bay if one was available or remain at the entrance to the majors area until a cubicle became available.
- During the inspection we observed handover between ambulance staff and ED staff took place efficiently. However, there was a delay to assessment by ED staff depending on availability of staff and space in the ED. Data showed 70% patients attending majors were not assessed within 15 minutes and during our inspection, some patients waited more than one hour for assessment.

- There were also times when we observed beds were available in the majors area and patients were in a queue waiting to be assessed. There were also periods in the day when the minors area had capacity but there was no evidence of flexibility to cross cover more busy areas of the department. We also observed the negative impact on the patient flow on the unit when major trauma cases were received and prioritised for assessment and treatment.
- In cases when capacity did not meet demand, the corridor, known to staff as the atrium, between the minors and majors areas was used to accommodate up to six patients on trolleys. The area was screened off when in use to limit public access. We observed two occasions when between one and three patients were treated in the screened corridor. Senior ED staff told us this continued to be used to accommodate patients and increase capacity. It was risk assessed as a safer option for patients who had been assessed and treated rather than increase ambulance handover times by requiring them to wait outside the department. A dedicated nurse supervised the atrium when it was used to accommodate patients.
- In the minors area a band 6 streaming nurse carried out the initial assessment. The nurse sent patients for blood tests, x-rays or diverted them to the small majors waiting area. The extended nurse practitioners in the minors department said they monitored the waiting room and expedited tests to, "Pull patients through ED."
- EAU had 31 beds and staff told us ED primarily used three to five beds in EAU for patients with mental health needs; for example, patients waiting psychiatric review, investigations and observations. The ED coordinator transferred patients to EAU if beds were available and the patient was expected to be discharged within 12 hours. Data for the last six months showed approximately 1500 (13%) patients were transferred to EAU from ED each month. Of these patients approximately 60% patients were discharged from EAU. The average length of stay in EAU during this period increased month on month from 10 hours in April 2016 to 19 hours in October 2016.
- Pathways were followed to reduce demand on ED. For example, GPs referred patients with acute medical needs to the ambulatory assessment unit (AAU) and patients with surgical needs to the surgical emergency unit (SEU). ED staff also referred patients who required tests/ investigations but did not need to be admitted, to the AAU. At the time of inspection there was conflicting information about the pathway from ED to the SEU. However, following the inspection the trust provided data to confirm patients initially assessed as in need of surgical assessment were referred to the SEU without a surgical review in ED. We reviewed the SEU pathway which clearly stated there was 'No barrier to acceptance of surgical patients referred from ED to SEU' and the default position was to accept the referrals from ED without condition. Data showed 2364 (30%) patients had been referred to SEU from ED since 1 April 2016.
- We spoke with members of the clinical coordinator and bed management team who were based in ED and worked closely with the nurse in charge of ED to facilitate patient flow through the department and hospital. For example, they arranged for patients who were ready for discharge to be transferred to the transfer lounge. The trust had also contracted an ambulance to facilitate patient discharge from ED, EAU and AAU between 12pm to 12am daily.
- The trust scored "about the same" as other trusts for all of the three A&E Survey questions relevant to the key question of responsive services.
- The trust had worked with partners to reduce the number of delayed transfers of care across the whole of Oxfordshire. For example, new initiatives to provide care and rehabilitation at home or in nursing home beds in the community had been introduced. Data showed the number of delayed transfers had reduced from an average of 116 in the six months up to January 2016 to an average of 78 in six months up to August 2016.

Learning from complaints and concerns

- The department had received 37 complaints between April 2016 and September 2016. Numbers of complaints and learning points from them were discussed at ED clinical governance meetings.
- The ED matron told us issues identified following complaints investigations related to lost property and staff communication. In response red pots had been

introduced to keep patient possessions, such as dentures, safe. Staff had been reminded about the importance of the right attitude and effective communication with patients and relatives.

- Complaints were handled in line with the trust policy. Patients were advised to contact the patient advisory liaison service for support with their complaint. Complaints were managed by the complaints team and investigated by senior staff.
- Information on how to complain was available in the main ED department and on the trust website.
- Formal complaints were investigated by a consultant or senior nurse and replies were sent to the complainant within an agreed timeframe. We saw the complaints log for June to November 2016 which showed actions taken in response to complaints and learning shared at ED clinical governance meeting.

Are urgent and emergency services well-led?

Requires improvement

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

We rated well-led as requires improvement because:

- Through discussions with staff we found there was a culture of some behaviours which negatively affected the way patient care was managed and flow through the department.
- Although a clear governance framework was in place, changes to the service with regards to service performance and patient flow through the department had not been sufficiently addressed to sustain improvement .
- Although the leadership had oversight of the challenges faced by ED, at the time of the inspection the service had not achieved the 4 hour standard and remained below the England average since October 2015. Achievement against the 15 minute assessment standard had been three times the England average since May 2016 (29 minutes compared with 10 minutes).

However:

- The department leaders were visible, approachable and valued their staff. There was an open culture of staff engagement and team work to encourage staff to raise concerns, including a programme of peer review.
- The service risks were recorded and monitored at department, division and board level.

Leadership of service

- The emergency department was located in the directorate of acute medicine and rehabilitation. The directorate's leadership team consisted of the clinical director, and operational services manager. The clinical director was supported by the ED matron and the consultant clinical lead.
- Through our discussions with the ED consultant lead and matron they demonstrated a clear understanding of the issues faced by the ED. The directorate leads, divisional nurse and members of the executive team: the directors of nursing and clinical services were also knowledgeable about the ED and were supportive of changes to improve the service.
- All staff we spoke with expressed confidence in their leaders and said the senior management team were visible and approachable.
- One of the ED consultants was the lead consultant for audit. We observed they effectively led the ED clinical governance meeting demonstrating an inclusive and learning approach for participants.

Vision and strategy for this service

- The trust core values were on display on literature across the trust: excellence, compassion, respect, delivery, learning and improvement. These values underpinned the trust's vision to be: 'At the heart of a sustainable and outstanding, innovative, academic health science system, working in partnership and through networks locally, nationally and internationally to deliver and develop excellence and value in patient care, teaching and research within a culture of compassion and integrity'. This vision was underpinned by the trust's founding partnership with the University of Oxford. Staff we spoke with displayed values consistent with the trust values and they told us they were proud to work for the trust.

- All areas had business plans in place to support their local strategy. Strategies had been or were being reviewed to ensure they were reflective of the trust vision and strategy.
- The medicine, rehabilitation and cardiac division business plan 2015-20, included the directorate business plan. Staff we spoke with were aware of the strategic priorities of the department: to meet the four hour target and the expansion and development of the ED.

Governance, risk management and quality measurement

- Our conversations with the divisional and directorate leads revealed they had clear oversight of key challenges and risks in their services. For the emergency department, patient flow was acknowledged as one of their biggest challenges. The plans in place focused on the development and expansion of the department to increase the number of beds in the resuscitation area.
- Service performance was reviewed and monitored at directorate level governance meetings and key metrics were reviewed at divisional level governance meetings. Risk registers were in place at directorate, divisional and corporate level. Any new risks on the risk register were a standard agenda item at the monthly clinical governance and risk meeting.
- ED performance including waiting times and patient safety metrics were monitored and reported on a daily basis to directorate leads. However, at the time of the inspection the service had not achieved the 4 hour standard and remained below the England average since October 2015. Achievement against the 15 minute assessment standard had been three times the England average since May 2016 (29 minutes compared with 10 minutes). Following the inspection the trust informed us changes had been implemented and improvements had been made in the achievement of the 4 hour standard.
- We saw the urgent care improvement plan to deliver the four hour standard was in place which included 41 actions from pre hospital admission to discharge to improve capacity, flow and patient experience.
- Monthly governance and quality meetings were open to all staff and took place during the inspection visit. We saw they were well attended and the emphasis was on an inclusive and learning approach. We reviewed the notes of the ED clinical governance meetings (August and September 2016). The notes covered all morbidity and mortality cases, incidents, complaints and NICE guidance. There was a focus on learning, audit results and actions were highlighted. At the children's department governance meeting, we saw updated protocols were discussed, for example, the dog bite protocol which had been produced in conjunction with the police and social services.
- Divisional quality reports were reviewed by the trust executive team and papers presented for discussion. For example, in July 2016 the trust's director of clinical services presented a paper on 'Analysis of key quality metrics in A&E and impact on quality of care'. This reviewed data on ED length of stay (LOS), crowding and mortality. It concluded there was a relationship between length of time in ED and median LOS and some evidence that antibiotics were delayed in an overcrowded department.
- The ED risk register included risks across both of the trust's EDs. There were wide ranging risks which included description of risk and mitigating factors, some risks were identified as being downgraded following review in September 2016. We noted issues on the risk register which we had observed during our visit, for example, staffing in resuscitation and space in the ED.
- A bimonthly ED governance newsletter titled, 'Hold the front door', contained a wide range of topics. It was used to raise awareness among the team of important departmental issues.
- We reviewed the previous two editions of the newsletter (June 2016 and August 2016). The August 2016 newsletter covered the introduction of the checklist for national safety standards for invasive procedures, cognitive assessment for patients over the age of 70 years, new equipment for the children's department and medication safety, domestic abuse and infection control.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED. Senior ED staff described the ED team as "Fantastic… staff try to do their best every day for patients." Staff we spoke with said they "Loved the work" but there were times when work demands of the job made it stressful.
- We observed a strong cohesive team which was centred on the needs of patients. Staff said the support they

received from their colleagues helped them cope with the pressure which resulted from a department that was often severely crowded. ED staff we spoke with said they felt the pressures faced by ED for example, the four hour target was considered by some parts of the trust to be "Only ED's responsibility as oppose to a hospital wide performance target."

- Through discussions with senior staff in ED: lead consultant, matron, clinical director and divisional nurse; they acknowledged for ED performance to improve some entrenched behaviours and cultures within the department as well as in the wider organisation needed to change. For example, in order to improve patient flow, ED consultants needed to provide active senior oversight of the department rather than junior staff approach them for advice. There was also inappropriate gatekeeping by junior medical/ surgical staff from specialist teams which potentially impeded patient flow and was a barrier to accepting direct referrals from ED.
- As of October 2016, the site reported, for urgent and emergency care, an average nursing sickness rate of 2.6% and 0.39% for medical staff against a trust target of 3%. Matron said psychological support through workplace occupational health was available for staff. For example, following a serious incident, as part of the debrief, staff support was provided.
- Divisional and directorate leads described a positive culture where learning and development was encouraged. They said they were empowered to take local ownership and make local decisions.
- We spoke with security staff based in an office in the ambulatory department. We saw staff wore bodycams and they said they only attended an incident if called by ED staff to provide support and reduce the risk to staff.

