Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at John Radcliffe Hospital

Inspected but not rated

The new adult critical care unit was praised by staff and met national standards. The unit was clean and the service-controlled infection risk well. Provision to support increased infection control measures if needed were in place.

Medicines were well managed. Staff assessed risks to patients and kept good care records.

The service managed safety incidents well and learned lessons from them. Incident reporting data demonstrated there was an open reporting culture and that incidents were reviewed, and action taken to drive improvement.

The service took a flexible approach to managing staffing to ensure they had had enough staff to care for patients. The service had taken steps to develop their own staff and aid them in improving the skill mix of their own staff.

Staff received annual appraisals and nursing staff were up to date with their mandatory training requirements.

There was a vision for the development of the service and business plans were under development to support the vision. Staffing and skill mix was a recognised challenge for the service.

Staff felt respected, supported and valued by local leaders.

However;

The service did not always have the right staff skill mix and was unable to meet the recommended national guidelines on nursing skill mix in intensive care units.

Staff fatigue was high, and morale was low. Relationships between unit, directorate and divisional managers, staff turnover and the pace of change at the unit all impacted on the working environment.

Medical staff had not completed mandatory training to a level required by the trust.

The processes for identifying and escalating risk appeared to be inconsistently used which created a disconnect between the unit and senior leaders. Leaders of various seniority were unaware of local risks or were interpreting risk differently to those on the unit floor.

Audits were not always being completed and therefore, this information was not being used to measure the quality and safety of the unit.

Critical care

Inspected but not rated

The adult critical care unit moved into new fully refurbished premises on 31 March 2021. The new unit covered three floors and was comprised of 48 beds. At the time of inspection, the service was funded for 24 beds, however only 22 were open over two floors. Of the 22 beds, 16 were dedicated for patients requiring level three care and the remaining six beds were allocated for patients requiring level two care. Level three patients are those requiring advanced respiratory support alone or monitoring and support for two or more organ systems. Level two patients are those requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.

The Care Quality Commission (CQC) received concerns from staff about the adult critical care unit based at John Radcliffe Hospital, part of Oxford University Hospitals NHS Foundation Trust. We received four reports from different staff members who told us they had concerns regarding admissions, staffing numbers and competencies, increasing clinical incidents, clinical governance and the culture of the unit. We shared this information with the senior management team at the Trust and due to the nature of the concerns, we undertook a focused inspection of the unit where the concerns were raised.

This was an unannounced focused inspection of the adult critical care unit at John Radcliffe Hospital. We inspected on-site on 9 November 2022 and conducted interviews via teleconference on 10 and 11 November 2022 and reviewed five patient records.

We spoke with; four consultants, 14 nurses and four nurses from the new cohort. We also spoke with the unit matron and deputy matrons, divisional leads, clinical governance leads, the education support officer, deputy chief nursing officer, the head of wellbeing, Freedom To Speak Up Guardian and members of the executive management team.

Is the service safe?

Inspected but not rated

This was a focussed inspection, solely reviewing the Safe and Well-Led key lines of enquiry at the adult critical care unit at John Radcliffe Hospital. As we did not inspect the other key lines of enquiry, or other critical care units at the hospital, we are not rating this service.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Nursing and non-medical staff had completed 96% of their mandatory training. Nursing and non-medical staff received an appraisal. At the time of the inspection, 98% of nursing and non-medical staff had received an appraisal within the last 12 months, including a values-based appraisal that looked at how staff worked within the Trust's values.

Critical care

Medical staff received an appraisal. At the time of inspection, 100% of medical staff had received an appraisal within the last 12 months. There was a specialist document for medical staff to record their appraisals, including; scope of work, changes since last appraisal and personal development plans. Only 78% of doctors in adult critical care unit had completed their mandatory training, the trust completion target was 85%, therefore the unit was not meeting this target.

When staff began working on the unit, they worked supernumerary for six weeks, they were then allocated a buddy for six weeks and completed a 12-month foundation programme which included 6 study days across the 12-months that was managed by the education team. The education team also organised daily learning and simulation training in the afternoon.

The Trust developed a 'Bridging' programme, to help integrate staff not from the UK into the unit and the NHS. The programme included practical information regarding living in the UK, to cultural differences for example equality and diversity. Staff were able to loan a laptop to help them complete on-line elements of their training.

The Trust had a preceptorship programme in place for newly qualified nurses, nurse associates, midwives and allied health professionals.

Preceptees are supported by preceptors in practice. The Nursing and Midwifery Council (NMC) standards state that "there is a sufficient preceptor capacity to support all of those who require preceptorship". The Trust response stated, there were "No reports of any clinical areas with more preceptees than preceptors". Although there were not more preceptees than preceptors, the Trust response did not reflect the feelings of staff on the unit. Rosters demonstrated that whilst not every shift had a preceptee, unit staff were regularly required to support new starters, which over time was described as "draining" and staff advised us they did not have the resilience to support new starters.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas of the ward across all three levels were visibly clean. The unit had a dedicated housekeeping team to oversee all cleaning on the department. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw housekeeping records for the day of inspection and saw they were fully competed including sign off, date and were checked by a senior member of the team.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff used personal protective equipment appropriately. The new unit had dedicated donning and doffing rooms at the entrance that could be reinstated in the event of any future infection outbreaks.

We observed excellent hand hygiene and environment decontamination processes that adhered to the National Standards of healthcare cleanliness 2021 and Department of Health, Health Building Note 00-09 requirements. Hand Hygiene Audit results, between May and October 2022, showed the audit was not completed in May and September, however the other months ranged from 92-100% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaned and labelled equipment after each use, staff also checked that equipment was clean before usage.

