

# Buckinghamshire Healthcare NHS Trust

# Stoke Mandeville Hospital

## Quality Report

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

## Ratings

### Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



End of life care

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Stoke Mandeville Hospital is one of seven hospitals that form part of Buckinghamshire Healthcare NHS Trust. The hospital is an acute district general hospital and provides a range of emergency and elective medical, surgical and specialist services, as well as maternity and outpatient services.

A comprehensive inspection of the acute services of Buckinghamshire Healthcare NHS Trust was conducted in March 2014. Following this inspection, urgent and emergency care and end of life care were rated as required improvement overall. However, urgent and emergency services were rated as 'inadequate' for responsive services at Stoke Mandeville Hospital, and end of life care was rated as 'inadequate' for providing effective services.

We therefore inspected this urgent and emergency care services and end of life care services as part of an unannounced focused inspection.

Overall, the urgent and emergency care services and end of life care services at this hospital 'requires improvement'. However, each service had demonstrated improvement since the last inspection. The ratings from this inspection did not affect the overall ratings for the trust (from March 2014) which was 'requires improvement'

Our key findings were as follows:

### Urgent and Emergency Care Services

- Overall we rated this service as 'requires improvement'. This the same as the previous rating in March 2014. However the service had improved its rating in three of the five domains we inspected in providing a caring, responsive and well-led service.
- During this inspection we found improvements in safety procedures, for example, more equipment had been purchased to monitor and treat patients. Medicines were appropriately managed and infection control procedures were being followed although this needed to be more consistent. Patients were assessed and treated within standard times and the modified early warning score was used effectively to identify deterioration in a patient's clinical condition. The service still had to improve its assessment and documentation of patient risks, for example, for falls and pressure ulcer damage. Do not attempt cardiopulmonary resuscitation (DNACPR) decisions for patients needed to be appropriately documented.
- National guidance was being used to support patient care and treatment.. Local clinical audit programmes were developed to review and improve standards. National audits demonstrated that the Emergency Department performed similar to other trusts. Patients received effective pain relief and had appropriate nutrition and hydration.
- Seven day services had extended and there had been improvements in senior medical presence and emergency nurse practitioner availability out of hours and at the weekend. There was still a need to increase this presence further to meet national guidelines. It was acknowledged that this needed to continue to improve as more staff were recruited. There was a recruitment plan to support this.
- Multi-disciplinary teams worked well together, although there were still some delays to patients requiring review by medical specialty teams. The rapid access early assessment care team (REACT) worked effectively to discharge frail and elderly patients, with 70% of referrals being ready for discharge within 24 hours. There was a new psychiatric in-reach liaison services (PIRLS) that had improved the support of people in the Emergency Department who had a mental health condition.
- Staff treated patients with care and compassion and with dignity and respect. Patients, relatives and carers, told us they had good experiences of care and their care and treatment was explained so that they could be involved. Staff made time to offer emotional support to patients who were anxious or distressed.

# Summary of findings

- Services were being planned based on the needs of the local population and action was being taken, in conjunction with health and social care partners across Buckinghamshire, to respond to service demands. There were new services to speed assessment and treatment of emergency patients and avoid patient admissions to hospital. The new services included an initial assessment and treatment centre in the Emergency Department, assessment and observation unit (AOU), short stay acute medical unit, and ambulatory care service.
- The service had improved its performance against the national emergency access target, that is for 95% of patients to be admitted, transferred or discharged within four hours. However, the target was not being met consistently. Escalation procedures identified specific trigger points for a hospital wide response to emergency pressures. Escalation was working in the Emergency Department although the hospital response needed to improve. We observed the Emergency Department to be busy but calm. Many patients were still waiting for excessively long periods in the Emergency Department although patients did not spend long waiting times on a trolley or in corridors.
- The transfer of patients between Wycombe Hospital and Stoke Mandeville Hospital still required review to ensure patients were appropriately transferred.
- The vision and strategy for the service was well developed and the trust was working with partners to improve the coordination of urgent and emergency care across the health and social care system in Buckinghamshire. The pace of change had been rapid over the last 12 months and there had been significant and clinically led service developments.
- Staff engagement had improved and staff identified a culture of positive leadership and support.
- The department had an effective governance structure and information was being used to monitor and improve the quality and safety of services. Risks were escalated and acted upon, but recorded actions were not timely to demonstrate ongoing work around patient flow and workforce planning.
- The service could identify many examples of innovation and improvement and action was being taken to ensure the sustainability and resilience of services.

## End of life care

- Overall we rated this service as 'requires improvement'. This was the same as the previous rating in March 2014. However the service had improved its rating in two of the five domains we inspected in providing an effective and caring service.
- During this inspection we found improvements. Nursing and medical care had improved and patients received better symptom control and anticipatory drugs for pain relief. Patients nutrition and hydration needs were being assessed.
- Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment.
- The specialist palliative care team was well led and staff were passionate about improving the quality of services. Staff across the hospital provided good emotional support for patients. The chaplaincy provided one to one spiritual support and worked closely with the bereavement officers to ensure relatives received a sensitive and individual service following the loss of a loved one.
- The hospice day care services provided well considered emotional support for their patients and conducted patient satisfaction surveys to measure effectiveness.
- Records were not always stored securely and in places could be accessed by patients and relatives. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not consistently completed.
- Patients being taken to the mortuary frequently arrived without any identification wrist bands. Technicians were reliant on a nurse from the ward coming down to the mortuary to identify the patient.
- Staffing levels in the mortuary were not safe. Technicians were often working long hours alone without support and they did not have appropriate equipment for bariatric (obese) patients.

# Summary of findings

- Patient areas were clean and staff followed infection control practices.
- There were interim care plans in use following the withdrawal of the Liverpool Care Pathway in 2014. However, these care plans, called Hearts and Minds – end of natural life, were not consistently completed to provide holistic care for patients. Staff did not have a clear understanding of end of life care and ceilings of care, which would involve the cessation of all invasive treatments and non-essential medication, were not consistently applied. The trust was working on a care pathway called “getting it right for me” and had involved staff and patients to develop this.
- The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI’s) but was similar to the England average for most of the clinical indicators of care. Local audit to monitor the effectiveness of services was not well developed.
- There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. However, there could sometimes be discharge delays. The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.
- There was good support from the specialist palliative care team and referrals, once completed, were responded to within 24 hours. Support and advice was available 24 hours a day seven days a week. Training was available for staff in relation to caring for patients at the end of their life.
- The hospital did not have a central register to identify a patient who was on an existing end of life care pathway and this could delay their care and treatment. However, a new electronic record, the Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily.
- Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved.
- The director of nursing holding responsibility for end of life care at trust board level. A new trust strategy was being developed but communication around this needed to improve. A review of the service had been undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was being used to monitor some key indicators relating to care but audit to monitor the quality and safety of end of life care services needed to develop. The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward.

We saw several areas of outstanding practice including:

- The rapid early assessment care team (REACT) provided nursing and therapy support to facilitate the early discharge of frail and elderly patients admitted to hospital. Patient pathways were to community hospital or to the patient’s own home and equipment could be delivered on the same day to support patients at home. The team saw 3 to 4 patients a day and 70% were discharged within 24 hours.
- There was a new psychiatric in-reach liaison services (PIRLS) that had been developed with the local mental health trust. This joint working had improved the support of people in the ED who had a mental health condition.
- The specialist lymphodema nurses at the hospice recently received a second place award for oedema management; this accolade was given by the Journal of Wound Care.

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

Importantly, the trust must ensure :

- Patient risk assessments and the documentation that supports these are routinely completed in the Emergency Department.
- There is effective clinical engagement for a hospital wide focus to patient flow and escalation processes.
- There are timely GP discharge summaries following a patient admission to the Emergency Department.
- There is a timely replacement for the Liverpool Care Pathway and all staff follow the current interim policies.

# Summary of findings

- Staff complete the end of life care plans (Hearts and Minds – end of natural life) appropriately so The National Institute for Health and Care Excellence (NICE) guidelines for holistic care are followed.
- All staff consistently and appropriately complete the DNACPR forms and discussions between patients and relatives are recorded in patient records.
- The overhead lighting lamps in the hospice are replaced to reduce the risk of patients coming into contact with hot surfaces.
- Staffing levels in the mortuary are reviewed to give staff adequate rest time between shifts and to reduce the levels of lone working.
- Mortuary staff have appropriate equipment for bariatric (obese) patients to reduce the risk of harm to staff from inappropriate manual handling.
- Deceased patients are clearly and appropriately identified when being transferred from wards to the mortuary.
- All staff involved in end of life care can identify a patient at the end of life (12 months) to ensure that referrals to the specialist palliative care team are made in a timely manner.

In addition the trust should ensure that :

- Recruitment of medical and nursing staff continues to improve models of care, decrease the current workloads of staff in acute and emergency medicine and ensure appropriate medical staffing at night.
- Infection prevention and control practices are consistently followed in the Emergency Department.
- Risk registers are maintained and kept up to date in the Emergency Department and records of incidents, once reported, are completed in a timely way.
- Infection control risks, in relation to storing patients' belongings in the bereavement office, are addressed.
- Interpreter services are provided to enable patients who do not speak English as their first language to receive the same level of care as other patients at the end of their life
- Transfer arrangement between Wycombe Hospital and Stoke Mandeville Hospital are clarified for staff and patients.
- Communication from senior management teams to all staff providing end of life care to improves.
- Patients who received end of life care are not moved unnecessarily between wards.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Requires improvement

### Rating



### Why have we given this rating?

Overall we rated this service as 'requires improvement'. This was the same as the previous rating in March 2014. However the service had improved its rating in three of the five domains we inspected in providing a caring, responsive and well-led service.

During this inspection we found improvements in safety procedures, for example, more equipment had been purchased to monitor and treat patients. Medicines were appropriately managed and infection control procedures were being followed although this needed to be more consistent.

Patients were assessed and treated within standard time. Staff in the department used the modified early warning score effectively to identify deterioration in a patient's clinical condition. The service had to improve its assessment and documentation of patient risks, for example, for falls and pressure ulcer damage. Do not attempt cardiopulmonary resuscitation (DNACPR) decisions for patients needed to be appropriately documented.

National guidance was being used to support patient care and treatment. Local clinical audit programmes were developed to review and improve standards. National audits demonstrated that the Emergency Department performed similar to other trusts. Patients received effective pain relief and had appropriate nutrition and hydration.

Seven day services had extended and there had been improvements in senior medical presence and emergency nurse practitioner availability out of hours and at the weekend. There was still a need to increase this presence further. It was acknowledged that this needed to continue to improve as more staff were recruited. There was a recruitment plan to support this

Multi-disciplinary teams worked well together, although there were still some delays to patients requiring review by medical specialty teams. The rapid access early assessment care team (REACT) worked effectively to discharge frail and elderly patients, with 70% of referrals being ready for

# Summary of findings

discharge within 24 hours. There was a new psychiatric in-reach liaison services (PIRLS) that had improved the support of people in the Emergency Department who had a mental health condition. Staff treated patients with care and compassion and with dignity and respect. Patients, relatives and carers, told us they had good experiences of care and their care and treatment was explained so that they could be involved. Staff made time to offer emotional support to patients that were anxious or distressed.

Services were being planned based on the needs of the local population and action was being taken, in conjunction with health and social care partners across Buckinghamshire, to respond to service demands. There were new services to speed assessment and treatment of emergency patients and avoid patient admissions to hospital. The new services included an initial assessment and treatment centre in the Emergency Department, assessment and observation unit (AOU), short stay acute medical unit, and ambulatory care service. The service had improved its performance against the national emergency access target, which is for 95% of patients to be admitted, transferred or discharged within four hours. However, the target was not being met consistently. Escalation procedures identified specific trigger points for a hospital wide response to emergency pressures. Escalation was working in the Emergency Department although the hospital response needed to improve. We observed the Emergency Department to be busy but calm. Many patients were still waiting for excessively long periods in the Emergency Department although patients did not spend long waiting times on a trolley or in corridors. The transfer of patients between Wycombe Hospital and Stoke Mandeville Hospital still required review to ensure patients were appropriately transferred. The vision and strategy for the service was well developed and the trust was working with partners to improve the coordination of urgent and emergency care across the health and social care system in Buckinghamshire. The pace of change had been rapid over the last 12 months and there had been significant and clinically led service developments.

# Summary of findings

Staff engagement had improved and staff identified a culture of positive leadership and support. The department had an effective governance structure and information was being used to monitor and improve the quality and safety of services. Risks were escalated and acted upon, but recorded actions were not timely to demonstrate ongoing work around patient flow and workforce planning. The service could identify many examples of innovation and improvement and action was being taken to ensure the sustainability and resilience of services.