Public engagement

- The friends and family test (FFT) survey was sent to patients as a text message to encourage feedback.
- Between July 2015 and June 2016, the trust urgent and emergency care FFT performance with regards to the proportion of patients who recommended the service was generally worse than the England average. In the latest period, October 2016 trust performance was 78% compared to an England average of 86% and a comparably higher response rate of 23.3% against an England average of 12.8%.

Staff engagement

- Medical and nursing staff said they had easy access to the senior staff in the department.
- A bimonthly ED newsletter contained a wide range of information on department topics, both operational and social. For example, the August 2016 newsletter recognised staff achievements, bid staff farewell and welcomed new staff to the department.
- The trust had developed a peer review programme to engage staff, encourage improvement and share learning across the different directorates. The ED had undergone the peer review process and staff spoke positively about the staff engagement aspect.

Innovation, improvement and sustainability

- The emergency department aimed to continuously identify and implement new processes and practices to improve patient and staff safety.
- Innovative projects included the development of coloured lanyards for specific grades of doctor to help staff better identify experience and level of ability. The nurse-in-charge also wore a specific lanyard to be easily identifiable.
- The department had developed its own track and trigger escalation amongst other triggers alongside a nursing documentation tool. This aimed to ensure timely escalation and good documentation.
- The emergency department psychiatric assessment service was awarded the Psychiatric Liaison Accreditation Network (PLAN) accreditation, which sets the standard for good provision of psychiatric services in general hospitals.
- The trust introduced a quality assurance process of peer review across the directorates to encourage improvement and foster shared learning.

Surgery

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

Information about the service

The John Radcliffe Hospital is the principal teaching hospital with a main complex of eight operating theatres and adjacent recovery and critical care areas. The surgery undertaken out of those theatres is emergency general surgery, emergency and urgent trauma, spinal, vascular, and cardiac surgery Additional theatres in other area's of the site provides maxillofacial, ophthalmology, plastic surgery, ENT, cardiothoracic, general surgery, neurosurgery, spinal surgery and trauma. Other surgery services such as gynaecology (women's surgery) are provided but these are not covered by this report.

The trust clinical services are split into five divisions, four divisions include directorates providing a surgery service, three of these include services at the John Radcliffe hospital. These are the neurosciences, orthopaedics, trauma and specialist surgery division which includes the three directorates that provide specialist surgery; trauma and neurosciences. The medicine, rehabilitation and cardiac division includes cardiology, cardiac and thoracic surgery directorate. The clinical support services include the two directorate's; anaesthetics and sterile services and critical care, pre-operative assessment, pain service and resuscitation.

Each division is headed by a divisional director, a practising clinician, supported by a divisional nurse or health care professional and general manager. Each directorate is led by a clinical director, operational services manager and a nurse leader.

There are three wards in the west wing where surgical patients are cared for. These are neuroscience ward, the specialist surgery in patients ward and the day surgery unit for patients having ENT, plastic, ophthalmology and oral and maxillofacial surgery. The cardio thoracic ward is in the oxford heart centre and there are five further surgical wards in the main hospital, two trauma wards, two surgical wards and the surgical emergency unit.

The John Radcliffe Hospital had 35,082 surgical spells between April 2015 and March 2016. A spell is counted when a patient is admitted under the care of a consultant. This site provided the greatest number of surgical spells for the trust, with 58.9% of the total. Emergency spells accounted for 37.8%, 48.7% were day case spells, and the remaining 13.5% were elective. Compared to the trust breakdown, this site had a greater proportion of emergency spells. A total of 30.9% of spells at this site were for general surgery, 16.8% for ophthalmology and 9.1% for plastic surgery with the remaining 43.2% being made up of other specialities.

During our inspection we inspected emergency general surgery, vascular cardiac surgery, maxillofacial, ophthalmology, ENT, cardiothoracic, general surgery, and trauma theatre suites. We spoke with nine patients, five relatives and 29 members of staff, including consultants, theatre and nursing staff, porters, housekeeping staff, allied health professionals, medical staff and the divisional leads. We also reviewed nine patient records, observed care on the wards, in the operating theatres and in the recovery area. We analysed data provided by the hospital after the inspection.

Surgery

Summary of findings

We rated this service as good because:

- There was a safe number of staff with appropriate skills, training and experience to keep patients safe. The service used agency staff who were familiar with the service and its procedures. The hospital followed the escalation policy and procedures to manage busy times.
- Staff planned and delivered patients' care and treatment using evidence based guidance and audited compliance with National Institute Health and Care Excellence (NICE) guidelines.
- Ward and theatre areas we visited were clean and tidy, we saw most staff following good infection prevention and control practices. Staff knew the trust's process for reporting incidents. They received timely feedback from managers regarding reported incidents the lessons learned. There was strong multidisciplinary working across teams at the hospital so patients received co-ordinated care and treatment.
- Nursing staff completed timely risk assessments for patients. If a patient became unwell, there were systems for staff to escalate these concerns. The hospital provided care to inpatients seven days a week. Staff ran an on call system with access to diagnostic imaging and theatres.
- We saw staff treated patients with compassion and care. They were kind and treated them with dignity, and respect. There were systems to support patients with additional or complex needs. Patients felt informed and involved in their care. Patients and families said they would recommend the service to others.
- Staff followed the trust's governance processes to monitor the quality and risks of the surgical service. They completed audits and monitored patient outcomes, making changes to practice when necessary. Staff told us the leadership across the service was good and the senior team was visible and accessible. Staff had an annual appraisal and could access additional training to develop in their role. The trust had employed a falls safe training lead and falls had reduced from three serious patient falls a month to zero falls.

However:

- Although we saw good practice with staff risk assessing patients at risk of developing pressure ulcers and obtaining pressure relieving mattresses, we did not see pressure relieving cushions used for identified 'at risk' patients.
- The resuscitation trolley located in the cardiothoracic theatres had not been checked since mid-September 2016. This meant staff could not be assured the equipment was ready to be used and accessible
- Nursing and midwifery staff did not achieve the trust 90% target in three of the six mandatory modules. Minutes from clinical governance minutes July 2016 showed the trust was aware and was taking actions to address the concern.

Surgery

Are surgery services safe?

Good

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

We rated this service as good for safe because:

- All clinical staff we spoke with were familiar with the process for reporting incidents near misses and accidents using the trust's electronic reporting system. Staff felt confident and able to report incidents. We saw minutes from clinical governance meetings, confirming incidents were discussed, lessons learnt and action plans agreed.
- Staff demonstrated a good understanding of duty of candour and gave examples where they had used this to support patients. All staff spoken with understood the term safeguarding and knew how to raise a safeguarding concern
- There was an infection prevention and control (IPC) lead for the trust. All clinical areas were visibly clean and staff had access to sufficient equipment to provide safe care and treatment. We observed staff following good infection prevention and control practices, to minimise the risk and spread of infection to patients on the wards and in theatres
- Ward and theatre managers described the escalation process if the staffing levels for their area dropped below the minimum safe staffing. Overall, staffing levels met the planned levels for theatre, nursing and medical staffing.
- The decontamination and sterilisation of surgical instruments took place on-site, meaning equipment was always available for routine surgical procedures.
- The trust had introduced electronic prescribing and medicines administration (ePMA) to assist staff with the safe administer of medicines.
- Risk assessments such as pressure risks, falls and venous thromboembolism (VTE) were completed regularly by nursing staff.
- Theatre staff followed the World Health Organisation (WHO) Five Steps to Safer Surgery checklist.
- Since August 2015 sepsis awareness training had been included in the medical induction process for all doctors joining the trust, regardless of grade.

However:

- The theatre environment was constrained both in size and layout. Although the trust was aware of this and had plans to address the issues.
- We saw good practice with staff risk assessing patients at risk of developing pressure ulcers and obtaining pressure relieving mattresses, we did not however, see pressure relieving cushions for these identified at risk patients.
- The resuscitation trolley located in the cardiothoracic theatres had not been checked since mid-September 2016. This meant staff could not be assured the equipment was ready for use in an emergency.
- Data provided by the trust September 2016 showed nursing and midwifery staff achieving the 90% target in three of the six mandatory modules.This meant three mandatory modules did not meet the target set by the trust. We did see July 2016 clinical governance minutes highlighting action plans to address this concern.

Incidents

- Incidents were reported through the trust's electronic reporting system. All clinical staff we spoke with were familiar with the process for reporting incidents near misses and accidents using this system.
- Clinical staff told us that there was a strong reporting culture within surgical wards and theatre with good and timely feedback.
- Clinical staff told us that the trust held a monthly Serious Incidents Requiring Investigation (SIRI) forum. This meeting was led by the trust deputy medical director with multidisciplinary staff in attendance. Serious incidents were discussed to share learning and any incident where duty of candour was triggered was highlighted.
- We saw a set of minutes from the SIRI forum September 2016. The minutes included an example were a patient due for planned complex surgery developed a grade 3 pressure ulcer and another was an unwitnessed patient

fall resulting in a dislocated shoulder. We saw the action plan for patient care and letter from the trust to the patient and this confirmed that the trusts duty of candour policy process was followed.

- The trust held monthly mortality review meetings about the care of patients that had died in hospital. We saw minutes from September 2016 clinical governance committee and morbidity and mortality meeting confirming these discussions took place. Senior nursing staff together with consultants reviewed the care and treatment of all patients who died in the hospital. Outcomes from investigations in hospitals were presented to the clinical governance committee to identify learning for improvement.
- The surgery directorate reported 44 serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016. Of these, the most common type of incident reported was pressure ulcer, with 15 of the 44 (34.1%) of the incidents reported.
- Staff also told us they had received grade three pressure ulcer e-learning as a result of trends identified at trust level from incident reports. We saw "at a glance" pressure ulcer prevention policy highlighting correct documentation for staff to adopt such as do not say intact skin, document unmarked or marked skin.
- We saw copies of the workbook January 2016 being used to ensure clinical staff are trained at recognising and managing pressure ulcers. Staff told us of the change to clinical practice; that all patients with hip fractures have pressure relieving mattresses on admission and regular analgesia. They report all pressure ulcers grade two and above, including those on admission.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between October 2015 and July 2016 the trust reported six surgical incidents at the hospital, classified as surgical/invasive procedure incident never event for surgery.
- One was for a wrong site incision (oesophagostomy), one wrong site craniotomy and two were for wrong site block, and one was for an incorrect lens implant and one for an incorrect nerve block during cataract surgery. The trust had investigated each incident and had an overarching action plan in place with a particular focus on human factors training.
- In response to the wrong site blocks, the theatres, anaesthetics and sterile services directorate (TASS) governance team newsletter included a safety reminder notice 'Stop before you block' highlighting 'do not enter the anaesthetic room when a patient is present, let the anaesthetic team work safely without distraction' information.
- All these events had a root cause analysis investigation and action plan.We saw minutes from team meetings and clinical governance meetings highlighting these incidents. These events were published in the trust newsletter for all trust staff to learn from the incident.
- Clinical Governance & Risk Practitioner (CGRP) trained staff in incident investigations and made sure appropriate individuals were involved in the investigation.They had oversight of all incidents graded as moderate or serious incidents; they were alerted by the electronic reporting system if any incidences were graded at this level.They monitored for trends and produced directorate and divisional monthly trend reports.
- The divisional leads monitored, on a monthly basis, the total number of incidents reported, looked for trends and reviewed the time for managers to sign off that they had investigated incidents allocated to them.
- Staff in the trauma unit were able to describe two serious incidents that had been reported, the investigation and the learning that had followed. One related to the sudden deterioration of a patient after a treatable condition and there followed changes in the patient pathway and a review of medication routes. The anaesthetic team told us they had introduced a new way of disposing of syringes containing unused medicines as a change to practice following the incident.
- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that