Critical care

Environment and equipment

The facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment followed national guidance. The new unit was opened in 2021 and covered three floors. Each floor had a multidisciplinary meeting room, separate donning and doffing rooms that were accessed via a one-way system in and out of the ward. There were separate fluid preparation rooms, medicines storage with CCTV and a sluice on each floor, all were securely locked. Access to the unit was via staff security card.

Each floor had four positive pressure isolation rooms with electronic skylights that reflected the time of day. These rooms had a positive pressure 'ante' room where staff could enter without disrupting the air flow in the patient cubicle. In a positive air pressure isolation room, the air pressure is higher than that in the adjoining areas. Therefore, positive pressure isolation prevents airborne pathogens from entering the room to avoid the air becoming contaminated. The positive pressure isolation rooms were not in use at the time of inspection. Single patient rooms were available on the unit and used if a patient required isolation. The hospital's managerial team, including the head nurse for workforce, divisional nursing director and matron completed a formal review of the layout of the positive pressure isolation rooms and advised the team that due to the poor visibility, there was no line of sight between the rooms, they would need an additional band seven nurse to oversee these cubicles.

All bed spaces had the same set up using colour coded space dividers. Therefore, regardless of what floor staff worked on, they knew where each item of equipment was stored. A dedicated stores team topped up consumables and ensured equipment was serviced and ready to use. The team was introduced after an ergonomic review found that staff took an extra 30 mins each time they prepared medication or sourced equipment, including walking to and from the stores.

Staff carried out daily safety checks of specialist equipment. It was the responsibility of the 'floating' nurse to complete daily checks of the emergency trolleys. All emergency trolley equipment was logged using a QR code that detailed the trolley security tag number, equipment expiration dates and a photograph of each item. Staff checked the log via an app to ensure all trolley equipment was ready for use. This system was introduced after staff found items were missing from the trolleys. The trolleys were not audited; however, the deputy matrons fully checked each trolley every time they were used. On the day of inspection, we found all trolleys were securely locked and had been checked.

Communication about procuring suitable equipment was not effective. The Trust provided us with evidence of trust-wide consultation in the procurement of beds that included risk assessments. However, staff on the adult critical care unit advised us they had not been consulted or engaged in this process. The initial bed chosen did not meet the needs of the unit and was found to be incompatible with the critical care equipment used and some of the procedures, for example access to intubate a patient. This was recorded on the directorate risk register with an initial score of red based on a red-amber-yellow-green rating, with red being the highest risk. Senior managers had since responded to staff concerns and the beds had been changed to meet the requirements of the unit.

The service had suitable facilities to meet the needs of patients' families. Families had access to their own waiting room, located at the entrance to the unit as well as a kitchen area with hot and cold drink facilities.

Staff disposed of clinical waste safely. Clinical waste was segregated and disposed of safely in line with national guidance.

Assessing and responding to patient risk

Critical care

Staff completed and updated risk assessments for each patient and generally took steps to remove or minimise risks. Staff identified patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used National Early Warning Scores (NEWS) to monitor patient risk of deterioration. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients.

Staff knew about and dealt with any specific risk issues. We viewed five patient records and saw they included completed and up to date assessments for sepsis, venous thromboembolism (VTE) and falls. VTE is a condition that occurs when a blood clot forms in a vein. VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE).

At the time of inspection, the unit did not have a tissue viability nurse, the hospital tissue viability team were supporting the unit until the post was filled. The critical care clinical governance team completed a deep dive into tissue viability in October 2022. Their findings were that staff were miscategorising pressure ulcers, there were lapses in wound care treatment and pressure care preventative measures were not always implemented. In response to this the team were creating a mandatory training e-learning package specific to tissue viability and wound care, this would be reviewed weekly to monitor improvement. Since then, audit results demonstrated 98% compliance and pressure ulcer prevalence was 11%, which was better than the national average.

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with some of the specific risk issues. Staff completed patient risk assessments using nationally recognised tools, such as falls and pressure damage. However, staff did not always use these consistently to inform individualised care. Task orientated care was not related to individual personalised care. For example; patients were routinely repositioned every 4 hours, this was not based on individual need or risk. We were advised by unit managers that due to time constraints they had introduced a daily task timetable that included timed patient 'Turns'. Therefore, whilst risk of pressure ulcers had been reduced, staff were not providing personalised care.

The Admission and Discharge Policy Statement 1 stated "All patients admitted to the Adult ICU and the Churchill ICU must be admitted under the name of the designated (admitting) consultant of the parent speciality service. Following admission to AICU or CICU, responsibility for the patient is shared between the duty ICU consultant and the admitting consultant of the parent unit. No patient may be admitted to AICU or CICU without referral to and acceptance by the duty ICU consultant". Staff told of us of occasions when this process had not been followed. They told us of one recent example where this process was not followed and disagreements between managers about the care of patients had contributed to a lack of trust within the managerial teams. The policy did not include information or pathways for prioritising of admissions to adult intensive care when there were conflicting prioritises and pressures to ITU admission and patients 'competing' for access to the same bed. We were advised the deputy matrons were in the process of completing a prioritisation flowchart at the time of inspection.

Staff shared key information to keep patients safe when handing over their care to others. Staff regularly checked patients for potential deterioration. Staff on the unit met throughout the day to ensure joint working and understanding of patient requirements including risks. The unit had two ward rounds a day, one in the morning (9am-midday) and the second at 4pm. Staff completed Situation Reports (SITREP's) twice a day, one at 8am and the second at 8pm. A SITREP is a form of status reporting that provides decision-makers and readers a quick understanding of the current situation. Staff completed handovers at the patient bedside in order to ensure all equipment, medications and patient observations were included as part of the handover. Staff also attended harm free meetings and situational awareness meetings (SAM).