## End of life care

### Requires improvement



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## Summary of findings

Staffing levels in the mortuary were not safe. Technicians were often working long hours alone without support and they did not have appropriate equipment for bariatric (obese) patients. Patient areas were clean and staff followed infection control practices.

There were interim care plans in use following the withdrawal of the Liverpool Care Pathway in 2014. However, these care plans, called Hearts and Minds – end of natural life, were not consistently completed to provide holistic care for patients. Staff did not have a clear understanding of end of life care and ceilings of care, which would involve the cessation of all invasive treatments and non-essential medication, were not consistently applied. The trust was working on a care pathway called “getting it right for me” and had involved staff and patients to develop this.

The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators of care. Local audit to monitor the effectiveness of services was not well developed. The trust had acknowledged this gap and audit needed to be introduced.

There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. However, there could sometimes be discharge delays. The trust was still not monitoring patients preferred place of death, although rapid discharge was being supported by the specialist palliative care team.

There was good support from the specialist palliative care team and referrals, once completed, were responded to within 24 hours. Support and advice was available 24 hours a day, seven days a week. Training was available for staff in relation to caring for patients at the end of their life.

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## Summary of findings

Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily. Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved. The director of nursing holding responsibility for end of life care at trust board level. A new trust strategy was being developed but communication around this needed to improve. A review of the service had been undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was being used to monitor some key indicators relating to care but audit to monitor the quality and safety of end of life care services needed to develop. The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward.

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# Stoke Mandeville Hospital

## Detailed findings

### Services we looked at

Urgent & emergency services; End of life care

# Detailed findings

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## Background to Stoke Mandeville Hospital

Stoke Mandeville Hospital is one of seven hospitals that form part of Buckinghamshire Healthcare NHS Trust. The hospital is an acute district general hospital and provides a range of emergency and elective medical, surgical and specialist services, as well as maternity and outpatient services.

A comprehensive inspection of the acute services of Buckinghamshire Healthcare NHS Trust was conducted in March 2014. Following this inspection, urgent and

emergency care and end of life care were rated as required improvement overall. However, urgent and emergency services were rated as 'inadequate' for responsive services at Stoke Mandeville Hospital, and end of life care was rated as 'inadequate' for providing effective services.

We therefore inspected this urgent and emergency care services and end of life care services as part of an unannounced focused inspection.

## Our inspection team

Our inspection team was led by:

**Chair:** Mike Lambert, Consultant in Clinical Effectiveness, and formerly Emergency Medicine Norfolk and Norwich University Hospital

**Team Leader:** Joyce Frederick, Head of Hospital Inspections, Care Quality Commission

The team of six included a CQC inspection manager and inspectors. They were supported by specialist advisers which included a palliative care consultant and palliative care nurses. Experts by experience who had experience of using the service were also part of the team. The team was supported by an inspection planner and an analyst.

## How we carried out this inspection

To get to the heart of people who use services' experience 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?

# Detailed findings

Before visiting Buckinghamshire Health NHS Trust, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We carried out an unannounced visit on 25, 26, and 27 March 2015.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We

observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

For the core services, the inspection team observed how staff were caring for people who use the service. We spoke with staff, patients, relatives and visitors.

## Facts and data about Stoke Mandeville Hospital

### **Buckinghamshire NHS Trust: Key facts and figures**

#### **Context.**

Around 728 beds (470 Stoke Mandeville Hospital)

Population around 505,000

Staff: 6,000

#### **Activity**

A&E attendances 108, 615 (2014/15)

Deaths 691 (2013)

**Intelligent Monitoring** – priority banding - Recently inspected (March 2015)

#### **Safety**

0 never events in A&E or for end of life care.

2 serious incidents (2014/15) in A&E – slips, trips and falls

0 serious incidents - end of life care

#### **Effective**

All within expectations

National Care of the Dying Audit - 5 out of 7 organisational indicators not achieved; clinical indicators lower, but similar to the England average.

#### **Caring**

CQC inpatient survey - similar to other trusts

FFT Inpatient : similar to other trusts (above England average overall ) A+E: similar to other trusts (above England average)

#### **Responsive**

A&E 4 hr standard – Inconsistent. January to March 2015 91%.

A+E left without being seen: similar to England average.

#### **Well led**

Staff survey 2014 – overall staff engagement worse 20% of trusts.

GMC survey :

Emergency Medicine - similar to other trusts.

## Our ratings for this hospital







Our ratings for this hospital are:

# Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	Requires improvement

## Notes

# Urgent and emergency services

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

## Information about the service

The Emergency Department provided care for both paediatric and adult patients and was the 'front door' for all patients referred by GPs and via 999 calls, as well as walk-in patients. The adult Emergency Department saw 108,615 attendances in 2014/15. There had been approximately 24,000 paediatric patients and 30,000 adult patients admitted to inpatient wards and 21% of adult attendances had resulted in an admission. There had been an increasing number of attendances compared to the previous year but the proportion of patients admitted had lowered. Figures for 2013/14 identified 73,757 new admissions for the year 2013/14, of which 24% of adult attendances had resulted in admission.

The trust has recently changed the department. The main department had five resuscitation beds, 10 major injuries ('majors') beds, an Initial Assessment and Treatment Centre (IATC) with six beds, three minor injuries ('minors') assessment rooms, and six beds as part of the assessment and observation unit. There were three assessment rooms in the waiting area and an assessment room in the triage area. The paediatric decisions unit (PDU) had five assessment rooms and four beds available for overnight short stay admissions. The ED is classed as a trauma unit and links with John Radcliffe Hospital, Oxford for major trauma services.

We visited Emergency Department, and assessment and observation unit and ambulatory care. We talked with six patients, our relatives visiting the department and 14 staff of different grades. These included nursing and medical

staff, therapists, administrators, managers, support staff and members of ambulance crews. We observed care and treatment and looked at eight care records. This was a focused and unannounced inspection.

# Urgent and emergency services

## Summary of findings

Overall we rated this service as 'requires improvement'. This was similar to the previous rating in March 2014. However the service had improved its rating in three of the five domains we inspected in providing a caring, responsive and well-led service.

During this inspection we found improvements in safety procedures, for example, more equipment had been purchased to monitor and treat patients. Medicines were appropriately managed and infection control procedures were being followed though this needed to be more consistent. Patients were assessed and treated within standard times. Staff in the department used the modified early warning score effectively to identify deterioration in a patient's clinical condition. The service had to improve its assessment and documentation of patient risks, for example, for falls and pressure ulcer damage. Do not attempt cardiopulmonary resuscitation (DNACPR) decisions for patients needed to be appropriately documented.

National guidance was being used to support patient care and treatment. Local clinical audit programmes were developed to review and improve standards. National audits demonstrated that the Emergency Department performed similar to other trusts. Patients received effective pain relief and had appropriate nutrition and hydration.

Seven day services had extended and there had been improvements in senior medical presence and emergency nurse practitioner availability out of hours and at the weekend. There was still a need to increase this presence further. It was acknowledged that this needed to continue to improve as more staff were recruited. There was a recruitment plan to support this

Multi-disciplinary teams worked well together, although there were still some delays to patients requiring review by medical specialty teams. The rapid access early assessment care team (REACT) worked effectively to discharge frail and elderly patients, with 70% of referrals being ready for discharge within 24 hours. There was a new psychiatric in-reach liaison services (PIRLS) that had improved the support of people in the Emergency Department who had a mental health condition.

Staff treated patients with care and compassion and with dignity and respect. Patients, relatives and carers, told us they had good experiences of care and their care and treatment was explained so that they could be involved. Staff made time to offer emotional support to patients who were anxious or distressed.

Services were being planned based on the needs of the local population and action was being taken, in conjunction with health and social care partners across Buckinghamshire, to respond to service demands. There were new services to speed assessment and treatment of emergency patients and avoid patient admissions to hospital. The new services included an initial assessment and treatment centre in the Emergency Department assessment and observation unit (AOU), short stay acute medical unit, and ambulatory care service.

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The vision and strategy for the service was well developed and the trust was working with partners to improve the coordination of urgent and emergency care across the health and social care system in Buckinghamshire. The pace of change had been rapid over the last 12 months and there had been significant and clinically led service developments. Staff engagement had improved and staff identified a culture of positive leadership and support.

The department had an effective governance structure and information was being used to monitor and improve the quality and safety of services. Risks were



# Urgent and emergency services

escalated and acted upon, but recorded actions were not timely to demonstrate ongoing work around patient flow and workforce planning. The service could identify many examples of innovation and improvement and action was being taken to ensure the sustainability and resilience of services.

## Are urgent and emergency services safe?

Requires improvement



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

We rated safe as 'requires improvement'

This was similar to the previous rating. In March 2014 we had rated safe as 'requires improvement'. At this time, we found that infection control procedures and medicines management procedures were not followed, and the department did not have appropriate equipment to monitor and treat patients. Staffing levels and the skill mix of staff was not appropriate and there was an over reliance on agency staff who did not have appropriate skills and training.

During this inspection we found improvements had been made but that there were still areas where safety needed to be assured. Documentation had been revised to improve the risks assessment of patients but this was not being used appropriately. Assessments for falls, pressure ulcer damage and venous thromboembolism, for example, were not routinely performed to identify risks and appropriate preventative action was not always taken.

The majority of patients were triaged within the national standard time of 15 minutes and treated within 70 minutes (this was similar to the national standard of 60 minutes). The modified early warning score was used effectively to identify deterioration in a patient's clinical condition. The principles defined for Sepsis treatment (within a Sepsis Six care pathway) were followed, but were not always appropriately documented. Do not attempt cardiopulmonary resuscitation (DNACPR) decisions for patients were not appropriately documented.

There had been improvements in the staffing levels in the department and there were more senior medical and nursing staff on duty. Senior medical staff presence had improved but were still a concern at night. The hospital was working to improve this. Senior nursing staff presence had increased to ensure standards of care were being maintained. Infection prevention and control practices had improved, but still needed to be

# Urgent and emergency services

consistently applied. The trust had purchased equipment and the department was appropriately supplied and this equipment was regularly checked. Medicines management had improved.

## Cleanliness, infection control and hygiene

- The Emergency Department (ED) and equipment was visibly clean. The 'I am clean' stickers were used appropriately for equipment. The trust was, however, worse than expected in the A&E survey 2014 for questions on the cleanliness of the department.
- Hand hygiene audits demonstrated 97% (January 2015) and 100% (February 2015) compliance.
- We observed staff using hand hygiene gel and personal protective equipment, such as gloves and aprons, although this practice was not always consistent. Staff followed the trust bare below the elbow policy in clinical areas.

## Environment and equipment

- The trust had invested £126k on new equipment in the department. Cardiac monitors, ventilators and defibrillators were available in all bays in the resuscitation room. There was appropriate equipment, such as two blood pressure machines in other areas of the department.
- The resuscitation area was now able to support non-invasive ventilation and arterial lines for patients.
- Equipment in the resuscitation bays was stored in standard places for staff to be able to locate in an emergency.
- Access to diagnostic imaging had improved with the new computerised tomography (CT) scanner in the department. A business case was being developed to replace the ultrasound equipment, which was old.
- The department had an identified team lead to monitor and support staff with training.
- The minor injuries unit did not have oxygen or suction facilities and the environment often made it difficult to observe patients.

## Medicines

- Medicines were stored correctly in locked cupboards and fridges when necessary. The medicines' fridge temperatures were correct and there were accurate records of temperature checks.

## Records

- The department had introduced a booklet where all assessment documentation was kept in one place for entry by all staff. However, assessment sheets were still being used in the department as they had run out of new documents on the day of our inspection.
- The new documents included guidance for staff to follow. However, assessments were not completed appropriately. We reviewed the records of six patients in detail. None had a fully completed risk assessment for pressure ulcer damage. None had a fully completed venous thrombolysis prophylaxis assessment completed. Five of the six had suspected Sepsis infection and only one had completed documentation for the Sepsis Six care bundle.
- Documentation completed by doctors followed a consistent approach and used the medical model of assessment that included: presenting complaint, history of presenting complaint, past medical history, medication and allergy history, social history, examination and initial diagnoses, and plan of care. Reviews were evident after investigations were completed and action plans clearly identified. However, the date, time and signature of the doctor was not documented consistently.
- The department had introduced intentional rounding where nursing and health care assistant staff regularly checked on patients every two hours. Staff did various checks on patients such as comfort checks, hydration, nutrition, pain and positioning. Patient records we looked at showed these rounds were being completed, although less frequently than every two hours.
- The patients we observed all had name bands.
- We reviewed eight patient records. The do not attempt cardiopulmonary resuscitation (DNA CPR) forms were not always completed appropriately. For example, the patients mental capacity was not appropriately recorded or the consultant had not signed off the decision.

