Oxford University Hospitals NHS Trust

Churchill Hospital

Quality Report

Old Road
Headington
Oxford
OX3 7LJ
Tel: 01865 226055
Website: www.ouh.nhs.uk

Date of publication: 14 May 2014
Date of inspection visit: 25-26 February and 3 March 2014

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	Good
Medical care	Good
Surgery	Good
Intensive/critical care	Good
End of life care	Good
Outpatients	Good

Summary of findings

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Summary of findings

Overall summary

The Churchill Hospital first opened in 1942 during the war as an American Hospital; it was taken over in 1946 by Oxford City Council and integrated with the John Radcliffe Hospital in 1993. There are 217 in-patients beds, 8 critical care high dependency beds, 10 theatres, day care and outpatient facilities. The Churchill Hospital in Headington is the site of the Oxford Cancer Centre and a centre for renal and transplant services, medical and surgical services, oncology, dermatology, haemophilia, infectious diseases, respiratory medicine, medical genetics, palliative care and sexual health.

To carry out this review of acute services we spoke to patients and those who cared or spoke for them. Patients and carers were able to talk with us or write to us before, during and after our visit. We listened to all these people and read what they said. We analysed information we held about the hospital and information from stakeholders and commissioners of services. People came to our two listening events in Banbury and Oxford to share their experiences. To complete the review we visited the hospital over two days, with specialists and experts and carried out an unannounced visit. We spoke to more patients, carers, and staff from all areas of the hospital on our visits. The regulatory activities diagnostic and screening procedures, surgical procedures, treatment of disease, disorder or injury were inspected.

Staffing

Staff were positive about working at the hospital they said it was a supportive environment in which to work. Where staffing levels were a concern wards were able to use agency and bank staff to maintain safe staffing levels. In cases where this was not possible beds would be closed. The hospital was actively recruiting to vacate posts.

Cleanliness and infection control

The hospital was found to be clean. Some areas of the hospital were found to be old, tired and worn. Hand washing facilities were readily available as was hand cleansing gel. Staff cleaned their hands between patients and this was supported by the feedback given by patients. It was observed that staff observed the hospital bare below the elbow policy. Infection control nurses were available to support staff and audits were undertaken to monitor practice. The trust's infection rates for Clostridium difficile and MRSA lie within a statistically acceptable range for the size of the trust. In the last three months there had been no incidents of MRSA cases at this hospital.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Good

Services at the hospital were safe. Staff were trained and responsive to any signs of abuse and avoidable harm. Patients reported that they felt safe. There were established systems for the reporting of incidents and there were processes for the sharing of learning from the outcome of any investigations. The hospital was clean and infection control protocols were followed. Medicines were managed safely.

Staffing levels were acceptable with systems in place to manage when staffing levels had the potential to impact on patient safety. Some of the older areas of the hospital are looking tired and worn and had the potential to place staff and patients at risk. The trust was aware of this and this was included on the hospitals risk register. When patients lacked the capacity to make decisions, the requirements of the Mental Capacity Act 2005 and multidisciplinary decisions acting in people's best interests were followed.

Are services effective?

Good

Outcomes for patients were good. National guidelines and best practice were applied and monitored. Pain management was done well. Staff worked in multidisciplinary teams to coordinate care around a patient. End of life care was integrated across the hospital and patients and staff were complimentary about this service. The critical care service provided excellent care with good outcomes. While staff had access to the equipment they needed the actual maintenance program was not clear and staff on the wards were not always aware of when equipment had last been serviced. There was a central maintenance programme with records held on a corporate database, but staff on wards were not aware of this.

New staff were supported through an induction program and students were supported by mentors. Staff were provided with core mandatory training. Concerns had been identified with the integrated care pathway for inpatients with diabetes and the trust was actively working to address this. On the medical wards care plans were not always current and up to date and reflective of patients' agreed care needs.

Are services caring?

Good

During our inspection, we observed staff were caring and patients were treated with dignity and respect. Staff in the critical care team provided outstanding care and emotional support. End of life care, which was provided across the hospital where needed, was caring, professional and supportive to patients' choices. When patients lacked the capacity to make decisions, the requirements of the Mental Capacity Act 2005 and multidisciplinary decisions

Summary of findings

acting in people's best interests were followed. Where every possible patients and their families were involved in the decision making process. Information was available in languages other then English for those whose first language was not English.