The SAM's were used to highlight patient safety concerns for that shift and included any tasks expected that day for example checking therapeutic drug blood levels. Weekly Safety reminders were circulated to staff reminding them of key learning from incidents. For example, information about time critical medications to help reduce the risk of delays in administration.

Nurse staffing

The service had enough staff on duty but they did not always have the right mix of qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, however a significant number of staff on each shift were bank or agency staff.

Staff told us that they should be staffing the unit according to the Guidelines for the Provision of Intensive Care Services (GPICS) (2021). This was corroborated by the Operating Model for Oxford Critical Care dated March 2022. The GPICS guidelines state that a minimum of 50% of registered nursing staff must be in possession of a post registration academic programme in Critical Care Nursing. At the time of the inspection, 30% of all staff had this qualification, therefore the unit was not meeting this standard. On the day of inspection, 25% of staff on duty had the qualification, however, we were advised this could be as low as 18% dependent on who was on shift.

One of the concerns raised to the Care Quality Commission was staffing skill mix. These concerns had been raised to the education team and formed part of the education plan we saw.

Staff also provided us with examples of where patients had waited 48 hours for specific treatment due to a lack of competency and experience on the unit. For example, a patient that was in deep sedation required the sedation lessening in order that further tests could be completed. Tests were delayed by 48 hours until staff attended the unit who had the competencies to do this. Investigation into the incident showed the delay did not impact the patient's outcome. However, was an example of how staff skill mix was impacting delivery of care.

The critical care governance leads had completed a staff skill mix risk assessment that gave specific examples of where standards were not being met. This was discussed with the Clinical Governance Risk Practitioner and the Divisional Team.

Staff advised us that the unit was funded for 24 beds, an increase from 16 beds in the previous unit. However, due to the current staffing levels and skill mix, the Trust had reduced this to 22 open beds to support safer staffing. In addition, only two of the three floors had been opened to reduce the number of areas that senior and experienced staff needed to cover.

Unit managers told us of their concerns about staffing and skill mix. These concerns had been shared with directorate and divisional leads via multiple emails which we saw. Staffing and skill mix were both recorded on the directorate level risk register. Staffing numbers were assigned an amber level of risk and nursing skill mix was assigned a red level of risk on a red, amber, yellow, green risk rating system.

The ward manager could adjust staffing levels daily according to the needs and acuity of the patients by using bank or agency staff or moving staff between the critical care units. However, the service had high rates of bank and agency nurses.

Critical care

Rosters were initially developed based on calculations and predictions of the number of patients and how unwell they were. On a shift-by-shift basis, these numbers were adjusted to account for the actual numbers and the acuity of patients. The service was in the process of piloting the trust-wide safer staffing tool. This had involved developing a bespoke acuity tool to be incorporated into the tool as it did not have a critical care element before. It was hoped the safer staffing tool would improve reporting and monitoring of rotas.

The adult critical care unit at the John Radcliffe Hospital and the adult critical care unit at the Churchill Hospital shared their nursing establishment. Staff had to contact a central number each day to find out which unit they would be working on that shift. The remaining critical care units, including paediatrics, would work flexibly to provide additional support and cover as needed. This would be decided on a shift by shift basis depending upon the acuity of the patients and staff sickness.

We viewed the unit staff roster and saw 34 out of 87 day and night shifts between 15 August 2022 and 9 November 2022 had over 50 hours of gaps in employee numbers per shift. This was covered by agency and bank staff. GPICSs (2021) states units must not utilise more than 20% of registered staff from bank/ agency on any one shift when they are not their own staff. On the staff roster we saw at night 30 to 40% of staff were agency or bank staff, on average 12% of day staff were bank or agency.

The service had high vacancy rates and turnover rates. At the time of inspection, the unit had a high level of staff vacancies, there were 27 band six vacancies and 12 band seven vacancies. Managers described numerous recruitment initiatives that had been implemented to reduce the vacancy rate, however we were told these had not been effective. On the day of inspection, we were informed that three band six staff and one band seven staff had handed in their notice, these were in addition to the reported vacancy numbers.

On the day of the inspection, study days were being supported for eight band fives to attend the in-house post-graduate intensive care course which is essential for them to become band six qualified in speciality (QIS). We were told that managers were assessing how to fast track band five nurses to band six and if they could make any adjustments to the skill mix profile of the unit. For example, they spoke about increasing the number of band seven staff and reducing the number of band six, as band six roles were more difficult to recruit to. The Trust provided evidence that the increased budget for 12 band seven vacancies was planned in the summer 2022 financial summary. Plans included retention initiatives such as the development of ACP roles.

In order to remedy issues with nursing staff shortages, there was an ongoing international recruitment campaign, which had resulted in the recruitment of 48 nurses from overseas. The critical care team were working with the central overseas recruitment team to ensure internationally recruited staff had critical care experience and a structured support package and development plan. There was a phased approach for internationally recruited nurses joining the unit.

At the time of the inspection, the divisional local recruitment plan had not been updated since 11 May 2022. The plan had outstanding actions for example a recruitment event had been planned for May 2022, however there was no outcomes of the success of the event or follow up actions recorded in the plan.

Exit interviews were provided to those who wanted to take part. We viewed the interviews from the 12 months prior to inspection, there were no obvious themes. ‘Stay’ interviews focus on those staff who currently worked in the unit and why they chose to stay working there. The matron was creating an action plan in response to stay interviews, this was in progress at the time of inspection.

Critical care

There was no critical care outreach team (CCOT). This team offer intensive care skills to patients with, or at risk of, critical illness receiving care in locations outside the intensive care unit – for example, on ordinary wards. The National Institute for Health and Care Excellence (NICE) Chapter 27 guidelines states the benefits of a CCOT are they "Help to prevent admission to ICU or ensure that admission to a critical care bed happens in a timely manner to ensure best outcome". However, the Trust has since provided evidence that it is reviewing how to develop this service.