person. Staff we spoke with were familiar with the concepts of openness and transparency and some could give examples of how they or their colleagues had applied the principles of the duty of candour. There was a process in place for the management of incidents that included the DoC. There were two moderate or above incidents (i.e. subject to DoC) for surgery directorate at the hospital in last six months. The duty of candour aspects both written and verbal were completed.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot of avoidable harms, in particular new pressure ulcers (grades 2, 3, 4), catheter-related urinary tract infections (C-UTIs), venous thromboembolism (VTE, or blood clots) and falls (with harm). This information was displayed on ward notice boards, where patients, visitors and staff could view the results and trends. The ward managers we spoke with confirmed this data was collected monthly. Data from the trust surgical wards patient safety thermometer showed that there were 64 pressure ulcers grade 2, 3 and 4 developed during hospital admission, 23 falls with harm and 44 catheter urinary tract infections between July 2015 and July 2016. We saw the monthly results displayed on all surgical wards. One ward (6F) highlighted a grade 2 pressure ulcer had developed whilst the patient was in the ward. Two wards (6D and 6E) showed that there had been no grade 3 or 4 pressure ulcers or serious falls with harm in over 365 days.

Cleanliness, infection control and hygiene

- All clinical areas we visited were visibly clean and tidy. We observed staff following good infection control practices, to minimise the risk and spread of infection to patients. We saw staff cleaning their hands before and after patient contact and ensuring they were 'bare below elbows'. Staff also had access to personal protective equipment (PPE) such as gloves and aprons, which we observed them using appropriately. Instructions and advice on infection control were displayed for patients and visitors. There were hand sanitiser points around the hospital for visitors and staff to use, to reduce the spread of infection to patients.

Environment and equipment

- We observed the wards we visited had controlled entry and exit to facilitate staff and patient security. The front door to the hospital was locked at night with push button access and security guards patrolling the hospital grounds.
- All the equipment we observed on the ward was in working order and staff said they had sufficient equipment available to provide patient care. We saw a request to the maintenance department to repair a broken handle was dealt with the same day efficiently.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines: Checking Anaesthetic Equipment 2012 recommends the checking of anaesthetic machine before each operating list. The logbook with each anaesthetic machine had showed that the machines had been checked on the days the operating theatres were in use.
- The trust was aware of the need for improving the overall theatre complex to address issues such as the ventilation system in the main operating department and the cramped conditions. Staff told us procedures were some times cancelled because of these issues. There was a business case awaiting approval to either refurbish the existing unit or to build a dedicated complex and this was viewed as a priority for the trust.
- Since the trust became aware of the ventilation issues nearly two years ago, theatres 1 to 8 main theatre suite had their ventilation systems replaced. Theatre 9 has been taken out of use completely and theatre 10 is only used for bronchoscopy procedures. All these changes have been risk assessed and approved by the trust infection control team.
- The theatre environment in the main theatre complex constrained practice in that clinical staff had to go up two flights of stairs to change into theatre scrubs. However, they are in still situated within theatre complex. The infection control lead nurse had assessed the situation and considered this was not a major infection control risk. The concern was on the trust risk register and the action plan identified by the trust infection control team was awaiting business case approval.
- We saw a copy of the clinical support services department business plan 2015/17 highlighting the ageing sterile services estate which could pose a risk of

operational failures within the theatre environment. The action plan highlighted the possibility of a single site solution to bring together all trust support services department into one single entity, reduce costs and improve efficiency was being considered by the trust.

- The layout of theatres direct admission areas did not take into consideration the patient's privacy and dignity. The theatres proposed refurbishment business case should address the lack of privacy and dignity situation in the long term. In the interim we were told the trust was planning to erect a substantial, temporary partition wall as an intermediate solution to provide privacy and dignity for all patients.
- Theatre staff told us that access for hoist equipment for managing bariatric patients was limited. Senior managers told us this concern should be addressed in the theatre business case.
- Each ward had moving and handling equipment to assist with the moving of patients. In addition bariatric equipment was available and staff could hire in additional specialist beds and pressure relieving mattresses if required.
- The central sterilising services department (CSSD) was on the hospital site. We saw staff operate a reliable system with strong working relationships with theatre staff. The sterilisation service had safe systems in place with daily documented checks of equipment and evidence of on-going audits to ensure compliance.
- We did see in one theatre scope room a specimen fridge that appeared not to be in use but still plugged in. No checks had been carried out since 2014. We discussed this with theatre staff who told us it was not used and it should be put out of action and removed.
- The theatres critical care ventilation system and the air handling units were serviced at least annually. This was confirmed by the service reports with actions taken when required.
- Emergency equipment was available. There was a process on each ward, the discharge lounge and in theatres for the resuscitation trolley to be checked daily. We reviewed logs on each resuscitation trolley which confirmed checks had been done. However, the resuscitation trolley located in the cardiothoracic theatres had not been checked since mid-September 2016 and had been covered with other items of equipment. This meant staff could not be assured the equipment was ready to be used and was accessible.
- The trauma unit was a purpose built and was able to accommodate all trauma related injuries. The trauma unit had single sex facilities available for patients. We observed, and staff confirmed, a good ward layout with two large observation bays which were used for confused patients. However, staff did tell us the metal framed windows were 'very hot in the summer and too draughty in the winter'. We were told the trust had explored applying a film to the windows but it is 'too costly'.
- All patients identified at risk of developing a pressure ulcer had a pressure relieving mattress in place on the bed. However, we did not see pressure relieving cushions on the chairs for when the patient identified at risk sat out.

Medicines

- The trust had introduced electronic prescribing and medicines administration (ePMA) system, used as an aid for staff to safely administer prescriptions. The clinical staff once trained scanned the patient's wristband which had a barcode to uniquely identify the right patient to the right medicine. Every patient was given a leaflet to explain the need for clinicians to scan wristbands every time before administering medicines.
- Appropriate systems, processes and policies were in place for the safe storage and management of medicines, including controlled drugs (CDs).A record was maintained of medicines given to patients to take out (TTO's).
- A pharmacist and a pharmacy assistant were allocated to the wards. They undertook regular reviews of patients' medicines and provided staff with advice such as drug dosages and contraindications and assisted with patients own medicines on admission.
- CD stocks were checked each night and CD record logs confirmed this practice. Keys for the CD cabinets were logged in and out at the beginning and end of each shift.

- We saw that 85.6% of staff had received controlled drugs training in September 2016 and there was a timely action plan to ensure the rest of the staff received this training.
- There was a system in place for the safe disposal of residual unused controlled drugs in a dedicated medicine disposal bin.
- Medicines were stored safely and securely in theatres and in all the wards we visited.
- Medicines were stored according to manufacturer's guidance and dedicated refrigerators were available for storage of some medicines. The fridge temperatures were monitored and recorded daily, records showed temperatures were within recommended ranges. Medicines stored at the wrong temperature and not according to the manufacturer's recommendations could reduce the efficacy of medicines given to patients
- Oxygen was piped to patient areas and where cylinders were used, for example on emergency trolleys; they were stored in a secure manner.
- The clinical risks register highlighted administration of medicines as a risk that patients could have medication delayed, omitted or given erroneously due to non-compliance with trust and professional nursing and midwifery council guidance. Solutions to improve this included nursing led initiatives, for example the medicines improvement project led by the practice development nurses and the core nursing standards. The trust redesigned inpatient medicines chart had been recently launched as part of this initiative.
- There were patient leaflets entitled 'Antibiotic Guardian' explaining the trusts stance on antibiotic resistance.

Records

- The trust had been working with an external software solutions company to produce core care plans to use with the electronic patient record, currently wards used individualised paper based care plans.
- There was a combination of paper and electronic system for patients' records in use. Access for electronic records was password protected and staff said this was secure. Paper records were stored on the wards in lockable trolleys. Staff did not raise any concerns about the availability of patient records
- We reviewed nine medical, nursing notes and other associated records as part of the inspection. We looked to see if the records were stored securely and at the quality and legibility of the records. We saw that all nine records contained adequate and legible and up to date patient information. Overall we found good compliance with record keeping.
- We reviewed a health record keeping audit in July 2016 which checked 20 surgical patients' records for 35 questions such as legibility, next of kin details, allergies, WHO checklist and documented consent. There was 86% compliance with an action plan to improve.
- Risk assessments such as pressure risks, falls and venous thromboembolism (VTE) were completed by nursing staff. A trust review of 12 VTE records showed these were completed except for those patients admitted within the last 24 to 48 hours.
- A standardised protocol was used for pre-operative assessments. Pre- operative assessments were completed for patients undergoing elective surgery.
- Patients had a comprehensive pre admission assessment which was recorded in the pre-assessment care pathway and placed in the patient's main hospital notes. If a patient's hospital record could not be found for their pre-assessment appointment, the last few clinic letters were obtained and a repeat history taken by the nurse.The patient's GP was also contacted if there were specific medical concerns.No audit was undertaken of missing notes for pre-assessment appointments.

Safeguarding

- The trust employed a safeguarding lead who devised a safeguarding training programme which included mental capacity act training and deprivation of liberty safeguards for all clinical staff.
- All staff spoken with understood the term safeguarding, and knew how to raise a safeguarding concern. Staff were aware of the actions to take to keep people safe from abuse. Staff gave us examples of when they had intervened if they suspected abuse.
- Staff had access to the senior ward staff and the hospital safeguarding lead if they had concerns. Staff recorded safeguarding concerns on the incident reporting system.

- Our review of patient records showed that safeguarding issues were identified and recorded.
- All staff were required to undertake safeguarding vulnerable adults and children training annually. Training records for September 2016 showed in the surgical division for medical staff 80.1% and 91.8% nursing staff had completed adult safeguarding training against the trust target of 90%. 93.1% medical staff had completed child safeguarding level 1 training. However, only 66% had completed safeguarding children level 2 training against a trust target of 90%. Ninety two percent of nursing staff had completed level 2 training against a trust target of 90%.