Are services responsive to people's needs?

Good

The hospital supported vulnerable patients well, to ensure care was delivered in their best interests. Discharge arrangements were a challenge. The trust was actively working with partners to improvements to the internal and external discharge arrangements so that people who do not require a hospital environment are discharged to community services timely and effectively. Arrangements were in place to support those who did not speak English and might need additional assistance and adjustments to enhance communication whilst in hospital.

Are services well-led?

Good

Generally staff were aware to of the trusts vision and values. Staff felt the hospital was well led at local and directorate level. Staff were supported by their peers and managers to deliver good care and to support one another. There was an appraisal system in place to support staff, which most staff had completed. The trust actively sort and considered feedback from patients through survey s and the friends and family test. During 2012 the trust launched a five year vision for the organisation, which included the Churchill hospital, and which aimed to deliver continuous quality improvement with a focus on three key areas for 2013 / 14: patient safety, patient experience and clinical effectiveness. This showed the commitment of the hospital to engage with improving services to patients.

Summary of findings

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

Medical care (including older people's care)

Good

Patients received safe care and were protected from risks. Infection rates were low and the hospital was clean. However, risks to people's safety increased during busy times. Medical patients were transferred to surgical wards and did not always see a specialist in a timely manner. Some equipment needed to be better maintained and some areas were in need of refurbishment. Patient records needed to include accurate and appropriate information.

Staffing levels were regularly monitored to ensure wards and departments were staffed with the right number of staff with the skills and knowledge to meet people's needs. The hospital continued to recruit into vacancies.

Integrated care pathways for inpatients with diabetes were still being formalised. In the trust diabetes affects 14.7% of adult inpatients. The diabetes quality group was responsible for the monitoring and delivery of the "Think Glucose" project to improve the quality of care. Diabetes specialist nurses were to be recruited and training was also being delivered to ensure that inpatient diabetes treatment protocols were implemented effectively and consistently in line with national guidance.

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

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

The hospital staff faced significant challenges when discharging patients to community services. They were working with stakeholders to deliver the discharge improvement programme including improving medication discharge arrangements.

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

Surgery

Good

There was consensus amongst patients, carers and staff that staff were dedicated and provided compassionate, empathetic care. Processes were followed to reduce any risks to patients undergoing surgical treatment.

Summary of findings

Staff made use of the language line facility and interpreters to ensure patients had a good understanding of their treatment and were able to make informed decisions.

Staff had a good understanding of the Mental Capacity Act 2005 which meant patients received the appropriate support to be able to make their own decision, or where required decisions involving appropriate people were made in the best interest of the patient.

Generally there was sufficient equipment available to meet the needs of patents. However, concerns were expressed about access to radiology for some patients. This meant that patients had to undergo radiography procedures on the day of their planned surgery, rather having all investigations completed prior to the day of planed surgery.

There was evidence that learning from incidents occurred and that changes were being made in response to findings from quality auditing processes.

We saw good evidence of team working at ward and departmental level.

Intensive/critical care

Good

Patients received safe care. Clinical outcomes were monitored and demonstrated good outcomes for patients. Care provided was effective with a multidisciplinary approach taken and good standards of facilities to meet patient's needs. Whilst staff recruitment and retention was recognised by the trust as an issue, the levels and skills of staff on a day to day basis were consistently managed by using staff from John Radcliffe Hospital.

Patients told us the kindness and care of staff was outstanding. The unit was responsive to the needs of the patient and learned from safety events or incidents. The departments were well led and demonstrated a positive leadership and open culture to enable staff to feel involved in changes.

End of life care

Good

Patients received effective and sensitive end of life care. Patients told us they felt safe and their needs were met by skilled staff. Patients knew the reasons for their admissions and had made decisions about where to have their end of life care. Patients' pain was well managed by the clinical staff and they did not have to wait for their medicines. Staff respected patients' rights and, in particular, their privacy and dignity.