The risk registers included a plan to meet National Institute For Health and Care Excellence guidelines regarding intensive care access to speech and language therapists (SALT). At the time of inspection there was no SALT that worked on the unit. The unit relied on the Trust SALT team; however, they did not have critical care specialism and were currently recruiting as the team was under resourced. Suggested staffing ratio of 0.1 SALT/ bed, available five days a week. The matron was reviewing the financing of this as at the time of inspection there were no budgeted funds for SALT.

Medical staffing

The service always had a consultant on call during evenings and weekends. Two consultants covered the on-site critical care department 24 hours a day, seven days a week. The on-site department included; the adult critical care unit, cardiac unit and paediatrics. The department also had one 'out and about' consultant Monday to Friday between 7.30am and 6pm. They covered trauma, resus and referrals and were introduced two weeks prior to inspection to provide support in order that the other consultants could focus on ward rounds and handovers. This met Guidelines for the Provision of Intensive Care safe staffing standards.

We saw the most recent version of the unit risk register. Regarding staffing concerns, the unit planned to increase consultant numbers by two whole time equivalent over the next two years.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff used an electronic system for reviewing and recording patient care plans and information. This information was securely stored on electronic tablets and PC and were password protected. We viewed five patient records and saw they were clearly documented including next steps and were signed and dated. Where appropriate, records clearly indicated do not attempt cardiopulmonary resuscitation (DNACPR) status.

When patients transferred to a new team, there were no delays in staff accessing their records. All electronically stored information was securely backed-up and was able to be transferred onto paper, either for discharge to another ward, home or for the information to be sent to the patient's GP.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The pharmacist supported the team and attended the unit every other day. Their role was to order medicines, audit and review medicine related incidents. The pharmacist trained staff to dispose of medicines safely and in line with legislation. Staff we spoke with understood this process and demonstrated an organised system. The unit was trying to recruit a pharmacy assistant to help with checking medications on the days the pharmacist did not attend.

Critical care

We checked 40 medicines across the three floors. On the fluid room on level 2, we found a box of 50% glucose with an expiration date of October 2022, all 39 other items checked were in date. The pharmacist was on site and removed the item immediately.

Medicines were stored in a securely locked, CCTV monitored storage room. Staff monitored the ambient temperatures of the room and refrigerators; these were recorded, and staff understood their roles and responsibilities in reporting when temperatures fell out of range.

Staff learned from incidents to improve practice. The controlled drugs cupboard had been rearranged and labelled after an incident involving controlled drugs. One cupboard was marked 'S' for sedation medication, the other cupboard was labelled 'K' and included potassium, epidurals etc. The deputy matrons audited controlled drugs daily following an increase in log book discrepancies. For example, drugs were ordered but not recorded, discrepancies in the format of the logbook, incorrect concentrations and incorrect requisition numbers.

Divisional managers were upgrading patient medicine records. A new electronic system was in the process of being piloted at the time of inspection, it scanned a barcode on medicines to ensure it correlated with the prescription.

The deputy matrons advised us staff were forgetting to send patients home with their own medicines including controlled drugs. In response to this, the discharge form now included a reminder to staff to check all medications before discharge.

Staff separately stored and highlighted medicines that were similarly named or had similar doses to reduce risk of a medicine errors. This was in response to an increase in medicine related errors where similar sounding medicines had been used in error. Matrons organised medicine situational training to demonstrate to staff the impact of not checking stock and not having drugs available. Where incidents identified a theme regarding a specific medication, matrons reviewed competencies and reminded staff at safety huddles about where to find safety information on prescribing and how to administer a specific medication.

At the time of inspection, the unit was developing a new electronic system where staff could enter the name of a medicine and the system would advise whether it was a stock item and where to find it. The system would also record current stock levels and if items were nearly out of stock and how to order. The system was in the final stages of being developed and was hoped to be operational before the end of November 2022. The deputy matrons were also working on a quality improvement project to improve the bed spaces and make them easier to use when drawing up medicines. This included labelling drawers and organising work surfaces.

Incidents

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff had good understanding of duty of candour, apologised and gave patients honest information. Staff did not always raise concerns and report incidents and near misses in line with trust policy. Managers were slow to implement change to cultural understanding of incident reporting.

Staff knew how to report incidents. Staff on the unit demonstrated using the online incident reporting system as well as where they received updates after an investigation.

Critical care

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. All staff we spoke with understood their responsibilities regarding the duty of candour and incident reports clearly identified where duty of candour was applied.

Staff met to discuss feedback and look at improvements to patient care. Any incident rated as moderate or above was reviewed daily by the executive team. Learning from incidents was discussed with unit staff at safety huddles, team meetings and via email.

Staff did not always raise concerns and report incidents and near misses in line with Trust policy. Staff advised us they did not have the time to report all incidents and near misses due to the unit being busy. We viewed five incident reports from the 12 months prior to inspection. All five incidents were reported retrospectively, four were medicine overdoses, and one was a chest drain that was not flushed. In response to the increase in medicine related incidents, unit managers had developed a medicines safety working group whose purpose was to closely analyse medicine related incidents, provide safety alerts and reminders and support staff with learning.

Staff advised us they reported what they considered the most important incidents. This was because they did not have the time to report all incidents. However, data did not indicate a reduction in the reporting of incidents. The unit saw a trend of increasing incidents graded as near miss since January 2022. We saw a review of all incidents graded no harm, minor harm or near miss, since January 2022 to assess whether the incident had been reported and graded correctly. The reasoning for the review was to ensure that potential or actual harm was not being under-reported. The report found; 361 No Harm incidents, 267 Minor Harm incidents, 115 Near Miss incidents and confirmed the incidents were reported correctly.