## Safeguarding children

- Staff used the trust safeguarding policy, which ensured appropriate referrals were made to safeguarding teams. Some staff had differences in their understanding as to whom to refer safeguarding concerns within the paediatric decision unit but referrals were being done.
- There was a safeguarding lead nurse that supported the department and 92% of nursing staff and 93% of medical staff had completed safeguarding adults

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training and 90% of medical and nursing staff had complete safeguarding children's training. This was above the trust target of 90%. We did not receive data on level 2 and level 3 children safeguarding training.

## Assessing and responding to patient risks

- Patients who arrived by ambulance were assessed by a senior nurse called a navigator and were streamed to appropriate areas of the department. Patients who arrived through reception were greeted by a receptionist and assessed by a triage nurse or the navigator to provide experienced assessment of patients.
- Paediatric patients were assessed by the paediatric nurses in the paediatric decisions unit and waited in a separate area designated for children.
- The trust reported time to initial assessment as 17 minutes in January 2015 but overall they had met national times of 15 minutes (July to December 2014). Children were being triaged within 15 minutes. The time to initial treatment was 70 minutes which was similar to the national target of 60 minutes (July to December 2014). We did observe two patients who had waited for 90 minutes to be seen by a doctor.
- Patients records demonstrated that risks were assessed. However, for risks for pressure ulcer damage records were incomplete. The department could not identify which patients were at risk and whether patients were on appropriate pressure mattresses. Most patients who had been in the department for more than 12 hours were on pressure relieving mattresses.
- A trust wide audit demonstrated that venous thromboembolism (VTE) assessment was 99%. We reviewed six patient records in detail, two had had a VTE assessment, for one of these patients the required prophylaxis, to prevent a thrombosis (or blood clot), had yet to be prescribed.
- The department used the modified early warning score (MEWS) tool to identify patients who were at risk of deteriorating. Patient records were appropriately completed and adult patients were appropriately escalated using the MEWS and the trust escalation policy on the vital signs chart. The department used the paediatric early warning score (PEWS) for paediatric patients. Paediatric patients who were assessed as having a high PEWS were escalated appropriately and staff said medical colleagues responded within designated timescales to high-scoring patients.

- The trust had introduced assessment standards with clear escalation triggers. The Emergency Department had a standard to assess and treat patients within two hours of arrival and specialty teams had a standard to assess patients within one hour following this. However, the medical speciality teams did not always meet this standard and the escalation process was not being implemented. When a patient was seen it was not always by the appropriate grade of doctor. For example, some patients we observed had timely input from critical care and medical registrars. One patient we observed with severe sepsis was seen by a junior doctor when it would have been appropriate to be seen by a registrar. For this patient there had been a delay to treatment as a blood result (lactate test) had not been acted upon in a timely manner.

## Mandatory training

- The trust mandatory training covered fire safety, infection control, safeguarding adults, safeguarding children, information governance, summoning help in an emergency, health, safety and welfare and moving and handling. Overall compliance with this training did not meet trust target of 90%. Only 77% of nursing staff and 58% of medical staff had completed their mandatory training.

## Nursing staffing

- The trust had recruited to nursing posts in line with the Royal College of Nursing (RCN) guidance. The trust had identified safe staffing levels according to an evidence based acuity tool and was currently staffing the department higher than this level. During February 2015, registered nurse staffing was on average 157% above optimum and 172% above minimum staffing levels and healthcare assistant staffing was 109% above both optimum and safe staffing levels.
- The department had, nine band 7 nurses 17 band 6 nurses and 40 band 5 nurses and 17.53wte healthcare assistants. There were 16.46wte emergency nurse practitioners (ENP). The number of nurse vacancies had reduced. There were currently 6 whole time equivalent (WTE) nurse vacancies and 2 wte ENP vacancies which gave an overall vacancy rate of 10.38%. This was an improvement compared to vacancy rate of 17% at the last inspection in March 2014.
- Bank and agency staff were used to fill vacancies. The ratio of permanent staff to agency staff was no longer

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1:1. Agency staff represented on average 38% of registered nursing staff in the department and 0% of healthcare assistants. One member of agency staff we spoke with told us she had had appropriate induction and support.

- There were two trained nurses for every five patients in the resuscitation area from 7am to 7pm daily and this was increased to three nurses from 11pm to 7am. There were three trained nurses for every 10 patients in the majors area over 24 hours a day and seven days a week.
- The service had two extra trained nurses above establishment to be used where necessary in the department to maintain a flexible service. There was also an additional healthcare assistant in the resuscitation area.
- There were 10 band 7 nurses who worked supernumerary shifts. They ensured that standards of care were maintained, for example, they ensured intentional rounding was complete and nurse staffing was appropriate for the emergency admission in the department. The band 7 nurses worked from 10am to 10pm overlapping shift changes at 8am and 6pm so that they could oversee and ensure structured handover of patient risks and standards in the department through shift changes.
- There were three emergency nurse practitioners (ENP) and they covered shifts in the department from 8am to midnight.

## Paediatric Unit staffing

- The paediatric unit had GP referred and walk in patients which were managed by the paediatric medical and nursing teams. Children who came in as emergencies were managed by the Emergency Department consultants and children were referred to consultant paediatricians. The paediatric and Emergency Department consultants worked as an integrated team to provide 24/7 cover.
- One Emergency Department consultants had a sub-speciality in paediatric care and did shifts in the paediatric unit to maintain their expertise.
- The staff in the paediatric team now rotated between the children's ward and the Emergency Department.
- All nurses that worked in the paediatric unit were paediatric nurses. However, paediatric triage defaulted

to the adult triage between the hours of 12 am to 4am as currently there was not enough nurses to continue this 24 hours a day and seven days a week. Most children (90%) were triaged in the paediatric unit.

## Medical staffing

- The trust had five consultants in post against an establishment of 8.5 whole time equivalent posts. Vacancies at consultant level were covered by locum doctors. The trust was aiming to recruit four more A&E consultant posts but had been unsuccessful so far. The trust was looking to develop joint academic consultant posts to attract applicants and considering rotating consultants with the acute hospital trust in Oxford.
- The consultants provided a service from 8am to 8pm during the week and from 9am to 11pm on Saturdays and Sundays. The consultants provided an on-call service outside these hours. The service was still not meeting the College of Emergency Medicine guidelines for consultants to provide 16 hours of consultant presence per day.
- The consultants aimed to work from 8am to 12 midnight but this could happen only when more consultants were recruited. The consultants were currently on call one week in every 4.5 and this was described as "quite onerous" and would not be sustainable.
- There were 14 middle grades and 14 junior doctors who worked shifts to provide cover 24 hours a day. There was one vacant post at middle-grade level and one at junior doctor level. These vacancies were being covered by locum staff. Two middle grade doctors were exempt from working at night and this meant that being short of doctors at night was sometime an issue.
- Medical teams were stretched overnight. There were four acute consultant physicians who covered the Emergency Department, short stay (ward 10), AOU and ambulatory care. The physician of the day (POD) worked from 8am to 8pm. However, with only four consultants, they provided consultant cover in a 1 in 4 rotation and the service was stretched.
- There was one registrar and one Senior House Officer (SHO) on call covering medical patients across the hospital. The hospital at night team included one SHO from surgery, orthopaedics and medicine. Many patients were regularly staying in the Emergency Department overnight until decisions were made by more senior

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doctors on the ward round in the morning. The trust recognised the need to strengthen arrangements for senior presence at night and at weekends and there was planned recruitment around this.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



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

We rated effective as 'good'

In March 2014, we had reported on effectiveness, but did not rate any A&E service as we were not confident overall of the evidence collected to give a rating.

During this inspection, we found that national guidance was being used to support patient care and treatment. Policies and procedures were developed in conjunction with best practice evidence from professional bodies. Local clinical audit programmes were developed to review and improve standards. National audits demonstrated that the Emergency Department performed similar to other trusts. Patients received effective pain relief and had appropriate nutrition and hydration.

Staff had training and appraisals had improved. Junior doctor training, previously assessed by the national GMC survey as worse than expected had improved. Junior doctors now identified overall satisfaction with training as similar to other trusts. Multi-disciplinary teams worked well together and local access to diagnostic imaging was improving. There were, however, still some delays to patients requiring review by medical specialty teams. Seven day services had extended and there had been improvements in senior medical presence and emergency nurse practitioner availability out of hours and at the weekend. It was acknowledged that this needed to continue to improve as more staff were

recruited. The rapid access early assessment care team (REACT) worked effectively for frail and elderly discharge patients with 70% of referrals being ready for discharge within 24 hours.

## Evidence-based care and treatment

- The Emergency Department used a variety of guidelines including those from the National Institute for Health and Care Excellence (NICE), the British Thoracic Society (BTS) and the College of Emergency Medicine (CEM).
- Local polices and care pathways were available for patients with specific conditions such as sepsis (a serious infection), fractured hip, community-acquired pneumonia, venous thromboembolism and head injury. Both nurses and doctors contributed to the completion of the relevant documents, and they were monitored and audited regularly.
- There was a local audit programme for the Emergency Department, which demonstrated that local and national audits were undertaken and action was taken to improve standards as a result.
- Monthly meetings were used to discuss outcomes of care and improvements were circulated via monthly departmental newsletter called Monthly Muse.

## Patient outcomes

- The management of patients with sepsis (a serious infection) was monitored and demonstrated 100% compliance with severe sepsis but only 60% compliance for patients with suspected sepsis.
- Unplanned re-attendance rates within 7 days were 6.5%. This was above the standard of 5% but below the national average of less than 7.5%.
- The trust participated in national audits undertaken by the College of Emergency Medicine, such as the recent audits on paracetamol overdose (2013/14), severe sepsis (2013/14), and the asthma children audit (2013/14). The summary performance of the Emergency Department in each audit was similar to other trusts.
- Metrics to demonstrate patient outcomes of care were underdeveloped. The trust could cite, however a reduction in the length of stay for patients with chronic obstructive pulmonary disease, heart failure and stroke, and lower in-hospital cardiac arrest rates.

## Pain relief

- Patients had their pain assessed on admission and medication was prescribed. Intentional rounding was



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used to reassess pain levels. We reviewed six records and saw that the intentional rounding was less frequent than every two hours. However, patient's pain relief was assessed and prescribed medication was administered.

- The patients we spoke with told us they received adequate pain relief.

## Nutrition and hydration

- A new system of regularly offering drinks and snacks to patients had recently been introduced. This was part of the "intentional rounding" and was meant to take place every 1 to 2 hours.
- We saw staff offering refreshments during the course of our visit although this was not always recorded in the patient record.
- The department now received sandwiches and snacks and had a hospitality trolley offering tea and coffee which meant they could provide food and hot drinks 24 hours a day.
- The trust scored similar to other trusts in the A&E Survey 2014 for the question on nutrition and hydration.

## Competent staff

- The National Training Scheme Survey, GMC, 2014 demonstrated that the training given to junior doctors had improved and overall satisfaction and other indicators, such as workload, adequate experience and handover, were similar to other trusts. The training was worse than expected for clinical supervision.

## Multidisciplinary working

- Medical and nursing teams worked well with other specialties and therapy services to provide multidisciplinary care. There were some delays for patients needing medical assessments by the specialty medical teams in the Emergency Department and AOU.
- The rapid early assessment care team (REACT) provided nursing and therapy support to facilitate the discharge of frail and older patients. The service included two lead nurses, a social worker, a physiotherapist and occupational therapist. Patient pathways were to community hospital or to the patient's own home, for example, equipment could be delivered on the same day to support patients at home. The team saw between 3 and 4 patients a day and 70% were discharged within 24 hours. We did not receive any data on readmissions to the hospital.

- There was an adult community healthcare team in the hospital, based in the Emergency Department to support the discharge of patients.
- There was a protocol based system to support trained radiographers to undertake CT scans in trauma cases, for example for head trauma. The system allowed for a verbal report within 30 minutes. Ongoing audits demonstrated that reports were available within 60 minutes.

## Seven-day services

- Consultant presence in the department was from 8am to 8pm weekdays and from 8am to 11pm on both Saturday and Sundays. They were supported by five middle-grade doctors and eight junior doctors over a 24-hour period. A second acute medical consultant physician of the day was allocated to increase senior medical presence at the weekend.
- Emergency nurse practitioners had extended their service which previously ran from 9am to 10pm. The service now ran from 8am to midnight Mondays to Wednesdays and from 9am to midnight from Thursday to Sundays.
- The service, though reduced at the weekend, now had two nurses and the workload which was previously described as 'too large' was now considered 'manageable and staff told us they did not feel under pressure to discharge patients too early.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm. There were two radiographers on call out of hours. The radiologist reporting service was subcontracted to another service out of hours and over the weekend. The service was described as "in development" and the threshold for requesting scans out of hours was being reviewed.
- The pharmacy was open until 1pm on Saturday and 12 midday on Sundays. Outside those hours, there was an on-call pharmacist to dispense urgent medications.
- The pharmacy was open until 1pm on Saturday and Sundays and there is ward pharmacy support until 4pm at weekends.