Palliative patients were able to make decisions about the medical procedures to be followed in the event of a cardiopulmonary arrest. If the decision was not to resuscitate in the event of a cardiopulmonary arrest, the decision was recorded and professionals made aware of the decision.

Patients were cared for with compassion by staff who knew how to care for patients at the end of their life. Hospital staff attended palliative care training and were able to attend study days on end of life care to update their knowledge.

Summary of findings

Palliative patients had access to a centralised helpline which offered advice and referrals for admissions. End of life patients arriving on the emergency medical unit were assessed and transferred to the most appropriate ward to meet their care and treatment needs.

Systems were in place to provide sensitive care to patients on end of life pathways and their families. Haematology palliative patients were able to receive treatment as day patients in a recently opened ambulatory room enabling them to remain longer in their own homes. A four-bed flat was available on site for families who wanted to be close to their relative during their end of life pathway.

Outpatients

Good

Patients received safe and effective care. Some outpatient and day services were in an old part of the hospital not well suited to the delivery of modern day healthcare. We saw that this was recorded in the risk register and that temporary actions had been taken to mitigate the risk. Identified remedial work had not been undertaken and genetics and cystic fibrosis services affected had not been relocated as planned. We were not able to establish when this would be completed. The clinics we visited were well led and patients told us that the care was excellent.

Summary of findings

What people who use the hospital say

In the November 2013 friends and family test, 47 wards at Oxford University Hospitals NHS Trust were included. There were 13 wards that scored less than the trust average of 68. Geoffrey Harris Ward the specialist medicine ward at the Churchill hospital was one of these.

From the NHS Choices website there were five comments relating to the Churchill Hospital that were rated five stars, themes from this included; excellent Urology ward, excellent care, professionalism, went that extra mile, dedication and commitment. There was also one comment rated as one start, the theme's coming from this comment were; poor people skills, poor dermatology ward, lack of listening and lack of respect & dignity. The stars ratings on the NHS Choices website give Churchill Hospital a score of 4.5 stars (out of a total of 5) for 'cleanliness' ; 4.5 stars for 'staff co-operation' ; 4.5 stars for 'dignity and respect'; 4.5 stars for 'involvement in decisions' ; 4 stars for 'same-sex accommodation' .

From the Adult Inpatient Survey 2012 the trust performed within expectations for all ten areas of questioning. These relate to the areas the emergency department,; waiting list and planned admissions; waiting to get to a bed on a ward; the hospital and ward; doctors; nurses; care and treatment; operations and procedures; leaving hospital; overall views and experiences.

Out of a total of 60 questions, the trust performed better than other trusts in two questions and worse than other trusts for none of the questions. The two positive questions were did a member of staff explain the risks and benefits of the operation or procedure? and were you told how you could expect to feel after you had the operation or procedure?

Within the Adult Inpatient Survey, there are two questions that refer to the process of discharge. These relate to the proportion of respondents to the adult inpatient survey who stated they were not given enough notice about when they were to be going to be discharged and the proportion of respondents to the adult inpatient survey who stated that their discharge was delayed for more than four hours, due to waiting for medicine, to see a doctor or for an ambulance. The trust scored similar to expected when compared with other trusts.

Areas for improvement

Action the hospital MUST take to improve

On the medical wards the trust must ensure that patient records accurately reflect the care and treatment planned and delivered for each patient in line with clinical guidelines and good practice standards.

Action the hospital SHOULD take to improve

- Consideration should be given to the management of the outpatient clinics in the older parts of the hospital. Particular consideration should be given to the patient's well fare and their health and safety. This is because of the limited space in some areas and the general condition of some of the facilities.
- The trust should continue making improvements to the internal and external discharge arrangements so that people who do not require a hospital environment are discharged to community services timely and effectively.
- Identified shortcomings in the care and treatment pathway of inpatients with diabetes were being addressed but the trust needs to ensure that outcomes are delivered to these patients in line with good practice and clinical guidelines.
- The trust should continue with its recruitment efforts to ensure that sufficient medical beds are available to patients and safe staffing levels are maintained.
- Identified concerns relating to the facilities in the older part of the hospital were being addressed but the trust needs to ensure that suitable well maintained premises are available to patients and staff.
- Codes used to inform staff of the medical procedures to be followed for specific patients in the event of a patient having a cardiopulmonary arrest should be standardised across the hospital.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- Patients and their families were positive about their experience in the critical care unit. They felt that they had been involved, kept informed and treated with dignity and respect at all times. They felt that both the medical and the nursing team took time to build a trusting relationship before and during the experience.
- Staff worked well between teams. The value off an effective multi-disciplinary approach, in improving outcomes for patients, was understood and actively encouraged.
- It was evident that significant efforts had been being made to improve the effective discharge of patients. The hospital was working closely with commissioners, social services and providers to improve the transfer of patients to community services.
- The trust internal peer review process, in which over 100 clinical areas had been reviewed in a three month period across the trust.