Emerging themes included medicine and tissue viability related incidents. The unit had also seen an increase in the number falls incidents between 2021 and 2022. However, the figures were still in line with national averages.

We saw examples of incidents and near misses that impacted patient care. For example, a staff member did not add water to a chest drain, this creates a seal and helps to prevent the backflow of air or fluid into the pleural cavity. The investigation reported that “This error could be brought about by; near end of shift, staff was tired”. This reasoning was repeatedly seen on incident investigation reports. The clinical governance leads had completed a staff fatigue risk assessment to support concerns regarding the expansion of the unit. Staff fatigue was recorded as an amber level risk on the Red, Amber, Green rated directorate risk register. We were not provided any further information regarding mitigations or improvement plans as a result of the assessment.

There was evidence that changes had been made as a result of an incident. We saw local learning from incidents including ‘Safety Reminder’ updates to highlight where errors were likely to occur. For example; labelling syringes in order to check doses, complete a visual bed space to include the handover of equipment in order to check pumps and ventilators were correctly connected and operating.

The clinical governance team had raised their concerns with the division around the increase in medication errors and pressure area and wound care. The division acknowledged the increase in medicine error incidents and was in the process of creating an executive summary. We saw the draft copy of this document and it included; trend and thematic analysis, updates regarding the medicine's safety groups and human factors analysis. One of the findings of the review showed an increase in these types of incidents when new staff started to work independently on the unit. These concerns had been included in the education plan for the unit.

Critical care

The education plan focused on the education staff working more closely with clinical nurses to supervise and teach at the bedside. This was structured to include learning from incidents. The education team now met once a week with the clinical governance team to highlight clinical incidents and safety concerns so that the education team could incorporate this learning into practice when they worked alongside clinical staff. Learning from incidents had identified that staff were not replenishing emergency trolleys after use or important bedside stock trolleys. The education team had incorporated this into their simulation training to emphasize the importance of having critical equipment to hand in the event of an emergency.

Six weeks prior to inspection, the unit introduced an 'I saved a medicine incident' initiative where staff scanned the medication QR code if they 'saved' an incident. This information was due to be independently reviewed by the Trust's medicines management group in order to look for themes with medicine types.

Is the service well-led?

Inspected but not rated

This was a focussed inspection, solely reviewing the Safe and Well-Led key lines of enquiry at the adult critical care cnit at John Radcliffe Hospital. As we did not inspect the other key lines of enquiry, or other critical care units at the hospital, therefore we are not rating this service.

Leadership

Local leaders understood the issues the service faced and were visible and approachable.

The adult critical care unit was part of the critical care, anaesthetics, preoperative assessment, pain management, resuscitation directorate which was part of the Clinical Support Services division. The directorate was led by a critical care clinical lead, supported by a team with leads for each area. For critical care, this included a service manager, a matron and a clinical lead. The directorate reported to the divisional leadership team which included a divisional director, a divisional medical director, divisional director of operations and a divisional director of nursing.

The local nurse leadership team was in its infancy, with a new divisional lead nurse and the adult critical care matron and their two deputy matrons had been seconded to their roles within the last two years.

All staff advised us they could speak with the matron and deputy matrons and that they practised an open-door culture.

Guidelines for the Provision of Intensive Care Services states a supernumerary clinical coordinator should be on duty 24 hours a day, seven days a week in critical care units. Units with greater than 10 beds require additional supernumerary cover over and above the clinical coordinator. Rosters showed that the unit was meeting this standard. However, staff advised that supernumerary co-ordinators often supported the unit clinically due to ward skill mix and staffing numbers.

Leaders understood the challenges to quality and sustainability, and they identified actions needed to address them. However, leaders did not communicate challenges via consistent methods. We saw ad hoc emails escalating concerns and where quality was discussed at meetings, minutes showed these were not regularly followed up.

Critical care

Vision and Strategy

The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action. The vision and strategy were aligned to local plans within the wider health economy.

The adult critical care service had moved to a new purpose-built facility in 2021. This build had been a focus for the trust and adult critical care provision. The building enabled the trust to provide a high quality, safe environment designed to current guidelines, with the additional benefit of delivering capacity for future population growth, demographic trends and increased acuity. The Trust had the facilities to be able to provide 48 level 3 critical care beds in response to any future pandemics.

The original strategic plan for the unit, developed during the refurbishment process, was to have one floor supporting patients requiring level three care, one providing level two care and the third floor providing level one care. This had been reviewed and amended with level three and two care being provided on two floors with one floor not yet in use. We were told this change had occurred to support the unit in providing safe care through safe and effective staffing.

The trust suspended local business planning at the start of the COVID-19 pandemic to support the command-and-control system as the trust was a regional surge centre for Critical Care.

The strategic direction was now focused on safe and effective staffing on the adult critical care service to enable the trust to fully open the facility. Plans had considered the 'Getting It Right First Time' (GIRFT) report for adult critical care and the desire to realise the clinical and financial benefits of enhanced patient flow. The initial focus had been a recruitment campaign to enable the trust to open beds up to 24, building on the trusts original 16 beds. At the time of our inspection the unit was funded for 24 beds, with 22 beds open.

The unit was funded for 24 beds being used over two floors. Divisional leads were in the process of creating a vision for the unit that included plans to expand adult critical care by an extra four beds every financial year until the unit reached its 48-bed capacity. The team were creating a business case that was to be reviewed by the investment committee in January 2023. The division were in the process of producing a business case to create a critical care outreach team. The Trust-wide strategy for critical care included a review of integrated care systems across Buckinghamshire, Oxfordshire and Berkshire regarding what the future of critical care will look like. The initial phased approach to increase staffing, which would take four years for the unit to reach its full potential, was under review. Skill mix was also being reviewed to consider how to address the challenge of recruiting band six nurses. This included a review of the band five to band six pathway.