**Are urgent and emergency services caring?**

# Urgent and emergency services

Good



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

We rated caring as good.

This demonstrated an improvement on the previous rating. In March 2014 we had rated caring as 'requires improvement'. At that time, we observed staff to be caring and patients told us they were involved in their care. However, the department had significantly lower than average scores in the A&E Friends and Family Test and pressures in the department had reduced the staff ability to provide emotional support to patients.

During this inspection we found that staff treated patients with care and compassion and with dignity and respect. The department performed similar to other departments in the A&E survey 2014 and similar to the national average in the A&E Friends and Family Test. Patients, relatives and carers, told us they had good experiences of care and their care and treatment was explained so that they could be involved. Staff made time to offer emotional support to patients who were anxious or distressed.

## Compassionate care

- The trust scored similar to the England average for the A&E Friends and Family Test (August 2014 to February 2015). The test asks patients if they are likely to or extremely likely to recommend the service to friends or family and 95 %of patients would. The Emergency Department had continued to improve its scores since these were worse than the England average in June and July 2014.
- Overall, the trust was similar to other trusts in the CQC Accident & Emergency (A&E) patient survey 2014. Although it was worse than expected for standards on cleanliness. The questions covered access to care, safeguarding, cleanliness, nutrition and hydration, pain relief, compassionate care, patient understanding and involvement, emotional support and access and flow and meeting patient individual needs.

- We observed staff being caring and compassionate to patients in the department,
- Curtains were drawn appropriately to protect patients' dignity when staff were delivering care and treatment.
- Patients told us they felt staff were caring and kind and kept them informed.
- Throughout our visit, we saw patients were offered food and drink at mealtimes, and their dignity and privacy were respected.
- Call bells were available in the rooms we observed and when used these were answered quickly for most patients.

## Patient involvement in care

- Most patients told us they felt involved in their care and were offered advice regarding their discharge.
- Patients waiting in the waiting room for assessment told us they were informed of waiting times and what would happen during their visit.
- We observed staff speaking to relatives in areas that ensured conversations remained private and confidential.

## Emotional support

- The trust was similar to other trusts in the CQC A&E survey 2014 for emotional support to patients. For specific questions, the trust was similar to other trusts for nurses and doctors discussing fears or anxieties about their condition or treatment but was worse than other trusts for staff reassuring patients who were feeling distress.
- We observed staff offering emotional support to patients. Some patients who arrived by ambulance and were waiting in the corridor, and some patients in the resuscitation area, were anxious and in distress. We observed staff speaking to these patients in a calm and considerate manner and staff made efforts to ensure patients felt supported and understood what was happening to them.
- A mother came into the department by ambulance and had two small children. The children were kept close to their mother and were supervised, offered food and drink and toys to play with by paramedic and hospital staff. When the mother was being assessed, we identified that the adult waiting areas was an unsuitable environment, and staff in the department ensured the children were supervised in the children's waiting areas.

# Urgent and emergency services

**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.

This demonstrated an improvement on the previous rating. In March 2014 we had rated responsive as 'inadequate'. At this time, the Emergency Department had been struggling with capacity issues, patients waited for hours on a trolley and in corridors while waiting to be admitted to the hospital. Neither the acute medical unit nor the surgical assessment unit functioned effectively to reduce waiting times.

During this inspection services were being planned based on the needs of the local population and action was being taken, in conjunction with health and social care partners across Buckinghamshire, to respond to service demands. The trust had identified peak attendance times in the Emergency Department and planned staffing to respond. There were new services to speed the assessment and treatment of patients and avoid patient admission to hospital. The new services included an initial assessment and treatment centre in the Emergency Department, assessment and observation unit (AOU), short stay acute medical unit, and ambulatory care service. These areas still needed to function appropriately across the hospital as patients were still delayed in the Emergency Department.

The service had improved its performance against the national emergency access target (that is for 95% of patients to be admitted, transferred or discharged within four hours). However, the target was not being met consistently. The navigator role the Emergency Department was helping to move people effectively though the department but there were delays from medical specialty teams in assessing and discharging patients in the Emergency Department and AOU. Escalation procedures identified specific trigger points for a hospital wide response to emergency pressures. Escalation was working in the Emergency Department

although the hospital response needed to improve. We observed the Emergency Department to be busy but calm. Many patients were still waiting for excessively long periods in the Emergency Department although they did not have long waiting times on trolleys or in corridors.

There was a new psychiatric in-reach liaison services (PIRLS) that had improved the support of people in the Emergency Department who had a mental health condition. Advice and information was available in different languages although these were not always on display. Interpreter and translation services were available and staff knew how to access them.

The transfer of patients between Wycombe Hospital and Stoke Mandeville Hospital still required review. The information now followed the patients so that their care and treatment continued and was not re-started. There was however, still a number of patients being transferred from Wycombe Hospital to Stoke Mandeville who were subsequently discharged from the Emergency Department without further treatment.

GPs were sent a discharge summary of a patient's attendance in the Emergency Department. The timescales for sending these had improved though the average time was five days.

The majority of patient were seen within three hours in the minor injuries unit and within four hours if they were not being admitted.

## **Service planning and delivery to meet the needs of local people**

- The Buckinghamshire Health & Social Care Operational Resilience & Capacity Plan 2014/15 included analysis of population information to plan services. This detailed peak attendances times in the Emergency Department). For people 75 the busiest days were Monday and Friday. For the 0 to 4 year olds the busiest day was Sunday. Evenings were the busiest times. The working hours of the second physician of the day and emergency nurse practitioner had been adjusted to reflect peak admission times.
- The trust has introduced the Initial Assessment Treatment Centre (IATC) in May 2014 as a 'one stop' area to quickly assess, undertake key tests and treat patients.



# Urgent and emergency services

This had increased the throughput of patients through the department. The department planned to introduce consultant driven rapid assessment when more consultants had been recruited to the vacant posts.

- The Assessment and Observation Unit (AOU) was opened in November 2014. This facility had 20 beds and replaced the clinical decision unit that was in the Emergency Department and the medical assessment unit. The Emergency Department had six beds on this unit for clinical assessment and there were 14 for medical assessment. Patients were expected to remain on the unit for 24 hours to receive further monitoring, investigations and prompt discharge. Surgical patients now went directly to the surgical assessment unit (SAU).
- GP patients were admitted to the AOU for medical assessment and the intention was for this to be the single point of access
- Ward 10 had become a short stay medical unit and patients were expected to be on this ward for 72 hours to allow short-stay patients to be discharged quickly.
- Patients who arrived through reception were greeted by a receptionist and assessed by a triage nurse or by a trained senior nurse who worked as the navigator to provide experienced assessment of patients. Patients who arrived by ambulance were assessed by triage nurse who worked closely with the navigator nurse to assign patients to appropriate areas of the department. Patients were allocated to the GP area, IATC, resuscitation or minor areas
- The trust had an improvement plan to improve patient flow in the Emergency Department and in the hospital. The trust had identified that there were still many patients waiting for unacceptably long period in the department and the pathway for these patients needed to improve to ease pressures in the Emergency Department.
- An escalation plan had been introduced to respond to the flow of patients in the Emergency Department and the hospital. This included an overcrowding tool which ensured a hospital response to when there was an increasing number of emergency admissions that would increase the risk that the Emergency Department could become “unsafe”. The trust had developed metrics to trigger escalation and these focused on an hour by hour analysis of the pressures and action that would be necessary. Factors that were included in the triggers were for example, more than six ambulance arrivals within an hour, beds taking over an hour to escalate,

delays over an hour for specialist opinion, more than two critically ill patients in the department and more than two doctors or one nurse or ENP missing from any rota.

- The overcrowding tool identified the need for senior staff support to patient flow in the hospital, for example, staffing increases in the Emergency Department, increased support from bed management speciality teams increasing ward rounds to discharge patients and the increasing reviews of patients in the Emergency Department.
- The trust had also opened an ambulatory care centre in November 2014, to assess and treat medical patients who did not require admission. The centre saw approximately 20 patients a day and had a target of reviewing between 10 and 15% of all medical admissions and had achieved 17% in January and February 2015. The centre was planning to expand to include “hot clinics” for patients who may have urological, neurological and gastroenterology conditions.
- The rapid early assessment care team (REACT) provided nursing and therapy support to facilitate the discharge of frail and older patients. The service helped to identify community provision and support to enable patient’s early discharge.
- The paediatric unit had GP referred and walk in patients who were managed by the paediatric medical and nursing teams. Children who came in as emergencies were managed by the Emergency Department consultants.
- There were three Emergency nurse practitioners (ENP) and they covered shifts in the department from 8am to midnight every day of the week. These nurses worked in the minor injuries unit. They saw new patients with minor injuries and also follow up patients, for example, with fractures or burns.

## Meeting people’s individual needs

- Advice leaflets were available in different languages. However, these were not displayed in the department.
- Information on translation and interpreter services was not displayed but staff told us they could easily access these services. There were many staff in the department who spoke different languages and often assisted when required.
- Mental health patients were cared for in the main department or AOU if a bed was available. The relatives’

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room was used for assessments. A new psychiatric in-reach liaison service (PIRLS) had started in April 2014. This had been developed with the local mental health trusts. Consultant psychiatrist and mental health nursing liaison team attended the Emergency Department every morning to review patients. Patient profiling and a flagging system was used to identify patients appropriately and to identify known patients to the liaison team. As of August 2014, the service was available in the department from 7am to 9pm seven days a week.

## Access and flow

- Throughout the calendar year 2014, the trust had met the emergency access target but this was not consistent. This target is for 95% of patients to be admitted, discharged or transferred within four hours of attendance at the Emergency Department. During December 2014, in line with the NHS as a whole, the trust was managing an unprecedented and significant number of emergency admissions and only 80% of patients (on average) had met this target. Between January to February 2015, this was improving and the trust achieved the target for 91% of patients.
- The Emergency Department doctors were identifying patients informally for admission. The decision to admit patients to the hospital was done by the medical speciality teams. There were still some delays with this approach when medical assessments were not timely. Many medical patients remained in the Emergency Department overnight. The response times of specialty teams was not being monitored.
- Medical specialty teams did a ward round the next morning (within 12 hours) but protocols for medical assessment and review were not defined for when a patient may remain in the department for over 12 hours.
- From April 2014 to February 2015, approximately 60% of patients stayed less than 24 hours on the AOU. The AOU was functioning as a short stay unit and medical specialty teams were not undertaking timely assessment to discharge patients. During our inspection, there were patients in the AOU who had remained there for over 48 hours. Some patients were still awaiting test results a few were awaiting review by the specialty medical teams and this had caused delays in the progress of their treatment and/or decision to discharge.
- The trust had improved figures for the percentage of patients leaving the Emergency Department before treatment. Having been significantly above the national average in 2013, latest figures demonstrated that the trust was similar to the national average (July to September 2014) at 2.5% compared to the national average at 2.7%.
- The trust quality dashboard identified the number of patients waiting over four hours in the department for treatment. For patients that were admitted, the average waiting time in the department was 14 hours (April 2014 to February 2015). During our inspection, the trust many patients waiting over 12 hours in the department. These are defined as 12 hour breaches. Many patients had stayed in the department between 13 and 15 hours and one patient for up to 20 hours. For example, on one morning we observed 10 patients waiting over 12 hours; by the afternoon we observed seven patients waiting over 12 hours. We did not observe any patients waiting in the corridors for treatment.
- The overcrowding tool identified the need for senior staff support to patient flow in the hospital, for example, staffing increases in the Emergency Department, increased support from bed management speciality teams increasing ward rounds to discharge patients and the increasing reviews of patients in the Emergency Department.
- We observed that the escalation policy had been triggered in the department.
- The bed managers were working within the department and across the hospital to free beds and increase availability according to the escalation policy.
- When the number of emergency patient attendances and patients were waiting in corridors increased, the nurse in charge worked with the IATC nurse to identify cubicle spaces. The department also flexed to use the corridor as an extension of the majors areas and the navigator nurse worked with the triage nurse to allocate patients to the GP IATC, minors and major areas.
- During our inspection, the department was very busy at times but the environment remained calm.
- If the Emergency Department became overcrowded, escalation procedures allowed for patients to be 'boarded' in the AOU, the unit which could increase the number of beds from 20 to 22 beds. However, this was not clearly determined and 'boarding' patients often happen in the majors area first which was an area where patients were at higher risk.

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- Patients who were wrongly admitted to Wycombe Hospital were transported to Stoke Mandeville Emergency Department. Whereas before they were re-admitted through the Emergency Department and this caused delays. The information now followed the patient and their care and treatment continued in the Emergency Department. However, the trust still identified a number of patients (approximately four per month) being transferred from Wycombe Hospital but who were subsequently not admitted.
- Patients stayed in the minor injuries unit from between two and three hours. This had helped to improve flow in the department. The average waiting time for patients that were not admitted was four hours.
- GPs were sent a discharge summary of a patient's attendance in the Emergency Department. The timescales for sending these had improved from 11 days to an average time of five days.