Mandatory training

- Each ward and department had a member of the nursing staff responsible for monitoring staff compliance with mandatory training. Mandatory training was a mix of eLearning and face to face training. Staff said the mix of styles of training met the varied learning styles of staff.
- Data provided by the trust September 2016 showed nursing and midwifery staff achieving the 90% target in three of the six mandatory modules. These included infection control 93% moving and handling patients 91% and safeguarding adults 91%. There was a range of safeguarding children level 3 85%, conflict theory 85% and conflict practical 65% We saw action plans to improve compliance highlighted in the July 2016 clinical governance meeting minutes.

Assessing and responding to patient risk

- Theatre staff followed the World Health Organisation (WHO) Five Steps to Safer Surgery checklist. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning and end of each theatre list and the WHO surgical safety checklist, which included sign in, time out and sign out. There was an adapted version of the WHO surgical safety checklist in use in ophthalmology and urology, in keeping with best practice guidance.
- We observed five operations and for all each stage was completed, with good engagement from all staff. However, we saw in the trauma theatre several people responsible for completing the WHO checklists, there was not one lead person responsible for the methodical check and this could lead to parts of the check being missed. Monthly audits took place and results from February to July 2016 showed 100% compliance.
- A theatre safety huddle where all staff members' attended to discuss staffing concerns, complex surgery and equipment checks took placed every morning seven days a week.
- We saw emergency call bells in working order in all theatres and all staff we spoke with were aware of the procedure for emergencies.
- Staff monitored patient's health during surgery, recovery and on the wards, and systems were in place to respond to any deterioration. The hospital used an electronic system called track and trigger to record patients' vital indicators. The surgical wards and recovery areas used the National Early Warning Score (NEWS), a scoring system that identified patients at risk of deterioration or needing urgent review. The observations were put into the electronic system. The scoring system alerted staff to take the appropriate action if a patient was identified at risk of deterioration. This included alerting a doctor who could see the patient's vital signs remotely so they could provide advice to nurses without having to attend the ward. Nursing and medical staff told us the system worked well.
- Staff assessed patients for their risk of developing pressure ulcers, VTE, for falls and malnutrition. They also reviewed risks relating to patients' medical history, medicines and lifestyle. The risk assessment process started at pre-assessment and staff monitored any changes throughout a patient's admission.
- The National Institute for Health and Care Excellence (NICE) recommends that all patients are assessed for the risk of developing venous thromboembolism (VTE) on a regular basis. Records showed staff assessed surgical patients on admission for their VTE risks. Where risk were identified, treatment was prescribed and administered to reduce the risk. Eighty nine percent of registered nurses in the trust had received training on assessment and prevention of VTE.

Surgery

- The trust had worked in partnership with the Royal College of Physicians with the falls safe campaign for over 11 years and had collected data and contributed to falls prevention strategies for other trusts to follow such as the fracture fragility conference in December 2015.
- The baseline for the trusts serious falls incidence in 2014/15 was high with three serious falls per month recorded. Since the trust employed a falls prevention and education nurse, the number of serious falls has reduced to zero.
- Each ward had a falls safe training lead who received a full days training on falls prevention and management. Changes to clinical practice had included patients identified of being at risk of falling being given non-slip slipper socks to wear. They were also given a yellow wrist band to identify them to others as a falls risk. We saw a prevention of falls padded 'crash mat' in place near the patient's bed who had been identified on admission from a care home as a high risk to falls. There was also an initiative working with patients and families to reduce falls in the hospital called "call don't fall".
- Ward staff and clinical development nurses had developed safety cards, these included key safety and organisation information to fit in the nurses' pocket. An example of information was where to locate pressure relieving mattresses. Clinical staff told us they were a useful reminder and were well received.
- We saw a clinician discuss with a patient the risk of a loose front tooth becoming dislodged during the surgical procedure and documenting this risk in the patients notes and highlighting the risk to the surgical team.
- Senior managers told us sepsis was an important trust-wide clinical priority. Since August 2015 the trust reported against the national sepsis requirements (delivery of antibiotics within one hour with review within 72 hours) to Oxfordshire Clinical Commissioning Group (OCCG). The OCCG has formally agreed a trajectory for implementation with the trust. We saw a trust wide electronic screening tool for clinicians September 2016 with a simple algorithm for staff to follow.

Nursing staffing

- Staff working on the surgical wards and in the operating department told us shifts were staffed appropriately based on the number of patients and the needs of these patients. An electronic staffing tool was used which highlighted where shifts did not meet the minimum staffing level for the ward, so managers could address this. We saw from rotas that in general shifts in both the operating department and surgical wards were staffed as planned.
- The trust also held daily bed occupancy meetings to monitor staffing levels due to changes to the needs or number of patients. There was an escalation process if the staffing levels for an area dropped below the minimum safe level. Managers told us senior staff were responsive and where possible reallocated staff from another ward or tried to recruit bank and agency staff at short notice.
- The trust used an online acuity tool which was updated by ward staff after every morning handover, and altered during the day if anything significantly changed. This alerted the trust to the acuity of patients on the wards.
- Ward managers reported staffing was a concern due to vacancy gaps in both senior and junior staffing grades.
- All wards we visited, displayed their planned and actual registered nurses and health care assistants for the day, for patients and visitors to refer to. Patients told us staff were very busy both day and night, but that the care they received felt safe.
- We reviewed the rotas for a month for two wards. The minimum staffing levels were met for both wards during that time.
- There was a nursing at night team who had an overview of the hospital situation and would respond rapidly when called. Staff told us they could move staff quickly if there was an emergency at night to make the hospital safer for patient care.
- As at September 2016, the hospital reported a qualified nursing vacancy rate of 12% in surgical care. The surgical site reported a 12% staff turnover. The whole time equivalent (WTE) for all vacancies for general surgery staff was 121.94, there was 105.08 WTE in post as

from September 2016. The WTE for plastic surgery was 92.73; there was 85.82 WTE in post as from September 2016. Vascular surgery and thoracic surgery were above the WTE level.

- Between October 2015 and September 2016, the site reported an average bank and agency usage rate of 9.5% in surgical care. Bank and agency usage has seen a downward trend over this time as in October 2015 it was at 16.88% and by September 2016 it was down to 8.58%.
- On the trauma unit, at the time of inspection, nurse vacancies were 8.69 whole time equivalents and for care support workers it was 17.5 whole time equivalents.
- We reviewed the staffing rotas for the operating theatres for the week of and all theatres were staffed in line with the trust standard operating procedure 'Safe staffing in theatres' (2015) which followed the staffing guidance from the Association for Perioperative Practice (AfPP).
- Ward managers in the trauma unit said on occasion they stayed and worked additional hours. Senior staff told us they co-ordinated the unit during early shifts but had their own patient caseload on the late and night shifts.
- We were told the wards run a primary nursing system which means there is a named responsible registered nurse per patient to give continuity of care. The staff told us they had resisted the move to long shifts due to the demands of the wards. It had been determined that it was too physically demanding for a 12 hour shift.
- Wards in the cardiothoracic unit were divided between cardiothoracic and cardiac. Staff were allocated to each ward according their skills and the patients risk profile.
- Nurse practitioners were available to support staff in the cardiothoracic ward and these roles were being developed by the trust on the cardiac ward.

Surgical staffing

- Each speciality had a system in place to ensure there was consultant led care available all day every day. We saw the on-call rotas for the operating department; theatre staff and anaesthetic staff were available if there were any unplanned returns to theatre or emergency admissions. There were two emergency teams on-site and an additional team on-call, which could attend, if there was the need to run three emergency theatres
- There was 24-hour medical cover to the wards provided by the junior and specialist grade medical staff. Consultants were on-call for a week at a time and during this time; the majority undertook no elective surgery work. They ran dedicated daily emergency operating lists to ensure emergency patients were seen within 30 minutes. We saw these were staffed appropriately, including anaesthetic cover.
- Medical staff held twice daily handover meetings to discuss elective and emergency surgical admissions. We observed a handover on the SEU, medical staff of all grades attended and everyone had input into the discussions about patient care.
- The trusts total surgery medical directorates position for August 2016 was 101.78 budgeted whole time equivalent (WTE) clinical staff and 96.06 actual WTE staff with a 5.72 variance. As at September 2016, the site reported a vacancy rate of 7.9% in surgery.
- As at September 2016, the site reported a turnover rate of 2.3% in surgery. No unit had a turnover greater than 2 WTE.
- Between October 2015 and September 2016, the site reported an average bank and locum usage rate of 8.4% total medical staff in surgery; Monthly usage has fluctuated between 3.9%, in November 2015, and 15.7%, in March 2016.
- Staff told us the consultant anaesthetic rota was separate from the theatre team. They told us it allowed the team to cover much more and be more efficient with their use of staff.
- We saw the on-call rotas for the operating department; theatre staff and anaesthetic staff were available to ensure 24 hour cover.

Major incident awareness and training

- The estates department told us that they were part of the emergency plan and that they operated an on call system to attend the hospital if an emergency occurred. One example was to attend the operating theatre out of hours with a plumbing concern.
- The trust undertook joint major incident scenario based training with multi agency and local emergency services. This training involved staff from most area's of

the trust using advanced simulation equipment. The event was carried out during the inspection and although the outcome was not known, initial feedback from the contributors was positive.

Are surgery services effective?

Good

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

We rated this service as good for effective because:

- We observed staff obtained patient consent where possible, before undertaking any clinical procedures.
- Staff planned and delivered people's care and treatment in line with current evidence based guidance, standards and best practice. There was good monitoring of compliance with these standards at departmental and division level.
- Patients were provided regular pain relief during their stay in hospital.
- Patient's nutritional status was assessed using the Malnutrition Universal Screening Tool (MUST). Where concerns were identified action was taken.
- Front-line staff worked well together, and there was obvious respect between a range of specialities and disciplines.
- Ward staff and the multidisciplinary team started to consider and plan patient discharges from the date of admission. The trust worked with partners to improve the coordination of patient discharges and transfers to remove barriers to delays where possible.
- The hospital had systems in place to ensure they provided care for inpatients seven days a week, including access to on-call theatre and diagnostic imaging staff in an emergency. Planned operations were performed mainly during the week.
- A 'hospital at night' team was used to co-ordinate care provided by medical staff. Staff reported no concerns accessing support at night and there were no issues getting tests, such as scans or x-rays, if required.
- Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, on one ward, two patients living with dementia did not have documented capacity assessments completed and they had been on the ward for over 10 days. We met with clinical managers who addressed this concern immediately.

However:

- Band 2 staff in theatre discussed that their roles were not clearly defined.
- New staff reported they were well supported. In general staff said training was available although most staff reported difficulties accessing training due to work pressures.
- We identified concerns on one ward where staff had not considered patients capacity. Overall training for mental capacity was below the trust target at 69%.