Culture

At unit level staff felt respected and valued but this was not always the case with other senior managers. The staff were focused on the needs of patients receiving care and were supportive and respectful of each other. There was not always a culture where concerns were effectively communicated and escalated.

We found a workforce where staff fatigue was high, morale was low, and staff felt their concerns were not listened to by senior managers. One staff member commented that the department was "Running off fumes". In the previous 12 months, there had been seven emails from unit managers to senior managers detailing concerns regarding staffing levels, skill mix and morale. Unit staff advised understanding of these concerns and implementation of actions had been slow. For example, it was agreed the number of beds on the unit would not be expanded until staffing improved, however it had taken 12 months for the teams to reach this agreement. Unit staff created a timeline of changes within

the unit over an 18-month period prior to inspection. We reviewed the timeline and saw 32 changes within that period including; significant onboarding and resignations of staff, several equipment changes and moving to the new unit. Staff advised us they felt fatigue over the changes coming off the back of the COVID-19 pandemic and felt like the changes were "Happening to us, rather than being included as part of the process".

Some unit staff did not feel positive about working for the organisation. We found a very emotional team who advised us that the pace of change off the back of the COVID-19 pandemic had "Drained our personal resources". However, staff across the service were proud of the work they did, and unit staff praised each other's work ethic, which was demonstrated by supportive and appreciative relationships among unit staff. On the unit we found a culture where staff felt supported by their immediate seniors, including consultants who showed caring attitudes towards the physical and mental health of staff on the ward.

Staff from the new cohort advised us they were reserved about reporting incidents as they came from cultures where admitting fault and could be used for disciplinary purposes rather than learning. Senior staff and unit managers informed us they had escalated concerns regarding the cultural impact on incident reporting over the last year, however this was ad hoc via emails and was not officially recorded. Divisional leads advised us the cultural impact of incident reporting had only been identified in the two weeks prior to inspection and were developing an education plan in response. Staff from the new cohort had worked on the unit for over a year. Therefore, managers were slow to understand and implement change and provide training that gave staff in the new cohort the confidence to report incidents.

The Trust implemented activities to support new staff acclimatise to working and living in the UK. The Trust provided information regarding the cost of living, and staff received a welcome pack with a grocery bag of basics and were given comprehensive support to introduce them to the area, including; a tour of Oxford, a 'Welcome to Oxford' pack and online banking support.

The Trust induction for the new cohort included a session by the Freedom to Speak Up Guardians, who were allocated a 15–20-minute slot. They used this opportunity to introduce what Freedom to Speak Up was, and the types of concerns that could be raised as well as duty of candour and other ways of speaking up at the Trust. We spoke with two staff from the new cohort who advised they struggled to understand the required level of personal care expected on the unit. Therefore, although the Trust provided information in understanding the logistics of living and working in the UK, there were fundamental gaps in the training that meant the Trust had not provided sufficient support to the new cohort to give them the confidence to put cultural knowledge into practice.

There were networks that staff could join in order to engage with the Trust, for example; a Black, Asian and minority ethnic staff network, a lesbian, gay, bisexual and trans + (LGBT+) staff network, a disability and accessibility network, a women's network, a young apprentice's network and a forum for nurses who were not from the UK.

The Freedom to Speak Up Guardian Lead provided support including; listening events and mentorship reviews. There was a Freedom to Speak Up 'You said We Did' page on the Trust intranet and the team provided a 6 monthly report to the board. The Trust was increasing the number of champions across all sites to support the upcoming Freedom to Speak Up month and associated events. The team monitored areas of the Trust where they were receiving complaints, however there was no monitoring of potential reasons why areas that did not engage were not doing so.

Critical care

One of the concerns raised to Care Quality Commission was around poor communication. This had been raised at the multidisciplinary Quality and Safety meetings with medical staff being encouraged to ensure nurses understood tasks and requests. We attended a multi-disciplinary handover that noted all staff contributed to discussions. The team allocated nurses from the new cohort tasks post-handover and we observed staff carrying out these tasks demonstrating they had understood what had been requested.

Governance

The governance and patient safety team within the unit had reduced as staff members had left the department. Staff had regular opportunities to meet, discuss and learn from the performance of the service, however messages of concern were often informal.

The matron and divisional team met weekly. This meeting was introduced in late summer 2022 as a result of a joint project between the unit's education team and matron after a review of the unit showed there were; quality care concerns, no formal process for reporting to the division as well as to improve communication. The matron advised us they found the meetings useful, at the meeting prior to inspection the team reviewed the elective admission pathway. The unit identified a risk that the pathway was slow as admission decisions were made late in the day, as a result the team created a timeline pathway detailing expectations. However, we were advised these meetings were not minuted.

The function of the critical care clinical governance team was to review and coordinate unit quality and performance data submitted by the matron and deputy matrons to produce a monthly quality report that was presented to the divisional team. Data included; incident data and reports, complaints and completed national audits. The critical care clinical governance team advised us they were concerned about the reduced local governance team. The concerns had been escalated informally, we could not see evidence that once concerns were raised they were formally reviewed and escalated. The critical care clinical governance team was supported by a number of substantive posts who worked on the unit. In the year prior to inspection, this team had dramatically reduced with the posts not being replaced. Posts included; the resus lead, band six deputy sister on secondment, risk practitioner, a second governance and resus lead had left, although they were not officially assigned to the post, the tissue viability lead, the nursing audit lead and the directorate governance lead. We were advised by unit staff and managers that there were no current plans to replace them and staff on the unit advised us they only had the time to complete National Audits and a few select local audits due to the reduced support. Trust seniors showed us plans to recruit to these roles, however unit staff were unaware of these plans, evidencing a breakdown in communication.