## Are urgent and emergency services well-led?

Good



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

We rated well-led as 'good'.

This demonstrated an improvement on the previous rating. In March 2014 we had rated well-led as 'requires improvement'. At that time the trust needed to improve its vision and strategy and leadership of the service. Staff engagement needed to improve and risks needed to be better managed to reduce the pressures on staff and the responsiveness of services.

During this inspection we found that the vision and strategy for the service was well developed and the trust was working with partners to improve the coordination of urgent and emergency care across the health and social care system in Buckinghamshire. The pace of change in the trust had been rapid over the last 12 months and there had been significant and clinically led service developments. The department had focused on effective

team building. Staff engagement had improved, and staff identified a culture of positive leadership and support, as well as being empowered to identify concerns and take action. The department had an effective governance structure and information was being used to monitor and improve the quality and safety of services. It was the documentation of issues that needed to improve. Risks were escalated and acted upon, but recorded actions were not timely to demonstrate the ongoing work around patient flow and workforce planning. Incidents were reported and actioned but the timeliness of review on the electronic report system needed to improve. The service could identify many examples of innovation and improvement and action was being taken to ensure the sustainability and resilience of services.

### Vision and strategy for this service

- The trust clinical strategy identified the need to integrate services and working in partnership across community, primary care and with social care. The aim for emergency and urgent care was to maximise the chances of survival and good recovery.
- The previous strategy for the Emergency Department was focused on improving staffing and patient flow and had been developed after an emergency care intensive support team (ECIST) visit in March 2013. The strategy included
  - Recruitment across consultant grades, advanced nurse practitioners and junior nurses.
  - Refurbishment of the department and open the new Initial Assessment and Treatment Centre and resuscitation areas.
  - Development of the new Psychiatric In-reach Liaison Service (PIRLS) to start in April 2014.
  - Closer work with commissioning groups to develop integrated emergency pathways.
  - Training for nurse practitioners to see patients with minor illnesses
  - To open the acute medical unit and surgical admissions unit in June and November 2013, respectively.
- The trust had had several further ECIST visits since this time. We identified during this inspection that this strategy had been implemented and updated. The acute medical unit was identified as not functioning effectively and this had developed into the assessment observation unit, acute medical unit (short stay, ward 10) and ambulatory care.

# Urgent and emergency services

- The Buckinghamshire Health & Social Care Operational Resilience & Capacity Plan 2014/15 identified how the trust was working with its partners to improve emergency and elective care. There were joint initiatives to improve planning and capacity across the ambulance, primary care, community and acute services across Buckinghamshire. The trust could demonstrate that they had increased the level of senior medical presence seven days a week, invested in nursing and medical workforce in the Emergency Department redesigning the Emergency Department, increased support for frail elderly people and increased seven day working of adult community healthcare teams in the acute hospital
- All staff in the Emergency Department had been involved in planning the changes to the Emergency Department. The staff could identify that risks in terms of patient flow and staffing levels needed further action. Physician engagement amongst medical and surgical specialties to ensure a hospital wide response to emergency admissions was an important next step. There was ongoing discussion and actions with the specialty teams.

## **Governance, risk management and quality measurement**

- There were structured monthly governance meetings where complaints, incidents, audits and service performance measures were discussed and actions agreed. Not all staff could attend these and the lead nurse in A&E attended governance and senior team meetings and fed back on investigations and actions from incidents.
- The department had a quality dashboard that included data on operational, quality, workforce and finance & activity.
- Results from the departmental quality dashboard were displayed in the patient areas and included hand hygiene audits and complaints about the service.
- The Emergency Department risk register identified the main areas of concern as patient flow and their workforce. The risks described, for example, recruitment of consultant staff and consultant staff presence, delays in the pathway for medical patients and not achieving the national emergency access target. Some of these risks had been on the registers since 2012 and the high risk score had not changed. There were action plans to address these main risks but not for other risk areas. We

had observed improvements in these risk areas but there had not been any recent updates to the risk register in 2015. Risks were appropriately escalated and acted upon.

- The department was reporting incidents and there was evidence of feedback and improvement and sharing lessons learnt. However, the department had a significant number of overdue incidents on the trust electronic reporting systems which required action. It would be important for there to be timely review of incidents to help prevent future reoccurrences. This had been recognised and actions was being taken to reduce the number.

## **Leadership of service**

- The five consultants and lead nurse provided senior leadership within the Emergency Department.
- There were now four band 7 nurses who had a lead role in managing the junior nursing staff team. They now worked on a 10am to 10pm supernumerary shifts covering across nursing shifts in the department to monitor standards of care and support staff with training. The band 7 nurses led on governance and performance issues.
- Many staff recognised that the pace of change had been rapid for emergency care in the hospital and considered that had happened because there had been effective engagement with staff from managers and leaders.

## **Culture within the service**




- The trust had invested in external consultants to support team building and staff empowerment in the department. The staff we spoke with identified a different culture and better support from senior managers. They told us they felt empowered to make changes and act on concerns. Initiatives were identified as clinically led.
- The hospital culture had changed so that the emergency care pathway was now 'owned' by the hospital rather than the Emergency Department. Pressures in the Emergency Department were being supported.
- The REACT team told us they were supported to provide appropriate discharge and were not pressured to discharge patients too early, which had happened in the past.

# Urgent and emergency services

## Innovation, improvement and sustainability

- Staff had identified the biggest change to the department in the last 12 months as the increase in focus and resources and improvements in working arrangements. There was a safeguarding lead nurse visible in the department, increased visibility and attendance of Patient Advice and Liaison (PALS) in the department, the psychiatric in-reach liaison team (PIRLS), the rapid access early assessment care team (REACT) team and adult community health teams working in the department. This integration of teams had helped to support patients for example, community therapy support for elderly patients who may have fallen.
- The introduction of band 7 nurses who worked 10am to 10 pm shifts was demonstrating its effectiveness. The nurses had a supernumerary role to ensure clinical standards of care in the department and they were involved in developing new documentation, introducing benchmarks to assure the appropriate mix of staff and auditing care.
- The trust was participating in a national pilot research project considering the role of a clinical pharmacist in the Emergency Department. The project was researching if patients needed to attend the department, or if they could be supported by a clinical pharmacist prescriber in the ED, or if they could have been supported by a community pharmacist. The project would determine pathways of care and aimed to make better use of the skill mix of staff in the ED and avoid admissions if community pharmacy could be encouraged to undertake medicine reviews.
- The trust was planning to have consultant led rapid assessment and treatment models of care within the Emergency Department and acute medical unit during hours of peak demand. This would happen when more consultants were recruited. The trust was planning to offer an academic post, such as a professorship or senior lecturer position, in the Emergency Department to attract medical staff
- The trust was working with the University of Reading on an associate practitioner course, a new clinical discipline to the Emergency Department, to improve the skill mix of staff working in the department.

# End of life care

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

## Information about the service

Buckinghamshire Healthcare NHS Trust provides end of life care for the acute service over two hospital sites: Stoke Mandeville Hospital and Wycombe Hospital. On the Stoke Mandeville site, the Florence Nightingale Hospice, provides specialist end of life care. The hospice provides 11 inpatient beds with an additional bed for day case treatments, day care facilities and an outreach service to patients at the end of their life. The specialist palliative care team based within the hospice, provides 24 hour support and advice regarding symptom management to patients, relatives and staff who required specialist guidance. There were 691 in-hospital deaths in the trust between April 2013 and October 2013.

End of life care is mainly provided by ward staff on inpatient wards, with specialist palliative care link nurses, consultants and other medical staff available for support when required. End of life care was also supported by other members of the multidisciplinary team: for example, acute oncologists, chaplaincy, clinical nurse specialists and the bereavement office.

This was an unannounced focused inspection to review concerns relating to end of life care service provision following a comprehensive inspection in March 2014. At the previous inspection concerns highlighted related to the availability of medication, adequate levels of nursing staff to provide appropriate care for patients at the end of their life, holistic care planning and the availability of a strategy trust wide, to replace the Liverpool Care Pathway. There were also concerns relating to availability and suitability of equipment and facilities.

During this inspection we reviewed trust policies and procedures, staff training records, audits and performance data. We also looked at computerised records and observed care being provided. We spoke with three patients, four relatives and 27 members of staff, including doctors, nurses, bereavement officers, physiotherapists, occupational therapists, mortuary technicians and members of the chaplaincy.

This report is looking at the end of life service provision based within Stoke Mandeville Hospital and the Florence Nightingale Hospice.



# End of life care

## Summary of findings

Overall we rated this service as 'requires improvement'. This was similar to the previous rating in March 2014. However the service had improved its rating in two of the five domains we inspected in providing an effective and caring service.

During this inspection we found improvements. Nursing and medical care had improved and patients received better symptom control and anticipatory drugs for pain relief. Patients nutrition and hydration needs were being assessed. Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment.

The specialist palliative care team was well led and staff were passionate about improving the quality of services. Staff across the hospital provided good emotional support for patients. The chaplaincy provided one to one spiritual support and worked closely with the bereavement officers to ensure relatives received a sensitive and individual service following the loss of a loved one. The hospice day care services provided well considered emotional support for their patients and conducted patient satisfaction surveys to measure effectiveness.

Patients being taken to the mortuary frequently arrived without any identification wrist bands. Technicians were reliant on a nurse from the ward coming down to the mortuary to identify the patient. Records were not always stored securely and in places could be accessed by patients and relatives. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not consistently completed.

Staffing levels in the mortuary were not safe. Technicians were often working long hours alone without support and they did not have appropriate equipment for bariatric (obese) patients.

Patient areas were clean and staff followed infection control practices.

There were interim care plans in use following the withdrawal of the Liverpool Care Pathway in 2014. However, these care plans, called Hearts and Minds – end of natural life, were not consistently completed to

provide holistic care for patients. Staff did not have a clear understanding of end of life care and ceilings of care, which would involve the cessation of all invasive treatments and non-essential medication, were not consistently applied. The trust was working on a care pathway called "getting it right for me" and had involved staff and patients to develop this.

The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators of care. Local audit to monitor the effectiveness of services was not well developed. The trust had acknowledged this gap and audit needed to be introduced.

There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. However, there could sometimes be discharge delays. The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.

There was good support from the specialist palliative care team and referrals, once completed, were responded to within 24 hours. Support and advice was available 24 hours a day seven days a week. Training was available for staff in relation to caring for patients at the end of their life.

The hospital did not have a central register to identify a patient who was on an existing end of life care pathway and this could delay their care and treatment. However, a new electronic record, the Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily. Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved.

The director of nursing holding responsibility for end of life care at trust board level. A new trust strategy was being developed but communication around this needed to improve. A review of the service had been

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undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was being used to monitor some key indicators relating to care but audit to monitor the quality and safety of end of life care services needed to develop. The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward

## Are end of life care services safe?

Requires improvement



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

We rated safe as 'requires improvement'

This was similar to the previous rating although some aspects of safety had improved. In March 2014 we had rated safe as 'requires improvement'. At that time, documentation was not appropriately completed and appropriate medicines were not always available for patients.

During this inspection we found that staffing levels in the mortuary were not safe. Technicians were often working long hours on their own without support. There had been a work place accident in the mortuary, in which a technician sustained a serious injury requiring surgical intervention. This had been due to the lack of appropriate safety equipment. Staff were also being placed at risk as there was no lifting equipment for moving bariatric (obese) patients in the mortuary. Patients being taken to the mortuary frequently arrived without any identification wrist bands. Technicians were reliant on a nurse from the ward coming down to the mortuary to identify the patient.

Records were not always stored securely and in places could be accessed by patients and relatives. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not consistently completed and a second different form was in use in the hospice.

Staff were aware of how to report an accident or an incident and changes had occurred as a result. For example a trust wide process has been implemented in relation to syringe drivers, as a result of learning from an incident. However, some risks were not addressed. The overhead lamps in the hospice, at patients' beds had been identified as presenting a risk in February 2014 as they were becoming too hot to touch. These lamps had still not been replaced and continued to pose a risk.

Patient areas were clean and staff followed infection control practices. Changes had been made to how patients



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were transported to the mortuary to reduce the risk of cross infection. However, the storage of patients' clothes in open bags in the bereavement office, continued to pose a risk of cross infection.

Information relating to symptom control was available in the form of line flow charts for symptom management medication. Intentional rounding was carried out every two hours; nurses used this opportunity to assess pain relief, fluid and nutrition and pressure areas. The wards had been provided with lists of anticipatory drugs that were available for patients at the end of their life.