Churchill Hospital

Detailed Findings

Services we looked at:
Medical care (including older people's care); Surgery; Intensive/critical care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Chris Gordon Director, Foundation Trust Support Programme at NHS Top Leaders, Department of Health & Consultant Physician at Hampshire Hospitals Foundation Trust

Head of Hospital Inspections: Mary Cridge Care Quality Commission

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

Background to Churchill Hospital

The Churchill Hospital is a centre for cancer services and other specialities, including renal services and transplant services, clinical and medical oncology, dermatology, haemophilia, infectious diseases, chest medicine, medical genetics and palliative care.

Developments in recent years include the opening of the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) - collaboration between the University of Oxford, the NHS and three partner companies, to create a centre for clinical research on diabetes, endocrine and metabolic disorders, along with clinical treatment and education.

The hospital, together with the nearby John Radcliffe Hospital, is a major centre for healthcare research, housing departments of Oxford University Medical School and Oxford Brookes University's School of Healthcare Studies.

There is an integrated Cancer and Haematology Centre, a Surgery and Diagnostics Centre and the Wytham Wing - housing the Wytham Ward (transplant) and private outpatients. These centres bring together a wide range of medical and surgical services including cancer medicine (clinical and medical oncology, clinical haematology and radiotherapy), surgery (gastrointestinal, breast, and gynaecological cancer and non-cancer surgery), diagnostic services (laboratories, radiology and breast screening) and a base for University research teams, working in partnership with NHS colleagues.

Detailed Findings

This location has been inspected twice on 11 July 2011 and 12 July 2011. The location was found to be compliant with two outcomes care and welfare of people who use services and staffing although there were minor concerns for supporting workers and assessing and monitoring the quality of service provision.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection inspected the following core services at each inspection:

- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- End of life care
- Outpatients.

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

We carried out an announced visit on 25 and 26 February 2014 and an unannounced visit on 2 March 2014. During the visit we held drop in sessions for all staff. We talked with patients and staff from all areas of the hospital including the wards, theatre, outpatient departments and critical care unit . We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

We held a listening event where patients and members of the public shared their views and experiences of the location.

Good

Medical care (including older people's care)

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

Information about the service

The Churchill Hospital provided care and treatment for people on three medical wards. The wards provided the following specialities: renal, respiratory, diabetes, endocrinology, infectious diseases and tropical medicine. We visited the medical wards and talked with six patients and ten staff including nurses, doctors, therapists and support staff. We observed care and treatment and looked at care records. We received information from our listening events, focus groups, interviews and comment cards. We used this information to inform and direct the focus of our inspection. Before our inspection we reviewed performance information from, and about, the trust and hospital.

Summary of findings

Patients received safe care and were protected from risks. Infection rates were low and the hospital was clean. However, risks to people's safety increased during busy times. Medical patients were transferred to surgical wards and did not always see a specialist in a timely manner. Some equipment needed to be better maintained and some areas were in need of refurbishment. Patient records needed to include accurate and appropriate information.

Staffing levels were regularly monitored to ensure wards and departments were staffed with the right number of staff with the skills and knowledge to meet people's needs. The hospital continued to recruit into vacancies.

Integrated care pathways for inpatients with diabetes were still being formalised. In the trust diabetes affects 14.7% of adult inpatients. The diabetes quality group was responsible for the monitoring and delivery of the "Think Glucose" project to improve the quality of care. Diabetes specialist nurses were to be recruited and training was also being delivered to ensure that inpatient diabetes treatment protocols were implemented effectively and consistently in line with national guidance.