Evidence-based care and treatment

- The clinical governance risk practitioners were clear about the process for the review and monitoring of compliance with national guidance. There was a rolling program of review that included an assessment of compliance, action planning to make change where required and the recording of rationale where practises deviated from the guidance.
- Staff working across the surgery service told us and the trust provided evidence to show how they used national guidance. For example, from the National Institute for Health and Care Excellence (NICE) and from relevant professional bodies for the care and treatment they provided for patients. Clinical governance meeting minutes covered changes to national guidance and the need for change.
- The clinical governance trust wide action log included whether staff needed to update local clinical guidelines or trust wide policy amendments in response to the update. The trust held joint monthly meetings with the local clinical commissioning groups (CCG) to discuss these guidelines and other areas of concerns relating to safe and cost effective prescribing in the local area.

- We saw the trusts detailed antibiotic point prevalence audit records and action plans to improve compliance for example ensuring clinicians document rationale for choice of antibiotic.
- The division had a robust audit programme in place, with submission to a number of national benchmarking audits, so service delivery leads could monitor the quality of their service. Also, audits were completed to monitor compliance with NICE guidance. The trust sent a monthly email to key lead staff to make them aware of NICE guidance released each month.
- We saw the trusts medicine storage audit highlighting non-compliance, such as treatment room doors being left unlocked, iodine solution left on a windowsill and different strengths of potassium fluid being stored together. The audit highlighted the improvement plan with a named lead and time line for completion.
- The trauma and orthopaedic service compliance with key sepsis screening and treatment targets in line with NICE guidance was discussed in the clinical governance meeting. They had identified areas of reduced compliance and action plans put in place to ensure patients received treatment within the recommended treatment time.
- In the June 2016 clinical governance meeting theatre staff discussed NICE guidance Quality Standard 49-Surgical site infection October 2013. This included future steps to follow to minimise the risk of infection during surgery.
- The trust monitored any new or updated technology appraisals from NICE. These are recommendations from NICE on the use of new and existing medicines and treatments within the NHS. The action log included whether staff needed to update local clinical guidelines relating to safe, cost effective prescribing in the local area.
- To improve patient outcomes for patients having elective orthopaedics surgery, staff followed evidence based enhanced recovery pathways. Staff prepared patients for surgery and provided a structured post-operative recovery plan, including pain relief and early mobilisation. This involved physiotherapists and occupational therapists where appropriate, to help patients with recovery and discharge arrangements.
- Patients at risk of venous thromboembolism (VTE) received VTE prophylaxis in line with NICE guidance. The trust monitored this to check compliance. Clinical staff were familiar with the trust wide Intravenous Thrombolysis with Alteplase for Acute Ischaemic Stroke: Clinical Guidelines.
- The services took part in national and local audits to check they provided care and treatment in line with good practice guidance. They developed action plans and worked with other health and social care providers to improve care pathways. For example, project teams worked to improved discharge arrangements for patients and carers.

Pain relief

- Patients we spoke with, and our observations, indicated pain relief had been managed well. One patient told us how they were now able to get out of bed whereas before they could not due to the pain.
- Records we reviewed showed staff monitored and recorded patients' pain levels on a score of 1-3.
- Patients and staff could access specialist advice from the pain management team. The team supported patients with acute and chronic pain and provided a daily weekday service to the wards and an on-call system out of hours.
- Staff on the cardiac wards explained how chest drains are very painful for patients. A dedicated resource within the pain team visited the ward to assist pain management for patients with a chest drain.
- We observed a handover between the anaesthetist to the recovery team, this included information around ongoing pain management for the patient, to ensure they remained comfortable.

Nutrition and hydration

- Patients were assessed using the Malnutrition Universal Screening Tool (MUST) which identified nutritional risks. The dietician was available to provide additional advice if needed.
- There was diabetic link nurse information on all wards for staff to access if a diabetic patient required dietary advice. We saw that the diabetic team had produced a

visual algorithm for the treatment and management of hypoglycaemia for adults in hospital in case of emergency and the safe way to give sugar if the patient's clinical condition required this.

- Patients had access to drinks by their bedside. Nursing staff checked that patients had regular drinks and where relevant monitored and recorded their fluid balance levels
- The speech and language therapist was available if patients required a safe swallowing assessment and would give nutritional needs advice for ward staff to follow.

Patient outcomes

- The hospital had 35,082 surgical spells between April 2015 and March 2016. A spell is counted when a patient is admitted under the care of a consultant.
- The site provided the greatest number of surgical spells for the trust, with 58.9% of the total. Emergency spells accounted for 37.8%, 48.7% were day case spells, and the remaining 13.5% were elective. Compared to the trust breakdown, the site had a greater proportion of emergency spells. A total of 30.9% of spells at the site were for general surgery, 16.8% for ophthalmology and 9.1% for plastic surgery with the remaining 43.2% being made up of other specialities.
- Between April 2015 and March 2016 the average length of stay for surgical elective patients at the hospital site was 4.2 days, greater than the England average of 3.3 days. For surgical non-elective patients, the average length of stay was 4.6 days, better than the England average of 5.1 days. Average length of stay at the site was notably longer for non-elective admissions in trauma & orthopaedics and longer than the trust average of 10.3 days.
- In the 2015 National emergency laparotomy audit (NELA), the trust scored 0-49% for case ascertainment. For the remaining questions, the site scored 0-49% for five questions. Of the five remaining questions, three scored 50-79% and two scored 80-100% The National recommendation of presence of consultant surgeon and consultant anaesthetist for high-risk patients with a predicted mortality above 5% was included in one of the trusts action plans.
- In the trust 2015 hip fracture audit, the risk-adjusted 30-day mortality rate was 5.1%, which is lower than expected. The proportion of patients having surgery on the day of or day after admission was 67.2%, which does not meet the national standard of 85%.
- The perioperative medical assessment rate was 96.6%, which does not meet the national standard of 100%.The proportion of patients not developing pressure ulcers was 98.0%, which falls in the middle 50% of trusts. The length of hospital stay was on average 14.9 days, which falls in the best 25% of trusts.
- In the trust 2015 bowel cancer audit, 63 % of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The risk-adjusted 90-day post-operative mortality rate was 1.2% which was lower than the expected range. The risk-adjusted 2-year post-operative mortality rate was 24.3% which falls within the expected range. The risk-adjusted 90-day unplanned readmission rate was 20.4% which falls within the expected range. The risk-adjusted 18-month temporary stoma rate in rectal cancer for a patient undergoing major resection was 41% which makes the trust better than the expected range.
- In the 2015 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.3% for abdominal aortic aneurysms, indicating that the trust performed within expectations. The 2013 figure was 2%. Within carotid endarterectomy, the median time from symptom to surgery was 14 days, the same as the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within the expected range
- The cardiac team reported an above national average survival rate for cardiac open heart surgery of 97.7% for July 2016. The National survival rate for open heart surgery is 97.1%
- The Patient Outcomes Reporting Measures (PROMS) from April 2015 to March 2016 for the groin hernia indicator was better than the England average. The hip replacement and knee replacement and all varicose vein indicators were worse than the England average and the groin hernia, hip replacement and knee replacement indicators were in-line with the England average.

- We spoke with a patient who had fractured their hip following a bike accident. The injury had occurred on Sunday and they were pleased the operation took place on Monday.
- Between March 2015 and February 2016, patients at the hospital site had a lower than expected relative risk of readmission for elective admissions and lower than expected risk for non-elective admissions. The risk of readmission for elective general surgery was notably lower than the England average while the elective neurosurgery speciality has the largest relative risk of readmission.

Competent staff

- New members of staff said they were supported on joining the hospital. They had completed a trust wide induction programme. When on the ward they had opportunity to understand processes and procedures. Agency and bank staff completed a local induction to the area they were working on.
- New theatre staff were allocated a "buddy" who stayed alongside them throughout the entire shift teaching and demonstrating procedures. We were told the "buddy" was in place for between three and four months. Trainee doctors were allocated a staff member who explained the rationale for each clinical procedure. The atmosphere was cheerful and positive. Theatre staff told us they enjoyed the challenge of new staff which made them think and keep up to date with new practices.
- The trust had employed a significant number of nurses from overseas. At the time of the inspection 50% of nurses in the trauma unit, and 70% of nurses on the cardiac wards, were from overseas. Staff reported there had initially been some language issues and the trust provided support such as English classes.
- New recruits were not included in staffing numbers for their first three weeks. This allowed them to carry out additional training and be supervised in providing medications, or giving intravenous infusions to patients.
- Staff told us they attended study days which included topics such as pain management and where they received training on pain medicine infusion devices.
- Most staff reported concerns with regard to training. Two ward staff and a physiotherapist told us that they had difficulties accessing training due to work pressures. All three reported they had secured places to receive training, but had to cancel at the last minute as the ward was "short staffed" and "patients came first"
- Staff told us they had difficulty accessing cardiac advance life support and resuscitation training as it had been oversubscribed. The trust was aware of this concern and was accessing alternative training resources.
- Data provided by the trust showed as of September 2016, compliance with appraisals for medical staff in the division of surgery and critical care was 92% and for non-medical staff 90%, against the trust target of 90%. For nursing staff the appraisal rates varied between 43% and 100% with the lowest being for staff on the cardiothoracic ward
- Band two staff in theatre discussed that their roles were not clearly defined. Some band two staff were expected to assist with the deep cleaning tasks in theatre and some staff did not. Not all staff has agreed to a dual role in theatres and band two staff told us that there were feelings of resentment. Senior staff told us that they were working with the band two staff to resolve this concern.

Multidisciplinary working

- Front-line staff worked well together, and there was obvious respect between a range of specialities and disciplines. We observed effective multidisciplinary meetings between staff, which showed they considered patient's individual risks and needs to coordinate patient care.
- The nurse consultant in trauma attended the daily doctor and spinal rounds.
- Care was led and delivered by named consultants and they carried out daily ward rounds. On call consultants carried out the ward rounds on Saturday and Sunday.
- ITU had a shared care agreement with a split rota which included a dedicated intensivist with a cardiothoracic background.
- The trust employed discharge planning staff; their role was to co-ordinate safe discharge home. They worked closely with the ward nurses, occupational therapists,

physiotherapists and community nurses to ensure all appropriate equipment and medicines were in place prior to a patient's discharge.They reported they were able to access all specialist equipment promptly.