## Incidents

- There was an electronic incident reporting system. Where staff had reported incidents they were given feedback verbally or by email, which meant they were informed of the outcome from the incident being reported.
- There had not been any serious incidents requiring investigation (SIRI's) reported in relation to end of life care between February 2014 and January 2015. From the data we had received, the trust had reported incidents for end of life care services.
- Staff were learning from incidents. For example, one incident reported that a syringe driver had failed for a patient. Following this, the trust had introduced a new process for syringe driver management. All staff that we spoke to were aware of the new policy and guidance was readily available on wards.

## Duty of Candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred
- Some staff demonstrated a good understanding of duty of candour and what their responsibilities were.

## Cleanliness, infection control and hygiene

- The cleanliness throughout Stoke Mandeville hospital and the Florence Nightingale Hospice was very good. There was evidence of infection control audits in ward areas with an average of 98% compliance.
- Personal protective equipment (PPE), such as gloves and gowns, were readily available and staff were observed using this equipment to help reduce the risk of cross infection.
- Infection control guidelines were being followed by staff and policies were readily available both in paper and online. Staff had a good understanding of infection control practices and were observed complying with hand washing procedures.
- The mortuary reported that all patients who were infectious were received by mortuary staff in a body bag. This was a cause for concern previously as patients who were infectious were not always sent from the wards in a protective body bag. This could have led to the spread of infection within the hospital and particularly to mortuary staff. This risk had now been reduced.
- In the bereavement office, there remained a potential risk of cross infection as deceased patients' belongings, which could be soiled, were being stored in cupboards in open plastic carrier bags while awaiting collection from relatives. The specialist infection control nurse had visited the bereavement offices to advise on best practice but the infection risk still remained.

## Environment and equipment

- A central register of equipment was held by the trust. An audit had been undertaken over the previous 18 months to ensure that the register was up to date. There was an established planned preventative maintenance programme for all medical equipment. The system could track equipment that could not be found when maintenance or a service was due.
- The trust had taken a risk-based approach to the testing of portable electrical appliances. This was reported to be in line with guidance and meant that some items would be tested annually and other items up to four yearly.
- The metal lamps above the patient's beds in the hospice had been identified as a risk following a health and safety audit in February 2014. We observed that only one lamp had been replaced and the risk remained. Patients and staff continued to be at risk as the metal lamps would become hot. There had been a recent incident when a light bulb had shattered but no one

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had been hurt. While the lamps were on the risk register the action to reduce the risk, which was to inform patients not to touch the lamps, did not appear to be adequate to reduce the likelihood of harm. This was because staff had to remember to verbally tell patients, who could be confused and might not remember what they had been told.

- The mortuary now had sufficient metal gauntlets to conduct a post mortem safely. There had been an accident in the work place involving a mortuary technician. This was a serious incident (recorded under the Pathology Department responsible for this service), which required urgent treatment and surgical intervention. The gauntlets had previously been requested by staff but had not been provided. Following the accident, gauntlets were provided for staff which would prevent similar accidents in the future.
- All mortuary provision for bariatric (obese) patients was provided at Stoke Mandeville Hospital. Staff working in the mortuary at Stoke Mandeville Hospital did not have lifting equipment for bariatric patients and staff have to do this manually. Staff were at risk of harm.
- In 2011, the National Patient Safety Agency recommended that all Graseby syringe drivers should be removed by the end of 2015. There was a policy in place to expedite the trust wide removal of the Graseby syringe drivers and the trust aimed to complete this by summer 2015.
- During inspection we learned that the withdrawal of the Graseby syringe drivers was due to be implemented on the 2 April 2015. The trust told us staff were aware and the new drivers were being stored in the hospice prior to the equipment library to ensure that the equipment was not used inappropriately. The trust subsequently told us that the roll out of the equipment was delayed by two weeks to allow for all staff to be appropriately trained.

## Medicines

- The management of medicines for patients receiving end of life care had improved since our last inspection. There were online flow charts for symptom management medication and the pharmacists had provided the wards with lists of anticipatory drugs that were available for patients at the end of their life.
- During our last inspection, it was noted as a concern that there were inadequate amounts of sedation available for syringe drivers, which meant patients' who

were at the end of their life could have faced delays in receiving medication for pain relief. Every ward we visited during this inspection had adequate doses of sedation available for syringe drivers.

## Records

- Since our last inspection in March 2014 and in response to the national withdrawal of the Liverpool Care Pathway (LCP) in July 2014, the trust had introduced an interim care plan. It was an adaptation of the 'Heart and Minds' care plan which was being used for all patients in the hospital and was called 'Hearts and Minds – end of natural life'. All staff demonstrated knowledge of this care plan for patients at the end of life, but its completion was inconsistent and relied upon staff recognising that a patient was on the end of life care pathway. It did not include prompts for recording nutrition and hydration or pressure area management. This information was written in the nursing notes or intentional rounding sheets. New paperwork which reflected a more patient centred care plan was being developed and was due to be piloted on participating wards in March 2015 but this had been delayed.
- The Bucks Coordinated Care Record – the (BCCR) was being developed which would enable patient consented information regarding their medical condition and any Advanced Care Planning to be electronically shared securely across organisations, was being rolled out. This would help to ensure that information about the patient's medical diagnosis, advanced care plans and end of life care preferences and wishes would be communicated effectively. Staff were being trained to access this record as part of a patient's admission
- The do not attempt cardiopulmonary resuscitation (DNACPR) forms were inconsistently completed. Two forms out of the 14 we observed were completed correctly. In the hospice, an internally produced 'DNACPR' form, replaced the official form or, in some cases, acted as a duplicate. Staff would then look at this form in place of the official paperwork. The rationale behind this was unclear. The issue with inconsistent DNACPR completion had been noted as a concern during our previous inspection.
- DNACPR forms were being used trust wide and the use was monitored through audit. The August 2014 audit relating to the trusts' compliance in completing these forms, found that overall there had been an improvement in documentation both in the completion

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of the forms and with the recording of DNACPR discussions between patients and their families, although there was still room for improvement. Other issues related to the verification of DNACPR forms by the responsible consultant, if the decision was made by a junior or specialty doctor. There was a very limited (15%) review of DNACPR decisions. We did not find consistent evidence of discussions with patients' and families being recorded in patient's notes. There was inconsistent completion of DNACPR forms.

- On several wards sites records were not securely stored. There were unlocked trolleys of notes in corridors where relatives, members of the public and patients had access to them. This could cause a breach of confidentiality as the notes were unsupervised in open areas.

## Safeguarding

- The trust had a safeguarding leadership team. The chief nurse was the board lead for safeguarding and was supported by a lead at associate director level. The lead for safeguarding adults was supported by a safeguarding nurse based in the Emergency Department and a learning disabilities nurse. A plan was being implemented to introduce safeguarding champions at division level. These staff members would have a training role and work to ensure that staff were kept informed about guidelines and policies.
- All issues relating to safeguarding were monitored and discussed at the trust's own safeguarding forum meetings held monthly and chaired by the director of nursing. Agenda items included but were not limited to the safeguarding scorecard, patients with learning disabilities, paediatric liaison /duty named nurse pilot, domestic abuse disclosure pathway, accident and emergency delivery improvement plan update, the prevent strategy and serious case review action plans.
- The staff that we spoke with were aware of trust safeguarding procedures and were able to give good examples of their understanding. Staff told us that there were guidelines available online and a safeguarding specialist nurse to contact if they had more complex issues to resolve. Safeguarding training for adults and paediatrics was a mandatory e-learning package. Safeguarding training was available as e- learning and as face to face. Completion of level one adult safeguarding training across the trust was 82%.

## Assessing and responding to patient risk

- The National Early Warning Score (NEWS) early warning tool was used to identify deterioration in a patient's condition. There was evidence in patient notes of this tool being used trust wide. Staff were clear about procedures to follow when a patient was deteriorating, alerting the on call medic at the earliest opportunity whilst continuing with vital signs observations.
- Intentional rounding was carried out every two hours; nurses used this opportunity to assess pain relief, fluid and nutrition and pressure areas. Evidence of intentional rounding being undertaken was observed in patient notes.

## Nursing staffing

- The specialist palliative care nurses were based within the hospice. The inpatient wards at Stoke Mandeville Hospital had access to a palliative care nurse specialist 24 hours daily. The wards felt that they provided a good support service.
- On many wards we visited, nurse staffing levels were low. Staff told us that they felt 'stressed' due to the lack of staff and often felt pressured to cover extra shifts on their wards. This would impact on the level of care being provided to patients at the end of their life who may require a greater level of nursing care, particularly to meet their emotional needs.
- Staff told us that a lot of the more senior nursing staff had left the trust and had been replaced by newly qualified or junior nurses. This has led to a poor skill mix on the wards and would impact on patients who may require more specialist care.

## Mortuary Staffing

- There were two technicians at Stoke Mandeville Hospital..
- Staffing levels in the mortuary at Stoke Mandeville were poor. Staff spent long periods of time lone working and worked over and above their hours. Staff were on call from home overnight on a one week on/one week off shift pattern and were still working a full working day before their night on call. Staff told us that they often worked later than 5pm, sometimes finishing as late as 8pm-9pm and they were then on call overnight. Often

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during the night technicians were called out two or three times, then had to go to work the following morning. There did not appear to be adequate rest periods for staff.

- During periods of annual leave or sickness, the remaining member of staff had to work alone until their colleague returned. Bank or agency staff were not used to cover these absences.
- On visiting the mortuary at Stoke Mandeville, we observed an incredibly busy environment, with one mortuary technician on duty. There was no administrative support for the mortuary and the mortuary technician was trying to answer a busy telephone line, which was the main contact number for relatives, undertakers, the coroner and pathologists as well as trying to meet clinical responsibilities.

## Medical staffing

- The specialist palliative care team provided on call consultant cover 24 hours a day seven days a week. Junior doctors on the wards told us that the medical cover within the specialist palliative care team was very supportive and they could always contact someone should they need guidance with complex end of life care symptom management.

## Are end of life care services effective?

Requires improvement



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

We rated effective as 'requires improvement'.

This demonstrated an improvement on the previous rating. In March 2014 we had rated effective as 'inadequate'. At this time, we found that end of life care was not being provided in line with national guidance. Patients experienced delays in pain relief and essential nursing care to relieve patient symptoms was not delivered appropriately.

During this inspection, we found that processes to improve end of life care were in development. The 'Hearts and Minds – end of natural life' care plan an adaptation of the generic care plan was being used. However, this did not

include key aspects that would reflect the holistic approach to end of life care. On some wards, this care plan was filed in the notes with nothing written on it. The hospice staff had created their own, more detailed care plan, which demonstrated a more holistic approach. Work was being undertaken to provide a pathway for adult patients called 'Getting it right for me.' Following a review of the five priorities of care and National Institute for Health and Care Effectiveness (NICE) guidance the new pathway had been developed. The new pathway was about to be trialled.

National guidance in relation to end of life care best practice was available in folders on all the wards we visited. Patients' pain was not assessed consistently but anticipatory medicines were being prescribed appropriately to respond to patients' need for pain relief. Patients' nutrition and hydration needs were being assessed. The roll out of the new syringe drivers, which would replace the Graseby syringe drivers, had not been fully implemented. Although there was a clear plan as to how this was to be achieved, there was limited knowledge of this in the wards.

Staff could not provide a clear definition of end of life. Some staff felt it to be within the final hours of a patient's life but did not recognise the 12 month end of life pathway. There was some evidence of ceilings of care in patients' notes, although this was not consistent trust wide.

The trust had participated in the 2013/14 National Care of the Dying Audit – Hospitals (NCDAH) and did not achieve five of their seven key performance indicators (KPI's) but was similar to the England average for most of the clinical indicators. Local audit to monitor the effectiveness of services was not well developed. The trust had acknowledged this gap and audit needed to be introduced.

There was evidence of good multi-disciplinary working practices on the elderly care wards, with doctors, nursing staff and allied healthcare professionals working together to ensure that patients at the end of their life were cared for in the correct setting. The daily facilitator meetings (DFM) were not always well supported by staff leading to delays in discharge, although, when required, patients were supported to have an early discharge. Support from the palliative care team was good and referrals, once completed, responded to very quickly.

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Support and advice was available 24 hours a day seven days a week. Training was available for staff in relation to caring for patients at the end of their life.