Improvement committees oversaw numerous governance meetings. For example, representatives from the department attended monthly mortality review meetings. We reviewed the minutes from this meeting for August and September 2022 and saw learning, action plans and review was discussed at each session. The monthly joint critical care governance meeting was attended by all critical care departments at the Trust. The monthly multidisciplinary quality and safety meeting and the monthly divisional clinical governance executive meeting was attended by the critical care clinical governance team and divisional leaders.

The management executive team reported to the board and managed the executive committees, for example, education, performance, business planning and clinical governance. The clinical governance committee reviewed; divisional and directorate quality reports, the divisional clinical risk register, assurance reports and external updates. There were numerous clinical improvement committees including; mortality review group, clinical audit, ethics and guidelines. Patient safety and effectiveness committees included; medicines safety, infection prevention and control, harm free assurance group and harm review group.

Critical care

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. However, poor communication between teams meant they had not identified gaps in systems and processes that may impact the accuracy of performance data.

We spoke with staff about risk registers and requested to see risk registers at different reporting levels within the organisation. We viewed risk registers identified as speciality-led; directorate level; divisional level and corporate level. The risk registers all used the same scoring system based on a red-amber-yellow-green rating, with red being the highest risk and green the lowest.

Staff told us that nursing skill mix was a high risk for the unit. This was confirmed by the directorate risk register where it was scored red indicting a high risk. This was not recorded on the divisional risk register. Staff told us they escalated this with the divisional leads in their weekly meetings with senior staff in the division and directorate. These meetings were not minuted. We saw minutes of the joint critical care meetings that had recorded the impact of skill mix on band six and seven staff and on clinical incidents.

Staffing challenges across the Trust were acknowledged and captured on the corporate risk register. However, it was not clear from this level of information if there was any further break down in understanding of the risk in different areas. Greater oversight was said to be maintained at divisional and service level. At a local unit, directorate and divisional level, the risk attributed to safe staffing varied. From a review of available information, it was not clear how the different assessments had been reached or discussed. Therefore, management of staffing risks was not consistent. Recruitment was ongoing, but staff still raised concerns about skill mix as detailed in the GPICS guidelines.

Managers we spoke with were unaware of set formulaic criteria for escalation of risk. They advised us it was dependent on numerous factors such as length of time, cost, impact as well as rating. A review of meeting minutes showed risk registers were not consistently reviewed or discussed. The minutes did not evidence of how risks were escalated. Therefore, there was a lack of assurance managers followed a clear format for escalating risks and a breakdown in the system meant that a risk labelled as red, was not escalated to the next managerial level.

We viewed the quality quarterly reports for the adult critical care unit from 1 April 2021 to 30 June 2022 and found that the quality indexes reviewed within the report did not impact patient outcomes during the period of staff changes in terms of band six vacancies and the reduced skill mix. We reviewed data regarding; sepsis, unit acquired infections in blood, discharges, number of bed days, transfers, unplanned readmissions and outcomes. Metric dashboards demonstrated improved performance across critical care, with the annual report for April 2021 to March 2022 showing an amber rating for ‘high-risk admissions from the ward’ and ‘high-risk sepsis admissions from the ward’. All metrics were rated green for dashboards between April 2022 to September 2022. Therefore, the data did not reflect how staff working on the unit felt regarding the safety of the unit.

Audits were recorded centrally on an electronic application. The adult critical care unit audit schedule was a mix of clinical and service evaluations, of the 22 clinical audits, seven had been completed. One audit (airway pressure release ventilation) had a completion date of January 2021 and at the time of inspection had not yet been undertaken. Staff advised us the depleted team numbers including support staff and skill mix meant not all audits were being completed. Therefore, there was a lack of assurance that the performance of the unit was effectively monitored. The matrons and divisional leads met weekly to discuss performance; however, these were not minuted. Therefore, opportunities to highlight lack of audit were diminished.

Critical care

A review of a variety of meeting minutes showed that where auditing was discussed, actions were not always recorded, and the matter not followed up at the next meeting. For example, we saw minutes for July, August and September 2022 from; the directorate clinical governance group, the multidisciplinary quality and safety meeting and the divisional clinical governance executive meeting. Although national audit completion and performances were discussed, the lack of local audits and risks to the unit, were not regularly reviewed, discussed or followed up.

A review of a variety meeting minutes showed that where staffing was discussed, actions were not always recorded, and the matter not followed up at the next meeting. For example, we viewed minutes from the joint critical care governance meetings. They stated in July 2022 that staffing skill mix was discussed as a concern due to the move to 24 beds. However, there was no actions recorded or update regarding this at the August 2022 or September 2022 meetings. General staffing concerns were discussed at the October 2022 meeting and the minutes noted the use of risk assessments to mitigate risks, however the minutes did not detail action planning, escalation or any other mitigations.

At the multidisciplinary quality and safety meeting in August 2022, which was attended by divisional leads and critical care governance leads, staffing skill mix was mentioned as a continuing risk, however there was no further discussion or update. The was no discussion regarding staffing at either the June 2022 or October 2022 meetings. At the divisional clinical governance executive meeting, there was no discussion of staffing at the July 2022 meeting. At the August 2022 meeting, staffing was discussed within other areas of the division but not within adult critical care, or the department. At the September 2022 meeting, the only update regarding staffing stated “There are ongoing issues with staffing. Two consultants have left and are yet to be replaced.” The clinical governance lead completed a staffing skill mix risk assessment that was discussed at the directorate clinical governance meeting in June 2022, however the assessment was not reviewed at the August or October 2022 meetings. Therefore, concerns around staffing skill mix were not regularly or routinely updated, documented and actioned.