- The hospital discharge planning team worked closely with the newly developed October 2016 home assessment reablement team (HART). This team provides a short period of care and support to patients as they regain their independence once considered medically fit enough to be discharged from hospital.
- Ward staff and the multidisciplinary team started to consider and plan patient discharges from the date of admission. The trust worked with partners to improve the coordination of patient discharges and transfers to remove barriers to delays where possible. Trust data showed a significantly higher percentage (44.2%) of patients waiting for a residential home placement, contributed to the delayed transfers of care, compared with the national average of 10.2%.
- We attended the weekly multidisciplinary meeting (MDT). There was good representation of clinical staff in attendance at the MDT, including specialist nurses and therapy staff. The consultant led multidisciplinary discussions about the patients and their families which determined the plan of care.

Seven-day services

- The median wait to be seen by a consultant in SEU from June 2016 to November 2016 between 8am to 4pm, was three hours and five minutes, while during the 24hours it was six hours.
- All specialities had a consultant on-site seven days a week, normally 8am-6pm during the week and varying daytime hours at weekends. Services held daily ward rounds for all patients and had twice daily handover meetings to discuss new admissions or complex patients. There were rotas in place to provide medical cover to the wards out of hours and at weekends. A specialist registrar was always on duty to support more junior medical staff.
- A 'hospital at night' team was used to co-ordinate care provided by medical staff as they changed shifts, discuss any patients of concern and make staff aware of bed capacity issues.
- We saw the on-call rotas for the operating department; theatre staff and anaesthetic staff were available if there were any unplanned returns to theatre or emergency admissions. There were two emergency teams on-site and an additional team on-call, which could attend, if there was the need to run three emergency theatres.
- Gerontologist's carried out a daily ward round, Monday to Friday, to support the elderly hip fracture patients. On Saturday and Sunday the elderly care team provided this function.
- The pharmacy department ran an on-call rota so staff could access clinical pharmacy advice seven days a week, at any time. The normal opening times for pharmacy are Monday to Friday: 8am to 5pm and Saturday and Sunday: 9am to 5pm
- The trust phlebotomy services worked on a rota basis to cover weekend and bank holidays
- The radiology department provided an on-call service outside of normal working hours and at weekends so patients had timely access to key diagnostic tests such as X-ray and computerised tomography (CT) scans.
- Staff reported no concerns accessing support at night and there were no issues getting tests, such as scans or x-rays, if required.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends. However, nursing staff on the day surgery ward told us the physiotherapists had sometimes gone home, if patients returned late from theatre. They gave patients an information leaflet and the physiotherapist called them the next day.

Access to information

- Nursing staff told us when transferring patients between wards or teams, staff received a handover of the patient's medical condition and on-going care information was shared. We observed informative and effective handovers between theatre and recovery staff. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.
- A discharge letter was sent to the patient's GP, staff placed a copy of this in the patient file for reference. The letter contained information on the operation performed and any support or medicines needed post-surgery so the patient's GP was aware.

- There was an electronic reporting system which staff had direct access to the results of investigations, diagnostic imaging and pathology results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained patient consent where possible, before undertaking procedures. Where patients lacked the capacity to make decisions for themselves, such as those who were confused, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records. Electronic alerts flagged patients with a learning disability on the electronic patient record.
- Patients told us they had been able to make an informed decision about surgery, before signing the consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The seven consent forms we checked on the wards and in theatre confirmed this.
- Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, on one ward, two patients living with dementia did not have documented capacity assessments completed and they had been on the ward for over 10 days. Clinical staff had not considered the assessment or the possibility of requiring a DOLS application even though the patients were being cared for an a one to two basis and been watched all the time. We met with the head of patient experience and nurse employed to complete MCA and DoLS assessments and this concern was addressed immediately.
- The trust data for MCA and DoLS training for surgery was 69%. The trust target was 90%. Senior staff told us that there is an action plan to improve figures.
- In the trust-wide June 2016 health record audit there was a score of 41% to the question "Is there a specific record of a discussion having taken place with the patient and/or family in relation to diagnosis, prognosis and further plans?" We saw the improving compliance plan of action in the clinical governance notes.

Are surgery services caring?

Good

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

We rated this service as good for caring because:

- Patients spoke positively about the emotional support that staff provided.
- Patients told us that staff spoke to them politely and respectfully.
- We observed staff behaved in a way to respect patients' privacy and dignity for example by closing doors and drawing privacy curtains before they provided personal care.
- The trust multi-faith chaplaincy service was on call 24 hours a day to provide spiritual and emotional support for patients and their relatives.
- The trust ran a dementia café once a month with tea and biscuits to answer questions and give advice for carers.
- The trust employed an outreach worker, three days a week to provide support and advice to informal carers. The trust ran a "here for health - carers health MOT campaign".
- Patients told us that they were' very happy' and 'comfortable'. They also said they had received 'very good care and everyone is lovely'.

However:

- On one ward we did see a lack of caring attitude from two qualified staff members towards a distressed couple. We raised this with the senior managers at the time who took immediate action to ensure the couple received support.
- Consideration had not been given as to how the lay out of the theatre direct admissions (TDA) area in the main operating department compromised patient's privacy and dignity, however we acknowledge the trust were taking immediate practical steps to address this.

Compassionate care

- The hospital site surgical care friends and family test average response rate was worse than the England average between July 2015 and June 2016. Ward level recommendation rates were generally high with an overall average of 93.8% during this time.
- Patients told us that staff spoke to them politely and respectfully.
- Patients told us that they were 'very happy' and 'comfortable'. They also said they had received 'very good care and everyone is lovely'.
- We observed staff behaved in a way to respect patients' privacy and dignity for example by closing doors and drawing privacy curtains before they provided personal care. We followed a patient being collected for surgery from the ward to theatres and privacy, respectfulness and dignity were observed from all members of the surgical team. The patient was informed of all processes from ward to theatre.

Understanding and involvement of patients and those close to them

- The trust employed an outreach worker, three days a week to provide support and advice to informal carers. The trust ran a "here for health - carers health MOT campaign". The service was available for hospital staff, patients and visitors, to access support with healthy living and health behaviour change. Carers could drop in at a time convenient for them, no appointment necessary, and support was available on a wide range of topics such as emotional well -being, eating more healthily and arranging a carer's assessment. The service also referred / signpost to relevant community services for ongoing support.
- The trust ran a dementia café once a month with tea and biscuits to answer questions and give advice for carers in order to provide support and guidance for them.
- We saw on one ward two patients who were living with dementia, accommodated next to each other in side rooms. We saw a health care assistant situated outside the rooms so they had full view of both patients. Staff told us this had helped both patients safety as they had been restless, at risk of falls and calling out disturbing other patients. Both had calmed since hearing the voice of the healthcare assistant.
- Patients told us all staff had given clear explanations and in sufficient detail to inform them about each stage of their care and treatment, from initial consultation through to discharge. One patient receiving complex surgery told us they had been actively involved in all stages of their care and treatment plan and felt the explanations staff gave were very comprehensive.

Emotional support

- We saw staff providing reassurance and support for patients who were anxious, understanding the emotional impact of surgery.
- Staff supported patients to keep their independence and maintain contact with family and friends.
- Patients spoke positively about the emotional support that staff provided. Patient comments included "staff just can't do enough for you" "they answer all my little worry questions and keep me calm".
- The trust multi-faith chaplaincy service was on call 24 hours a day to provide spiritual and emotional support for patients and their relatives. The chaplaincy team had links with other local faith leaders if needed. The hospital had a chapel / prayer room in the main corridor, of the hospital and a smaller prayer space in another part of the hospital to assist with patients and families spiritual needs.
- We saw specialist nurses provided prompt emotional and practical support for patients with specific conditions, such as cancer.
- We saw on every surgical ward thank-you letters of appreciation from patients and families for the good care received.
- We did however; see two qualified staff on one ward display a lack of compassion, understanding and kindness to a distressed couple who requested treatment and support. We raised this with the senior managers who took immediate action to ensure the couple received additional support.
- We saw that the layout of the theatre direct admissions (TDA) area in the main operating department did not facilitate patient's privacy and dignity. We spoke with the manager who immediately started to take action to address this concern. The trust followed up with a letter outlining action changes. These include, patients were not asked to change into their theatre gowns until their

surgery was due. Then once a patient has been asked to change, they would wait for a short period in a cubicle to maintain their dignity until they were called through to theatre. A temporary barrier was put in place to preserve patient dignity as the patients walked to theatre in their gown. Confidential discussions were now held in a screened off area of TDA.

Are surgery services responsive?

Good

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

We rated this service as good for responsive because:

- Patients had timely access to emergency treatment and the trust was taking action to minimise the waiting time for elective surgery. The trust was pro-actively managing capacity new initiatives included a change in the referral pathway for GP referred urology patients, which had released capacity within the SEU to manage other patients.
- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been consistently better than the England overall performance since July 2015.
- The trust employed a lead dementia nurse who could offer specialist advice to all staff.
- The trust was better than national average for treating cancelled operations within 28 days.
- Staff took account of the needs of different people, including those with complex needs when planning and delivering services. Staff showed good understanding and made reasonable adjustments to meet patients' individual needs. We saw confused patients were managed safely.
- The trust dealt with the majority of complaints within the agreed response time. There was evidence the division leads and frontline staff discussed complaints and used these to improve the quality of care.

However:

- Staff in the trauma unit described issues regarding repatriation of patients. They told us being a major trauma unit meant they received referrals from other trusts but that repatriation did not happen in a timely way. This often led to capacity issues for the unit and travelling issues for the patients' visitors.
- Medical outliers were reducing patient flow and restricting bed access for surgical patients.
- The number of patients with a fractured neck of femur seen within 48 hours was below the national average, while for total hip replacements (where eligible) was above the national average.

Service planning and delivery to meet the needs of local people

- Staff in the trauma unit described issues regarding repatriation of patients. They told us that being a major trauma unit meant they received referrals from other trusts but that repatriation did not happen in a timely way. This often led to capacity issues for the unit and travelling issues for the patients' visitors. Senior staff told us that they were in discussion with other trusts to try to resolve this concern.
- One patient told us that they were being moved to a private provider and the reason given was capacity issues in the hospital. The patient said this would make visiting very difficult for family and friends as they live some distance away. The spoke to staff who explained the patient was being moved to a "cold" site as the patient's needs were no longer acute and the unit needed capacity for emergencies coming in.
- Following a review the surgical emergency unit (SEU) had changed the referral pathway for urology patients. All urology patients, referred by GPs, now attended another hospital site where they were treated. This had released capacity with the SEU to manage other patients.
- To improve outcomes for patients having elective orthopaedics surgery, staff followed evidence based enhanced recovery pathways. Staff prepared patients for surgery and provided a structured post-operative recovery plan, including pain relief and early mobilisation. This involved physiotherapists and occupational therapists where appropriate, to help patients with recovery and discharge arrangements.

Surgery

Access and flow

- The trust scored 69.3 % of fractured neck of femur patients seen within 48 hours; the national average was 76.1%. However, total hip replacement (where eligible) was 40.8% well above the national average of 26.9% in October 2016. We saw clinical governance meeting minutes with agreed action plans to improve.