## Evidence-based care and treatment

- The trust was in the process of replacing the Liverpool Care Pathway (LCP) which was withdrawn in July 2014. Inpatient ward staff were following best practice guidelines from the specialist palliative care team and referring to the NICE QS13 'quality standard for end of life care for adults when required. This document provided staff with information about providing good end of life care. Most staff told us that they referred to this guidance if they required clarification about a matter relating to providing end of life care to their patients. A replacement for the LCP was being developed, to be published in October 2015.
- There was no evidence of adequate holistic care planning for patients at the end of their life, which was recommended in NICE guidelines QS 13 (3). The 'Hearts and Minds– end of natural life' care plan which was available for staff, was an adaptation of the current generic care plan. However, this document did not include key aspects that would reflect the holistic approach such as, nutrition and fluid intake, pressure area management, pain management and how to recognise a deteriorating patient. On some wards, this care plan was filed in the notes with nothing written on it. The hospice staff had created their own, more detailed care plan, which demonstrated a more holistic approach. However, this was only used in the hospice.
- Work was being undertaken to provide a pathway for adult patients called 'Getting it right for me.' There had been a three phase approach. The first phase had been workshops for staff with an aim of raising the profile of end of life care as well as educating staff about what good end of life care looks like. The second phase was engagement with members of the public and patients. This had led to 11 volunteers forming a group to develop the resource further. Following a review of the five priorities of care and NICE guidance and with joint working with a staff group, the new pathway was developed ( the third phase). The new pathway was about to be trialled.
- There was some evidence of ceilings of care in patients' notes. This included the cessation of all invasive treatments and non-essential medication. This was not

consistent across the trust. The impact of this was that staff did not know from looking at a patient's notes, what the appropriate treatment or level of care should be to meet the patient's needs.

- New guidelines issued in October 2014 by the British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing, stressed the importance of resuscitation decisions being part of end of life planning. Involving the patient in treatment escalation plans and focusing on what treatments were appropriate for a patient at a given stage in their illness and as it progressed. The trust had established a group to develop a treatment escalation plan. The new document was about to be trialled on two wards in April 2015.
- The symptom management process, although widely used, was not being evaluated for effectiveness. This meant that patients with more complex end of life care symptoms may not have been managed effectively, with no tool in place to monitor this.
- None of the ward nursing staff whom we spoke with could accurately provide an end of life definition, believing it to be within the final hours of a patient's life. The General Medical Council's (GMC 2010) definition of patients that are on the end of life care pathway is those who are likely to die within the next 12 months, including those who are likely to die imminently.

## Pain relief

- Throughout the trust pain assessment tools were not used for end of life care and there was inconsistent assessment of patients' pain. However, intentional rounding was carried out every two hours and nurses used this opportunity to assess pain relief. Intentional rounding was being undertaken and was observed in patients' notes.
- Anticipatory medications were being prescribed appropriately.
- Pain management in end of life care had not been audited to establish whether pain was being managed effectively. The trust management told us that policies were being developed but there were no timescales for this to be actioned.

## Nutrition and hydration

- The National Care of the Dying Audit Hospitals (NCDAH) confirmed that 36% of patients on the end of life care



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pathway received an assessment of their nutritional needs; this was lower but similar to the England average at 41%. The same audit showed that 36% of patients at the end of their life received a hydration assessment; this was lower but similar to the England average of 50%.

- Nutrition and hydration was not reflected on the 'Hearts and Minds Care Plan – end of natural life' care plan. On the intentional rounding sheets, on the wards that participated in intentional rounding, the nutrition and fluid intake for end of life care patients was clearly identified.

## Patient outcomes

- There was limited information made available that related to the monitoring of quality and outcomes. The trust was not using the End of Life Care Quality Assessment Tool (ELCQuA) although it had been recognised that an audit tool did need to be used.
- The Florence Nightingale Hospice monitored quality indicators such as harm free care and infections. The scorecard demonstrated standards were met.
- The trust has failed to achieve five of their seven key performance indicators (KPI) in the NCDAAH. An improvement plan was in place to ensure that the trust achieved these essential KPI in the next audit.
- The trust figures were below England average for the majority of the clinical KPI's in the NCDAAH but the range was not an outlier and this was therefore similar to the England average and other trusts.
- The specialist lymphoedema nurses at the hospice recently received a second place award for oedema management. This accolade was given by the Journal of Wound Care. The Lymphoedema service is jointly funded by the trust and charity and has approximately 600 patients. 40% of whom were cancer patients. They have one clinical nurse specialist (CNS) and one nurse who undertakes lymphatic drainage.

## Competent staff

- The specialist palliative care team supported the delivery of regular updates on end of life care to all staff on the trust induction programmes, the preceptorship programme, annual and three yearly nurse updates, and medical devices study days. They also taught on the healthcare assistant cancer journey course which was run by the cancer and haematology department. The team had input in the trust's induction for medical staff

and 'breaking bad news' training. The trust's intranet learning and development site referred to the leadership alliance for the care of dying five priorities and stated that the training will support the trust in delivering these priorities.

- Sixty eight staff had completed a palliative care update in the previous three years. There were bespoke modules booked to take place in September 2015 and January 2016.
- Staff were clear that they would refer to the palliative care specialist nurses if they had any queries or required support.
- Specialist palliative care nurses provided support to the hospital wards and there was a consultant available to give support 24 hours a day seven days a week.
- Senior nursing staff told us that all ward and community nursing staff had been given training to be able to operate the new syringe drivers when the Graseby driver was withdrawn on 2 April 2015. They further informed us that ward staff champions would be trained by specialist palliative care nurses and the champions would then go back to their wards to support other staff members on the day of implementation. Our inspection was eight days prior to the implementation date. Nursing staff told us that they had received no training, or training materials and were not aware of ward champions or in some cases, the actual implementation date. The organisation of this project was not cohesive. Staff were under prepared for the implementation date. This would impact on patients receiving medication through syringe drivers to manage their pain effectively within a timely manner.
- Most staff, across inpatient wards and within the hospice had received annual appraisals. This was confirmed by reviewing staff files. According to the information provided by the trust 92% of all staff in the specialist division, of which the palliative care team were part, had a current appraisal.
- The bereavement team frequently dealt with distressed relatives and very sensitive situations but had not been offered any form of supervision or training in relation to this.

## Multidisciplinary working

- Daily facilitator meetings (DFM's) were held on wards in the morning and afternoon. This was a multi-disciplinary meeting to look at discharges and to provide a formal handover to medical staff and nurses

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starting their shifts. Doctors told us that they were not always able to attend these meetings which sometimes led to a delay in decision making. This could delay discharge for patients at the end of their life, who wanted to receive palliative care in their own homes from the community nurses rather than in the hospital environment.

- There was an emphasis on patients being able to go home to be cared for in the community. These meetings were separate from the daily DFM. They also confirmed that support from the palliative care team was very good and that referrals, once completed, were responded to very quickly.
- There was evidence of good multidisciplinary team (MDT) working practices on the elderly care wards. Where doctors, nursing staff and allied healthcare professionals worked together to ensure that patients at the end of their life were cared for in the correct setting.
- A chaplain would also attend multidisciplinary meetings.
- The hospice had weekly MDT meetings which were well attended. They also had a weekly consultant ward round.

## Seven-day services

- The specialist palliative care service was available 24 hours a day, seven days a week. Specialist palliative care nurses were available to support patients, relatives and staff. Staff told us that the team were easy to contact, responded very quickly and provided very good support. The hospice provided a day care service seven days a week for up to 12 patients.
- There was a palliative care consultant available during the day on site, and during evenings, overnight and at weekends on call. Medics told us that they also found the consultant easy to contact and valued the support they were given to ensure that patients at the end of their life were able to be given the appropriate treatment 24 hours a day.
- Allied Health Professionals (physiotherapists and occupational therapists) were also available during the day, being attached to individual wards. At night, a physiotherapist was on call for urgent cases.
- Diagnostic imaging provided a service 24 hours a day seven days a week. A radiologist was on call overnight and at weekends for urgent reporting.
- The bereavement service provided support Monday to Friday during office hours.

- The mortuary team were available physically Monday to Friday during working hours, with a technician on call overnight and at weekends.

## Access to information

- All staff had access to information in relation to caring for patients on the end of life care pathway through the specialist palliative care team based at the hospice. There were also end of life care folders on wards and information available on the intranet.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff knew about the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Some staff could give clear examples and had received mandatory training in relation to this.
- We identified a concern that would normally be reported under our maternity and gynaecology core service but we have reported here as our inspection did not include this core service. Staff in the bereavement office had identified that the patient's wishes were not appropriately sought in relation to the burial of foetal remains and products of conception. The trust was not following national guidelines for the handling of products of conception. Guidance on labelling, paperwork and the wishes of parents were not followed and there was a risk that hospital burials would occur when parents were expecting to arrange funerals. This had happened on at least one occasion in December 2014 and there were two further unresolved queries by parents.

## Are end of life care services caring?

Good



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

We rated 'caring' as 'good'

This demonstrated an improvement on the previous rating. In March 2014 we had rated caring as 'requires



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improvement'. At this time, we observed staff to be caring and treating patients with dignity and respect but this was not consistent. Patients did not always have the emotional support they required.

During this inspection, we found that in addition to nurses on the general inpatient wards, specialist palliative care nurses provided emotional support to patients within the hospital. Patients and relatives gave examples of compassionate nursing care. They felt involved and informed regarding their care and treatment. Patient's privacy and dignity was observed and relatives receiving distressing news were taken to quiet rooms to discuss matters privately. Relatives told us that they were offered emotional support by nursing staff following their bereavement.

The hospice day care services provided well considered emotional support for their patients and conducted patient satisfaction surveys to measure effectiveness.

The chaplaincy provided one to one spiritual guidance throughout the trust and worked closely with the bereavement officers to ensure relatives received a sensitive and individual service following the loss of a loved one.

## Compassionate care

- The hospice conducted a 'you say, we did' patient satisfaction survey. They also carried out a survey sent to carers and relatives post bereavement to gain feedback about the service their loved one received.
- We observed kind, supportive interactions between staff and patients. Relatives were treated sensitively and nurses were caring towards those who were distressed.
- The wards used the friends and family test, but this was not specifically designed for patients at the end of their life. The friends and family test survey did not accurately portray patient satisfaction for end of life care provision.

## Understanding and involvement of patients and those close to them

- We spoke to patients who were receiving end of life care and their relatives. One relative told us "the care here is excellent; it is good old fashioned nursing care". A patient told us, "you cannot fault the care here, the nurses are wonderful". Overall, patients we spoke to were very happy with the care provided at the hospital

and felt involved in the decision making relating to their treatment. They told us that nurses had given them time to talk over any concerns, which made them feel informed and supported.

- Relatives told us that they felt included in all decisions relating to their loved ones care plan and even though some discussions were difficult and sometimes distressing, they were informed and updated at every opportunity.

## Emotional support

- The palliative care specialist nurses provided emotional and practical support for all patients at the end of their life, not only in the hospice environment but also on hospital wards. One senior nurse told us that at day care sessions within the hospice, if a patient had died, she would gather the group around first thing in the morning to let them know and give patients an opportunity to talk about how they felt.
- Patients at the hospice were given the opportunity to produce memory boxes to leave for their relatives when they died.
- Counselling services could be provided within the hospice for patients who were at the end of their life.
- One to one spiritual guidance was offered by the chaplaincy service. The chaplaincy worked closely with bereavement officers to ensure that bereaved relatives received a sensitive service both on the telephone and in person.

## Are end of life care services responsive?

Requires improvement



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

We rated responsive as 'requires improvement'.

This was similar to the previous rating. In March 2014 we had rated responsive as 'requires improvement'. At this time, not all patients were referred appropriately to the specialist palliative care team. Patient had been moved several times during their inpatient stay and patients preferred place of death was not monitored.

During this inspection, staff told us that the hospital did not have a central register to identify a patient who was on an

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existing end of life care pathway and this could delay their care and treatment. However, a new electronic record, the Buckinghamshire Care Co-ordination Record was being implemented to ensure that patients who were receiving end of life care were identified more easily.

A patient who spoke Polish was in pain and nearing the end of their life was not given access to an interpreter. There was inconsistent use of interpreter services throughout the hospital. There was no information readily available for patients for whom English was not their first language.

The trust was improving its complaints recording process as it currently could not identify any complaints specific to end of life care.

Access to the specialist palliative care service was good, and within 24 hours, when a referral was made although patients were not always identified in a timely way. Patients at the end of their life were still being moved several times around the hospital despite trust guidelines recommending that patients on the end of life care pathway should not be moved. The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.

The chaplaincy service provided good support to patients, carers and staff and was available 24 hours a day. The bereavement officers worked closely with the chaplaincy and provided a good service for relatives who had suffered a bereavement.

## Service planning and delivery to meet the needs of local people

- The trust did not have a system to ensure patients already on the end of life care pathway were identified when they were admitted to hospital. However, the Buckinghamshire Care Co-Ordination Record (BCCR) was being implemented. This was an electronic information sharing record that will enable hospital and community staff to identify and share consented information with each other and other providers. This should ensure patients on the end of life care pathway will be easily identified upon admission and their care managed appropriately, reducing the risk that they would not receive the level of care and treatment they

required. Wards had access to the Patient Management System (PMS, an IT system) in which patients on the end of life pathway could be identified, but this was sporadic.