The multidisciplinary teams in the division were well integrated and had a strong collaborative approach to care. Care and treatment that was agreed and delivered was not always recorded. A written record was not always available to all parties to ensure continuity of care.

Good

Medical care (including older people's care)

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

The hospital staff faced significant challenges when discharging patients to community services. They were working with stakeholders to deliver the discharge improvement programme including improving medication discharge arrangements.

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

Are medical care services safe?

Requires Improvement

Safety and performance

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

The hospital used the "safety thermometers" to measure their risk performance. The NHS Safety Thermometer Report 2012 - 2013 showed a fluctuating performance for new pressure ulcers, falls, venous thromboembolism (VTE) and patients with catheter related urinary tract infections.

We saw the outcome of a recent audit to monitor the number of patients who were screened for venous thromboembolisms on admission to the Churchill hospital. The audit showed 87% compliance which was below the trust's quality target of 95%. We spoke with the acting divisional head of nursing and governance to understand this performance. They told us that the division had improved the assessment of patients for VTE which resulted in a sudden decline in patients developing thrombosis across the trust. Some areas still required improvements and action had been taken to ensure that doctors undertook the assessment and VTE screening for patients on admission.

Pressure ulcers and falls remained a concern for the division and action plans were in place to improve the management of people at risk of falls and pressure ulcers. Work had also been done to ensure that the same fall was not recorded multiple times as an incident which had happened in the past.

Learning and improvement

Following the investigation of grade three and four pressure ulcers, a new pressure ulcer management policy was introduced. To prevent grade one and two pressure ulcers from deteriorating these were now also recorded and monitored closely. A new tissue viability nurse had been appointed to support the medical wards to manage pressure ulcers effectively. Training in the new policy was provided to staff. Investigations of incidents were monitored at the monthly quality meeting to ensure that they were completed in a timely manner and learning shared.

Good

Medical care (including older people's care)

Systems, processes and practices

Staff told us they had access to appropriate and suitable equipment within the hospital to provide care and treatment. We observed that equipment like syringe drivers and electro cardiograph machines had dates recorded on them which showed they had not been checked or serviced recently. One service date we saw was in 2011 and another in 2003. Some did not have any date or asset number recorded. We reviewed the trust policy and procedure regarding the management of medical devices. This specified that all test equipment should be calibrated annually (unless indicated otherwise) and current calibration certificates retained. Medical equipment which had been purchased by individual wards was detailed in a log held by the housekeeper. During discussions with the manager of the technical engineer department we were told there was an electronic database held of all the medical equipment used in the trust. It was acknowledged that some equipment would not be reflected on this list if purchased by wards who had then not advised the department of its existence. We heard equipment was not routinely maintained or serviced according to a fixed annual schedule. An appropriate service schedule was determined for items of medical equipment at the point of entry to the trust. In some cases, the service schedule might involve no routine maintenance unless a fault was reported to the department.

Some facilities and buildings were not well maintained at the Churchill Hospital. The hospital had been expanded over the years. Some parts of the hospital were in a state of disrepair, with windows that did not close, leaks through ceilings and windows in areas that were used by patients requiring refurbishment. We saw the older part of the hospital had doors which accessed the outside that could not be locked or secured at night. When it rained the floor became wet and was a slip hazard. Security cover was not provided across the 24-hour period, with a two hour gap in the morning and a one hour gap in the evening. The security person could also be called away to attend other hospitals across the trust if the need arose. This would leave the Churchill hospital without security, with staff and patients potentially at risk. The security guard locked the external doors and held the keys. Their absence from the site as given as to the reason why the large access doors were not kept locked. The trust had identified these concerns relating to the Churchill estate environment. The trust risk register noted concerns with ''poor environment and building fabric for John Warin ward'' as well as ''building problems due to the design of the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) building including Geoffrey Harris ward''. Actions were being taken to manage the temperature, leaks and noise. Several business cases were also being drafted for relocation of some services. The risk register noted that there had been some delays in completing actions and it was recorded that ''Problems with lack of progress have been escalated to directorate and are currently being escalated to executive level''.