Meeting people's individual needs

- During the patient's pre-assessment, staff recorded information on patients' additional needs. This included information about any translation or interpreter services required, the patient's vision and hearing needs, and any social support required.
- Staff said they had access to interpreters for patients who could not easily communicate in English. However, in practice staff often relied on family members or other staff to translate. The trust had access to telephone, face to face and sign language interpreters. As well as written information in large print, Braille and audio translations. The trust encouraged carers to assist with information that would help staff to care for their loved ones, who could not speak for themselves. We saw four patient trust care plans called "knowing me" which were all correctly completed and had key information such as how the person liked to be named, the time they liked to be woken in the morning and likes and dislikes for food and drink.
- Staff said they had access to the learning disability specialist nurse for advice and support. We were told the community learning disability team would attend promptly if required to provide advice to the patient, family and staff.
- The trust was working in partnership with the Oxfordshire dementia action alliance to improve services for people living with dementia, and their carers.
- Ward staff used a coloured magnet on the ward boards to quickly remind staff which patient required additional help such as hearing, sight or difficulty understanding (cognition)
- We observed lots of examples of support for patients living with dementia for example reminiscence boards for patients to look at and also items used by patients to occupy their hands and to provide comfort. On one ward we saw staff use an electronic hand held memory box device to visually see waves as well as hearing the sound of waves which we saw had a soothing effect on the confused patient.
- Patients told us when they pressed the call bell it was answered promptly by the nurses.
- The staff in the discharge lounge understood patients concerns about going home and we saw staff take time to quietly discuss arrangements and telephone numbers to call if problems arose once home.
- Patients told us the meals they had were tasty and sufficient in portion size. We were told there was plenty of a menu options.
- We saw health care assistant's supporting a patient who was confused and required support with eating.
- Staff told us they provided snack boxes for patients being discharged home who lived alone.
- We saw staff gave patients and families information leaflets to support the discussions that had taken place, such as preventing falls in hospital, thoracic surgery information and enhanced recovery programme patient diary.

Learning from complaints and concerns

- There had been 27 formal complaints between April and August 2016.One was categorised as admission and discharge, three appointments, 12 clinical treatment, four communication, five patient care and two values and behaviour. The surgical directorate, acute and elective received seven complaints during October 2016, which is a 20% increase when compared to September 2016. Two complaints were about patient care, two were regarding communication, one was regarding staff values and behaviour and one was regarding clinical treatment.
- Staff in the hospital wards and theatres followed the trusts complaints policy. Staff on the wards told us they tried to resolve any concerns from patients or relatives in a timely way to quickly improve the outcome for the patient and avoid escalation to a formal complaint.
- 'You said, we did' boards were displayed to show how the ward staff had responded to complaints and feedback from patients and visitors. For example, we saw one complaint from a patient on the ward saying

they wanted time to sleep in the day. Staff on the ward introduced rest time with lights turned low from 1pm to 3pm with a written notice at the ward entrance explaining the initiative to staff and visitors.

- We saw Patient Advice and Liaison Service (PALS) leaflets available around the hospital.
- The trust dealt with the majority of complaints within the agreed response time. There was evidence the division leads and frontline staff discussed complaints and used these to improve the quality of care.
- Staff recognised that early resolution of patients' concerns prevented the concern from escalating into a formal complaint. When a concern was first raised, it was highlighted to a senior nurse. If the senior nurse was unable to deal with the concern directly, they would direct the patient to the Patient Advice and Liaison Service (PALS) to formalise the complaint.
- The medical director, chief nurse and head of patient experience had responsibility for ensuring complaints were processed and responded to in a timely fashion, and discussed across the trust. They also ensured the surgery service took action because of a complaint to improve the quality of care. An investigating officer was assigned complete a full investigation of any formal complaints.
- We saw incidents were discussed in the clinical governance meeting minutes and one of the action plans was to remind prescribers to complete all arrangements for warfarin medication follow up on discharge. Another action was the trust discussed delivering a programme of value and behaviour training for clinical staff.
- Patients and relatives have identified, through their complaints that they have not been kept informed with discharge arrangements. There has been a particular divisional focus on improving communication between doctors, nurses and pharmacy so that patients are provided with accurate information and included in their discharge process.
- The trust recognised waiting times to see a doctor, be transferred, wait for a bed or wait for referral as a key priority. Work was underway to reduce waiting times for surgery and improve communication to patients about waiting times. The Division has identified perceived uncaring attitude of clinical staff resulted in a lack of personalised care, not meeting expectations and lack of explanations. Any unprofessional or uncaring attitudes are challenged and managed at the time of the complaint. This has also been addressed, strategically, through clinical supervision sessions to review complex cases, understand the implications and understand the patient's perception. Complaints were discussed with staff to develop an understanding against implementation plans developed to enable the delivery of personalised compassionate care.
- Staff told us that they had improved the patient pathway in the surgical emergency unit by using an ambulatory ultrasound to give patients a priority slot and reduce waiting times.
- Between July and September 2014/15 and April to June 2016/17 the trust cancelled 996 elective operations, of which 4.8% were not treated within 28 days. This was better than the England average of 6.8%.
- Since July to September 2015/16, the overall number of cancelled elective operations had reduced although the proportion not treated within 28 days increased sharply in April to July 2016/17 to 14.4%. Between July to September 2014/15 and April to June 2016/17 the trust had a consistently better rate of cancelled operations as a percentage of elective admissions than the England average. From July to September 2015/16, the trust rate had shown a trend of improvement in contrast to the England average which showed a worsening trend from this point.
- The trust's referral to treatment time (RTT) for admitted pathways for surgical services have been consistently better than the England overall performance since July 2015. The latest figures for June 2016 showed 76.2% of this group of patients were treated within 18 weeks.The following specialties were above the England average for admitted RTT (percentage within 18 weeks) general surgery 97.7% England average 78.7% cardiothoracic Surgery 93.8% England average 85.7% ophthalmology 88.4% England average 81.4% plastic surgery 84.7% England average 84.4%
- Staff told us patients that had been moved to other wards in the hospital to help with capacity concerns. The patients were reviewed daily by the medical team but not always by the specialist nurses. The ward staff

liaised with the surgical team who tracked where the patient was placed within the hospital. We were told that some wards were keen to care for the patients completely and requested assistance with discharge planning from the ward where the patient originated.

- Ward staff and the discharge team started to consider and plan patient discharges from the date of admission. Patients told us nurses had started to plan their discharge with them. One patient was concerned as they lived alone, however the nurses were aware and were taking this into account. Another said they already had carers in place but the nurses were ensuring the cover was sufficient prior to discharge.
- The trust had weekly theatre planning meetings to discuss case mix, equipment and theatre utilisation.
- Bed availability and capacity within ITU and across the hospital sometimes resulted in delays in transferring patients in and out of the ITU department. This has led to some operations being cancelled or delayed due to the lack of available beds.

Are surgery services well-led?

Good

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

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

- The surgical services had a robust governance structure that went from team level to the trust board. The quality, risks and performance issues were monitored through the governance framework.
- Clinical staff were aware of the trust's vision and their part in it. We saw the trust's strategy which included the new theatre building development.
- Staff felt valued by their line manager. Staff felt able to raise concerns with openness and honesty encouraged. The majority of staff enjoyed coming to work at the trust and felt the team working was a particular strength
- Each ward and department had a risk register and managers and staff worked hard to reduce known risks.
- The new clinical governance lead had made a difference to staff championing an action plan at clinical governance meetings. There were effective governance arrangements in place to monitor the quality, risk and performance of the surgical service. Actions plans were used to address areas of concerns. There were processes in place to escalate identified risks, both within the divisions and to the trust executive team. The clinical effectiveness committee was well attended and action points were closely monitored for improvement.
- We saw good partnerships with volunteers in all parts of the hospital. Volunteers told us that they felt valued by clinical staff.

Leadership of service

- Divisional and directorate leads spoke positively about the relationship with the CEO who was seen as a leader who had a presence in the hospital and encouraged innovation at a local level. Nursing staff spoke positively about the chief nurse saying she was visible, accessible, supportive and fair.
- Each division was led by a divisional director, a practicing clinician, supported by a divisional nurse or healthcare professional and a general manager. Each directorate was led by a clinical director, operational services manager and a nurse leader. There were service delivery unit leads in place for each clinical speciality. During our inspection we spoke with ward managers, matrons and directorate leads in theatre and on the surgical wards. They all demonstrated a clear understanding of their services.
- The executive team distributed regular updates to staff by email, by video and at meetings.

  Members of the executive team were described by staff as 'inspirational' and that there was a change in culture and improved staff engagement since the new chief executive had been in post. Staff told us that the executive team were visible and often undertook 'walk-arounds'.
- Ward staff told us of very supportive senior staff and ward sisters. Some wards had experienced staffing pressures, meaning some staff had not received breaks

or time off. Ward management had worked hard to improve the situation. Staff we spoke with said they felt managers listened to their concerns but were not always able to solve the problems such as staffing.

- Medical teams told us of their positive relationships with nursing leadership. Some of the leadership within the nurse's teams was new and were working well.
- Trainee doctors reported consultants were responsive to provide support and training. They said that consultants listened to their concerns.

Vision and strategy for this service

- The trust core values were excellence**,** compassion**,** respect**,** delivery**,** learning and improvement**.** These values underpinned the trust's vision to be: "At the heart of a sustainable and outstanding, innovative, academic health science system, working in partnership and through networks locally, nationally and internationally to deliver and develop excellence and value in patient care, teaching and research within a culture of compassion and integrity.
- The trust's strategic objectives were to deliver compassionate care, a well governed organisation, better value healthcare, integrated local healthcare, excellent secondary and specialist care, benefits of research and innovation to patients.
- Staff were aware of the trusts vision and objectives through information training sessions and regular updates in the trust newsletters.
- Division and directorates had developed business plans or were reviewing existing plans. These covered strategic vision for the next five years and the operating plan for the next two years 2015-16 and 2016-17. The plans were shaped by the trust's five year strategy and the trust's six objectives. Managing demand for efficiencies and productivity with a growing demand for services was the main point of the plan.
- The divisional strategies included specific divisional and specialty objectives. The main focus of the operational plans for the next 2 years was ensuring capacity meets demand. Enabling the divisions to provide a high quality service that consistently meets performance standards such as 18 week referral to treatment and cancer standards. The divisions were focusing on ensuring workforce and estates capacity was met within wards, clinics radiotherapy, endoscopy, dialysis and theatres. A key strand through all these was to improve collaborative working with other health and social care providers to deliver integrated services.