- Patients at the end of their life were cared for on the wards. When available, side rooms were allocated to protect privacy and dignity. In the Florence Nightingale Hospice, inpatients were cared for in small ward areas. Throughout the trust, rooms were available for relatives to discuss difficult or distressing news in private.
- The hospice facilities and premises were appropriate for the services provided. The day services for patients were particularly well delivered and provided activities and support for patients for up to 12 weeks.
- There was a single point of access for patients to be referred to the palliative care team. For a referral to be made it was essential that patients were identified and the referral made in a timely manner to ensure that the support could be provided.

## Meeting people's individual needs

- Although some staff mentioned an interpreting service, most staff told us that patients for whom English was not their first language were often accompanied by relatives or friends who interpreted for them.
- A patient receiving end of life care on one ward spoke Polish as a first language and no English. It was recorded in the patients' notes that throughout the previous day and night the patient had been visibly distressed. At no time had an interpreter been sought to speak with the patient to offer reassurance and obtain further information about what was causing the distress. The ward waited for a relative to visit over 24 hours later to assist with interpreting. This individuals needs were not met in a timely way.
- The chaplaincy service provided 24 hour support for patients of all faiths, and patients who did not belong to a particular denomination but required spiritual guidance. While the permanent chaplains were of the Christian faiths, they had access to religious leaders from other world faiths as and when they were requested. The chapel and the multi faith room were well presented and open to patients, staff and relatives.
- The bereavement service had employed three new members of staff. This had made the workload more

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manageable for existing staff. The bereavement officers responded to the needs of the local community in dealing with the death of a relative and worked in partnership with the chaplaincy team.

## Access and flow

- The specialist palliative care nurses were fairly visible on the wards. Some wards knew how to contact the specialists for support but did not know the name of their palliative care nurse. Other wards report seeing their specialist nurse almost daily. Once referred all wards reported waiting no more than 24 hours to see the specialist nurse.
- Of three patients that we tracked, we observed that one patient who was at the end of their life had been moved several times around the hospital. In the patients' notes and after tracking was complete, it was confirmed the patient had been moved four times in a period of only a few days, contrary to NICE guidelines in relation to end of life care provision.
- Discharges back into the community for patients receiving end of life care were often delayed due to the lack of nursing home beds and delays in setting up packages of care with other providers.
- The trust was still not monitoring patients preferred place of death although rapid discharge was being supported by the specialist palliative care team.

## Learning from complaints and concerns

- The trust management told us there was not a specific category for end of life care on the electronic system in relation to complaints recording. Trust data on complaints, did not specifically indicate end of life care complaints and no complaints were identified overall. This had now been rectified and the trust has introduced a category for end of life care. There were no examples yet of learning that had taken place as a result of complaints specific to end of life care.

## Are end of life care services well-led?

Requires improvement



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

We rated well-led as 'requires improvement'

This was similar to the previous rating. In March 2014 we had rated well led as 'requires improvement'. At this time, the service strategy was out of date and the trust leadership and monitoring of the service standards needed to improve. The specialist palliative care team was well led.

During this inspection, there was a leadership team for end of life care with the director of nursing holding responsibility at trust board level. A new trust strategy was being developed but communication around this needed to improve. The leadership of the mortuary service was not a visible presence and staff often felt unsupported when they were busy. Staffing in the bereavement office had improved and three additional bereavement officers had been employed to ease the workload for existing staff

A review of the service had been undertaken and some key areas of work were in progress which included the new care pathway and the treatment escalation plan. A dashboard was being used to monitor some key indicators relating to care but audit was required to monitor the quality and safety of end of life care services.

The specialist palliative care team was well led and staff were passionate about improving the quality of services. Staff in the trust expressed a desire to ensure that patients at the end of their life were provided with the best possible care. This was confirmed by the patients and relatives that we spoke with.

The trust had held engagement meetings with staff and patients to establish how best to move the end of life care service forward.

## Vision and strategy for this service

- The trust wide strategy for end of life care was about to expire and a new strategy was in development in

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accordance with new national guidance published in 2014 following the withdrawal of the Liverpool Care Pathway. It was due to be published in October 2015. Patients had been invited to become involved in the review and 11 people had volunteered and the Patient (user) Reference Panel had been formed.

- There was a clear vision to provide individualised patient care, encouraging people to 'live well until we die.' A strap line had been adopted by the EOLC team 'End of life care is everyone's business.'
- The specific aims of the Palliative Care Service were that patients could be seen at any point in their illness (malignant and non-malignant) as an inpatient or an outpatient within the acute, community or hospice setting. To provide access to specialist nursing and medical advice for symptom management; psychological support for patients and relatives/carers; staff support; complex discharge planning (hospital team); information; advance care planning and high quality end of life care in any location through guiding principles for good end of life care.
- Staff across the inpatient wards were not familiar with any vision or strategy for end of life care, but most were aware that there was a strategy being developed.

## Governance, risk management and quality measurement

- A score card was used to monitor and report on the quality of the service provided against a number of agreed performance indicators. The score for April 2014 to February 2015 was green (good) across the board for indicators relating to care. These were also discussed at the service delivery unit (SDU) (specialist palliative care) clinical governance meetings. We reviewed the minutes for the last two meetings and saw that the indicators were monitored and discussed at these meetings. Minutes from the general team meeting also showed that this information was discussed.
- An agreement using the Commissioning for Quality and Innovation Framework (CQUIN) was awaited, with an aim of securing improvements in quality of services and better outcomes for patients, while also maintaining strong financial management. This would help to frame the measurement of success.

## Leadership of service

- The responsibility for leading and developing the end of life care service for the trust appeared to be with the specialist palliative care team matron, consultant and a project lead. At board level this was the director of nursing.
- Communication between the leadership of the service and the staff on the inpatient wards was not always clear. In relation to the management of the implementation of the new syringe drivers, there were substantial inconsistencies in relation to the understanding at ward level, of when, how and what was happening despite management telling us that all the wards were aware, trained and ready for the implementation. Some senior nurses we spoke with were not aware of the changeover at all. Staff were not aware of the new strategy being developed or timelines for its publication. Some staff and patients had attended the 'One chance to get it right' meeting which looked at improving end of life care, but generally staff who did not attend the meeting were unaware of the outcome of this. The communication of these changes was not cascaded to staff as a whole.
- The matron in the specialist palliative care was described as a good leader.
- The leadership of the mortuary service was not a visible presence and staff told us that they rarely saw their senior manager and often felt unsupported when they were busy. They also had long periods of working alone, with a heavy workload. A third member of mortuary staff based at Stoke Mandeville had left the department and was never replaced.
- Most staff told us that they felt supported by their immediate line managers, but felt disconnected from the senior management team.
- Most staff felt that the board were not a visible presence within the trust. Most nurses could not name the chief nurse.

## Culture within the service

- Staff within the specialist palliative care service were passionate about end of life care and they worked effectively with ward staff and multi-disciplinary teams.
- Hospital staff described good, supportive working relationships with the specialist palliative care team
- Staff throughout the trust expressed a desire to ensure that patients at the end of their life were provided with the best possible care. This was confirmed by the patients and relatives that we spoke with.

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- Some staff reported that they had been told not to speak to the inspection team regarding any concerns they had about the end of life care service. This brought into question the openness and transparency of the trust.

## Public and staff engagement

- Staff and patients had been heavily involved in looking at improving the end of life care service. Meetings had been held to encourage both groups to contribute to ideas for service development.
- A working group, that involved patients and the public, had been initiated as a response to these meetings.

## Innovation, improvement and sustainability

- The end of life care project lead had been employed by the trust to review the end of life care service. They had given a presentation to the trusts assistant chief nurse in January 2015. This outlined the progress of the project and the approach that had been taken in creating the tools to support the service. Areas of improvement which had been identified included identification of people at the end of life, effective person centred care

planning which encompassed a holistic assessment of need, high quality, evidence based care and symptom control management 24/7 and public and clinical engagement in developing end of life care at the trust.

- The specialist palliative care consultant had been the lead in developing a new do not attempt resuscitation/ treatment escalation plan which was due to be piloted. A new end of life care plan had been developed with input from service users and was about to be trialled on some wards.
- There had been improvement in relation to staffing in the bereavement office. Three additional bereavement officers had been employed to ease the workload for existing staff
- As part of the project there had been recognition of the need for the trust to conduct a yearly end of life care audit which would need to include the views of carers post bereavement. This was to be developed.
- The specialist lymphedema nurses at the hospice recently received a second place award for oedema management. This accolade was given by the Journal of Wound Care.

# Outstanding practice and areas for improvement

## Outstanding practice

- The rapid early assessment care team (REACT) provided nursing and therapy support to facilitate the early discharge of frail and elderly patients admitted to hospital. Patient pathways were to community hospital or to the patient's own home and equipment could be delivered on the same day to support patients at home. The team saw 3 – 4 patients a day and 70% were discharged within 24 hours.
- There was a new psychiatric in-reach liaison services (PIRLS) that had been developed with the local mental health trust. This joint working had improved the support of people in the Emergency Department who had a mental health condition.
- The specialist lymphoedema nurses at the hospice recently received a second place award for oedema management. This accolade was given by the Journal of Wound Care.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

The hospital MUST ensure

- Patient risk assessments and the documentation that supports them are routinely completed in the Emergency Department.
- There is effective clinical engagement for a hospital wide focus to patient flow and escalation processes and this is monitored.
- There are timely GP discharge summaries following a patient admission to the Emergency Department.
- There is a timely replacement for the Liverpool Care Pathway and all staff follow the current interim policies.
- Staff complete the end of life care plans (Hearts and Minds – end of natural life) appropriately to NICE guidelines for holistic care and they are followed.
- All staff consistently and appropriately complete the DNACPR forms and discussions between patients and relatives are recorded in patient records.
- The overhead lighting lamps in the hospice are replaced to reduce the risk to patients of contact with hot surfaces.
- Staffing levels in the mortuary are reviewed give staff adequate rest time between shifts and to reduce the levels of lone working.
- Mortuary staff have appropriate equipment for bariatric (obese) patients to reduce the risk of harm to staff from inappropriate manual handling.

- Deceased patients are clearly and appropriately identified when being transferred from wards to the mortuary.
- All staff involved in end of life care can identify a patient at the end of life (12 months) to ensure that referrals to the specialist palliative care team are made in a timely manner.

### Action the hospital SHOULD take to improve

#### Action the hospital SHOULD take to improve

- The hospital SHOULD ensure Recruitment of medical and nursing staff continues to improve models of care, decrease the current workloads of staff in acute and emergency medicine and ensure appropriate medical staffing at night.
- Infection prevention and control practices are consistently followed in the Emergency Department.
- Risk registers are maintained and kept up to date in the Emergency Department and records for incidents, once reported, are completed in a timely way.
- Infection control risks, in relation to storing patients' belongings in the bereavement office, are addressed.
- The provision of interpreter services enable patients who do not speak English as their first language to receive the same level of care as other patients at the end of their life
- Transfer arrangement between Wycombe Hospital and Stoke Mandeville Hospital are clarified for staff and patients.
- Communication from senior management teams to all staff providing end of life care improves.

## Outstanding practice and areas for improvement

- Patients who received end of life care are not moved unnecessarily between wards.



## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p> <p>The trust did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients.</p> <ul style="list-style-type: none"><li>· Mortuary staffing.</li></ul> <p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p><b>Records</b></p> <p><b>How the regulation was not being met:</b></p> <p>Patient records were not always accurate maintained.</p> <ul style="list-style-type: none"><li>· Documentation in the Emergency Department.</li><li>· Documentation for end of life care</li><li>· Documentation for DNA CPR</li><li>· Identification of deceased patients from ward to mortuary</li></ul> <p>Regulation 20(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

## Requirement notices

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

**How the regulation was not being met:**

The trust did not have suitable arrangements to protect patients and others who were at risk from the use of unsafe equipment.

- Mortuary equipment for bariatric patients
- Overhead lighting lamps in Florence Nightingale Hospice

Regulation 16(1)(a)(2) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

**How the regulation was not being met:**

The trust did not have an effective operation of systems to enable it to identify, assess, and manage risks relating to incidents and near misses relating to the health and welfare of patients and others.

- Clinical engagement to improve the hospital wide focus to patient flow and escalation processes and this is monitored.

This section is primarily information for the provider

## Requirement notices

Regulation 10(1)(b) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

#### **How the regulation was not being met:**

The trust did not take proper steps to ensure that each patient was protected against the risks of inappropriate and unsafe care.

- Risk assessment in the Emergency Department (ED)
- GP summaries from the ED
- Care planning for end of life care
- Referrals to specialist palliative care team.

Regulation 9 (1)(a) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.