We found teams at all levels struggled to effectively communicate their concerns, which led to different interpretations of the same information. For example, staff on the unit stated the number of near misses was concerning, that they were worried about the potential for a serious incident and described incidences where they felt staffing numbers and skill mix had impacted care. When we spoke with divisional leads, they described the increase in near miss incidents as a positive reflection of a good reporting culture. Communication was worsened by staff using informal methods to escalate concerns rather than via Trust processes. In response to this, the matron requested a performance report from the division perspective to try to understand where there was a potential breakdown in communication regarding concerns, incident reporting and escalation of the risk register to the board.

The Trust-board received assurances regarding performance via the Trust clinical governance committee. The committee received quarterly performance updates based on data from directorate and divisional quality reports. There was also a sub-committee of the board that reviewed concerns specific to critical care. The trust risk committee reviewed all risks that formed the corporate risk register and the trust audit committee-maintained oversight of national audits across the hospitals.

Although staff reported issues of fatigue, unit staff continued to work together to provide good care for patients. This was evidenced in the unit winning this years’ European Pressure Ulcer Advisory Panel Quality Improvement Project Award. This award aimed to recognize and acknowledge innovative quality improvement projects relating to the prevention of skin breakdown. The unit also won the platinum OxSCA award, which was an internal Oxford Scheme for Clinical Accreditation.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The critical care service submitted data to the Intensive Care National Audit and Research Centre, (ICNARC). ICNARC annually published data showed improved performance by Oxford Critical Care with all metrics graded as green.

The unit used dashboards in order to have oversight of service performance measures. For example, we saw the safe staffing dashboard from September 2022, that monitored the nursing and midwifery staffing situation by ward/ department. The data was triangulated with incidents, HR records data, electronic rostering key performance indicators and friends and family test results.

The matrons attended a weekly meeting to review quality performance data with the division. We were advised this was where concerns and risks were escalated. These meetings were not minuted, therefore, we were unable to see physical evidence that the risks and concerns experienced by staff on the ward floor were escalated via this meeting.

Information systems were electronic, and password protected, we saw staff locked computers before they left a station.

Engagement

Leaders provided initiatives to engage with staff and equality groups. However, the culture on the unit had impacted the willingness of staff to communicate and engage.

Results from the most recent staff survey showed; recognition, appreciation and acknowledgment and leadership and team cohesion were the two areas that required most improvement. In response to survey results, the unit organised focus groups in order that staff had a say in reviewing the findings and input into the responsive action plan.

Through focus groups, staff were invited to review the findings and engage in the development of the responsive action plan. We saw the action plan which included time frames as well as plans to evaluate impact; however, it was still in progress at the time of inspection. Managers had not yet had the opportunity to review whether the changes made had resulted in improvement.

A 'Time to Talk' session was also arranged to discuss staff survey results for those staff unable to be a part of focus groups. One action that came from this was that an organogram of the structure of the department was to be displayed in the staff room as several members of staff did not know which division the unit was a part of, we saw this was now on display.

The Trust produced a monthly wellbeing newsletter, we saw the most recent newsletter that included information on upcoming events, for example, stress awareness day and self-care week, as well as details of individual events occurring across the Trust. We saw the critical care wellbeing summary that was specific to the department and listed ongoing quality improvement projects, current support systems as well as future events, for example Christmas parties.

The unit's wellbeing champion organised monthly breakfast catch up days, these were designed to unify unit staff.

Staff advised the inspection team of two initiatives that were discontinued with little information as to the reasoning behind them and these impacted their faith and trust in the senior management team. The culture of the unit and fatigue appeared to impact staff willingness to engage. The inspection team noted there was a clear disconnect between the ward and the board. Unit managers did not have effective systems in place to demonstrate a correlation between

their concerns and the impact these had on patient outcomes and staff wellbeing. For example, concerns were raised via ad hoc emails and not discussed at formal settings or recorded and followed up accordingly. This may have impacted senior managers ability to understand these concerns and escalate them in a timely manner. The result was a culture where lack of understanding, poor communication and staff feeling like they were not listened to meant staff felt they had to report their concerns to the Care Quality Commission, rather than through internal methods.

Outstanding practice

We found the following outstanding practice:

The new unit provided state of the art facilities which were spacious and designed using proven modern practices for improving infection prevention and control standards and reducing patient risk of contamination.

Areas for improvement

SHOULDS

John Radcliffe Hospital, Adult Critical Care Unit

- The trust should ensure that the staffing skill mix and agency/bank usage meets the requirements as set out in The Faculty of Intensive Care Medicine 'Guidelines for the Provision of Intensive Care Services'. (Regulation 18)
- The trust should ensure the unit meets National Institute for Health and Care Excellence guidelines regarding intensive care access to speech and language therapists (SALT). (Regulation 18)
- The trust should consider progressing their plans to introduce a critical care outreach team.
- The trust should ensure medical staff mandatory training rates meet or exceed the trust target. (Regulation 18)
- The trust should ensure a patient prioritisation document is developed to enable staff to prioritise conflicting patient demands on the unit. (Regulation 12)
- The trust should consider reviewing how teams communicate across the trust structure and implement an improvement plan.
- The trust should ensure local audits are completed in line with the audit schedule and used to assess the quality and safety of the service. (Regulation 17)

Our inspection team

The inspection team included two CQC inspectors and two specialist advisors, one was an experienced critical care level 3 nurse and the second was a governance lead who specialised in equality, diversity and inclusion. The team was led by an inspection manager and overseen by Carolyn Jenkinson, Head of Hospital Inspections.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

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

This section is primarily information for the provider

Enforcement actions

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