Governance, risk management and quality measurement

- Clinical staff told us that the new clinical governance lead had made a huge difference working alongside the staff on the wards to hear concerns first hand and championing an action plan at clinical governance meetings.
- We reviewed the notes of the clinical governance committee meetings for the medicine rehabilitation and cardiac (MRC) divisional clinical governance meetings.The divisional clinical governance meetings discussed the contents of the divisional board report, which covered quality and safety information including incidents, mortality reviews, audits, infection rates, venous thromboembolism (VTE) prevention, sepsis update, complaints and patient feedback.
- The MRC clinical governance notes showed brief points of discussion, which covered the same topics as in the divisional clinical governance meetings. We saw minutes from the July 2016 clinical governance meeting and the May 2016 trust-wide health record audit and outcomes paper, together with the action plan and date for re-audit.
- Each service delivery unit (SDU) had monthly clinical governance meetings. The notes of the monthly clinical governance meetings showed attendance by medical nursing staff and therapy staff. Incidents and learning was discussed. Returns to theatres were discussed at governance meetings. Surgeons, trainees and nurses were all involved, with outcomes and actions documented. Outcomes are monitored and compared and we were told that there had been an improvement over past 5 years.
- Performance was reviewed and monitored at directorate level governance meetings which in turn fed into divisional governance committees. The divisional leads had a good understanding of service performance and barriers to improvement. A range of projects were in place to promote improvement, for example to improve discharge arrangements and treatment pathways. The

divisional governance committees captured key actions for named leads to report on within a stated timeframe. They also received the department's mortality and morbidity meeting minutes and escalated any learning.

- Divisional and directorate leads spoke positively of the trusts peer review process. This was seen as a learning opportunity with local departments taking ownership ensuring directorate leads had over sight of their key challenges and risk.
- Across all areas staffing was acknowledge as a key challenge, with leads talking about learning and development as an important aspect of the retention program.
- The trust had taken steps to positively tackle the issues of recruitment and retention by taking actions such as introducing apprenticeships, introducing the retention enhancement premium for staff and the introduction of the surgical divisional recommend a friend scheme.The trust also runs a care certificate program for health care assistants, and had supported staff to complete the assistant practitioner programme.
- Monthly ward sisters meetings and ward meetings took place and were well attended with local ward based discussions such as staffing, medicine management and safety alerts and incidents.

Culture within the service

- We spoke with five members of staff who told us they had worked at the trust for over 15 years. They told us they "loved" working at the hospital, "it's like one big family". Staff told us they felt the trust recognised the skills of all staff and what each individual could contribute by working at the hospital. Nursing staff we spoke with on the surgical wards told us they worked well as a team and, "pulled the stops out" to prioritise patient care.
- Theatre staff told us the culture around reporting incidents had improved and there was now more transparency in reporting. Both ward and theatre staff confirmed they had no hesitation in reporting incidents. Staff said there was an open culture where they were prepared to ask questions.
- Staff told us they were most proud of the team work approach to solving problems to ensure they gave high quality of care. Theatre staff told us, "we are proud that we all work hard to make sure we do not close lists"
- Staff told us that everyone felt part of a big team. Housekeepers told us that they felt included by the ward staff, that they had a varied role and that they were happy to undertake additional duties if requested by ward management, for example if the ward clerk was absent.
- Divisional and directorate leads described a positive culture where learning and development was encouraged. They said they were empowered to take local ownership and make local decisions.

Public engagement

- We saw up to date notice boards in ward areas that had displays showing results from Friends and Family surveys, details of staffing and patient questionnaire results. We saw a team photo board that displayed photos of staff so that patients and visitors could easily identify members of staff. However, we saw out of date information seen in a lift lobby relating to incidents and learning in 2013.
- On a number of wards we saw boards displaying 'you said-we did'. Changes made included one ward purchasing inexpensive radios to relieve patient boredom and hear news from the outside world.
- Patient feedback was shared with staff in a variety of ways. These included electronically via newsletter or team feedback. If a staff member was mentioned by name then they would get personal feedback

Staff engagement

- Two hundred and forty three staff took part in the NHS 2015 staff survey. This was a response rate of 30% which was in the lowest 20% of acute trusts in England. Examples of low scores included; working extra hours 74% worse than the national average of 72%, bullying and harassment 39% worse than the national average of 37%. The percentage and quality of appraisals for staff had improved to 88% since the 2014 survey and was better than the national average of 86%.
- In response to the staff survey the trust produced a bimonthly 'Oxford university hospital and you news' magazine. This contained a wide range of information

on department topics, both operational and social to keep staff and volunteers up to date with latest developments. For example, the September 2016 newsletter highlighted the endoscopy refurbishment, a visit from a government minister to learn about the trusts digital innovation to improve the management of sepsis and the newsletter recognised staff achievements.

- In order to address concerns raised by staff in the operating department of low morale and poor communication a 'happiness lunch' and governance newsletter had been introduced.
- Sickness absence across the surgical directorate for September 2016 reported an average sickness rate of 0.58%. There were six units which had zero sickness for the whole of the last financial year.

Innovation, improvement and sustainability

- Staff were encouraged to make suggestions on how services could be improved to help with innovation and sustainability.
- We saw good partnerships with volunteers in all parts of the hospital. Volunteers told us that they felt valued by clinical staff. We saw volunteers situated in the front foyer of the hospital and directed persons to departments of the hospital. They arranged wheelchairs to assist carers bringing patients for appointments and ran a twice daily trolley round on all wards, bringing confectionary and newspapers to patients. One female patient said, "the volunteers are always smiling" and that she looked forward to seeing them visit the ward.
- Clinicians on the SEU had recently introduced the initial stages of a 10 point surgical site infection (SSI) bundle. Doctors were to provide training for nurses regarding wound care and there would be a dedicated auditor. This would also involve the use of a smartphone app for patients to use to help monitor their wounds after 30 days.
- The trust had implemented a partnership initiative the Royal College of physicians and with patients and families in a successful bid to reduce falls called "call don't fall". Following the employment of a falls prevention and education nurse, the number of serious falls for the trust have reduced to zero.
- The Neurosciences Orthopaedics Trauma Specialist Surgery (NOTSS) division vision was to deliver excellence in care supported by clinical leadership and its management teams; and provide consistently high quality patient experience and satisfaction. We saw a copy of business plan 2015/20 with plans to increase efficiency these include for example more minor operating on one hospital site, routine surgery six days per week and the use of elective services. Action plans to reduce the number of did not attend (DNA) and length of stay (LOS) were highlighted.
- The divisional business plans we viewed were in a standard format the first part detailed the division's strategic plan and included an introduction and description of the division; market analysis and context; strategic initiatives and the long term strategic priorities 2017-2020.
- The second part was the operational plan which included information on quality objectives / SMART Objectives (Directorates); an activity plan; impact on capacity; workforce; key risks to delivery of activity plan and plan to adjust inputs to match different levels of demand; transformation, productivity and efficiency ; supporting financial plan; capital plans; risk assessment and management
- The 2016-18 theatres, anaesthetics and sterile services directorate education strategy highlighted the induction of new staff to theatres with induction packs and competencies to be completed within set time scales. Preceptorship and mentorship and competencies for extended roles were documented. We saw an education action plan which had been agreed by clinical support services, with time frames for completion and named leads.
- We were told by staff of a new theatre build due to commence in 2017. Staff were encouraged by this and told us of plans to extend the scope of surgery and expanding their repertoire of procedures.
- Clinical leaders told us their vision to identify common patient pathways through their service. To evaluate and re-evaluate progress within the service and to embed key decision points for individual pathways for example with ambulatory pathways.

Outstanding practice and areas for improvement

Outstanding practice

- Ward staff and clinical development nurses had developed safety cards. Each nurse had a pack of cards which have key safety and organisation information to fit in their pocket. An example of information was where to locate pressure relieving mattresses. Clinical staff told us they were a useful reminder and were well received.
- The trust had employed a falls safe training lead and falls had reduced from three serious patient falls a month to zero falls.
- The trust held a weekly serious incident requiring (SIRI) investigation forum open to all staff to discuss learning from incidents and duty of candour requirements.
- The trust had introduced a peer review programme to engage staff, encourage improvement and share learning across the different divisions.

Areas for improvement

Action the hospital MUST take to improve

- Improve mandatory training levels for medical and nursing staff.
- Improve safeguarding children level 3 training for medical and nursing staff
- Improve the appraisal rates for nursing staff.
- The trust must ensure that patients receive an initial assessment by an appropriately qualified member of ED staff within 15 minutes of arrival in the ED.
- The flow of patients through the hospital must be improved to enable the emergency department to meet waiting times and enable patients to have timely access to specialist care and treatment.
- Provide an appropriate and safe environment for the care and treatment of detained patients in the emergency department.
- Review the use of both paper and electronic records in ED to ensure contemporaneous notes are maintained at all times.

Action the hospital SHOULD take to improve

- Ensure all emergency resuscitation equipment is checked daily.
- Consider the theatre business plan to agree a way forward to address the constrained theatre environment.
- Improve patient's privacy and dignity in the theatre direct admissions (TDA) area in the main operating department.
- Ensure administrative and clerical staff receive training in how to identify and report abuse in adults.
- Ensure patients who at risk of developing pressure ulcers in the emergency department (ED) are cared for on appropriate pressure relieving mattresses according to their assessed needs.
- Continue to find solutions to ensure all clinical staff attend compulsory cardiac advance life support training.
- Ensure staff consistently follow and record the sepsis pathway in the emergency department.
- Consider ways to improve the arrangements for the safe care of patients at risk of absconding in ED.
- Ensure patients' pain in the ED is appropriately managed in a timely manner.
- Improve multidisciplinary working between ED, specialist services and teams to facilitate patient flow through the department.
- Consider the timeline of plans to expand the resuscitation area to determine if these could be brought forward.
- Improve the arrangements for preserving patients' privacy and confidentiality in the children's ED.
- Ensure patients within the ED are offered food and drinks where clinically safe and appropriate to do so.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing All staff had not received appropriate training and appraisal to ensure compliance with the requirements of the regulation because: Mandatory training levels for medical staff in the emergency department were significantly below the trust target for safeguarding children level 3 training and Mental Health Act and Deprivation of Liberty Safeguards Training . Appraisal rates for nursing staff in the ED were low. Regulation 18 (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Systems were not in place to assess the risks to the health and safety of service users of receiving care and treatment because: Initial assessment of patients presenting to the emergency department was not completed within 15 minutes of arrival in the department. The accident and emergency department were regularly missing waiting-time targets due to the availability of beds, the challenges encountered by junior staff when implementing patient pathways and the slowness of referrals to specialist nurses.

This section is primarily information for the provider

Requirement notices

The ED did not always provide an appropriate safe environment for the care and treatment of detained patients.

Inconsistencies in the use of paper and electronic records impacted on the management of patients with regards to completing the sepsis screen.

Regulation 12 (1) (2) (a)