Medication used on the ward was stored securely and the clinical room was accessed by a key pad style lock. We were told that only staff who required access were provided with the code to this room. Resuscitation trolleys were located throughout the wards and the emergency medications held on these were regularly checked to ensure they were in date. The pharmacy prepared the emergency medication boxes and sealed them, while ensuring the dates of medication contained within were visible for checking.

Medication monitoring systems were not consistently implemented in line with quality standards. Drug treatment charts showed that staff did not always record medication that had been administered to patients during the procedure of renal dialysis. This did not enable effective monitoring of the patient's drug treatment. We found that the manufacturer's guidelines for the storage of a liquid medication had not been followed and the medication could have become ineffective. A medication audit had been undertaken across the medical division and actions were in place to ensure that medication was managed in line with quality standards.

Monitoring safety and responding to risk

Nursing and medical staff told us the staffing levels on the wards were generally at a level to enable them to provide safe care and treatment to patients, although at times they were at minimal levels. They added that agency and bank nurses often worked on the wards to cover duties that were the result of staff vacancies and sickness. We were also told that on occasions staff were moved wards to provide cover for staffing shortages, for example due to sickness at short notice. Staff considered this sometimes placed pressure on them. The matron told us that the hospital continued recruiting nurses to fill vacancies.

Green, amber and red staffing levels were set for each ward. Risk management actions had been agreed when staffing levels fell to amber or red. We saw that amber and red staffing levels were discussed at the twice daily bed management meeting and action taken to address the risks. This at times included closing medical wards. We looked at staff rotas for some of the medical areas and found that shifts had been referred to agencies and bank staff for cover and ward based staff also worked additional hours to cover the shifts. This was confirmed by the trust wide NHS staff survey for 2012/2013 which identified that 73% of staff worked extra hours. The trust had carried out reviews of acuity and dependency of patients to determine safe staffing levels in April, October and December 2013.

A system was in place to alert all ward based staff to patients who were at risk from inadequate nutrition by the use of red trays to present their meals on. Staff we spoke with had different interpretations of the use of red trays and some suggested they indicated the person required assistance with feeding while others considered they were a reminder to prompt them to monitor the person more closely. The information contained in the handover sheets, regarding the use of red trays, was not included in individual patient's care plan documentation. This indicated the system to safeguard patients from insufficient nutrition was not consistently followed.

On admission to the hospital, either through the emergency admissions unit or directly to the ward, assessments were carried out to identify the care and treatment risks and requirements of each patient. Full written records of the assessment in the medical records were completed by the medical staff.

Care plans had not consistently been completed. Staff, particularly agency and bank staff new to the ward, did not have detailed information to guide and direct them on how to meet patients care and treatment needs. Two staff we spoke with were not aware of patients care plans and referred to the progress notes as the care records. Staff told us they would refer to these daily progress notes which were recorded by medical and nursing staff. This meant that patients could not be assured that records would inform staff how to manage risks to their health and welfare.

Handovers between shifts did not always correspond with care plans and staff understanding of patients' care. Care and treatment that was agreed and delivered were not always recorded so that a written record was available to all parties to ensure continuity of care. One patient was receiving oxygen but their medication record was not clear and their care plan did not reference this. The handover sheet which one member of staff held stated the patient required oxygen. The nurse and doctor we spoke with were not aware that this was part of their treatment. Where dieticians required nutritional intake to be monitored we found that fluid and food charts had not always been completed. There were several blood sugar monitoring records in use which increased the potential of these not being completed accurately to inform clinicians' treatment decisions. Staff could describe the personal care provided to patients. However, mouth care, washing and dressing, mobility and continence care plans were not seen for people who could not direct staff. The matron told us that a working party had been set up to review ward paperwork to ensure that it provided sufficient information for planned care and treatment to be delivered effectively.

Staff had received information and training to ensure that patients were protected from abuse. Information was available for patients, their representatives and the staff on how to report and respond to abuse. Patients who lacked the mental capacity to make a decision were supported in line with the principles of the Mental Capacity Act 2005 (MCA). Staff received training in the safeguarding of vulnerable adults, MCA and Deprivation of Liberty Safeguards (DOLS). Staff understood how these principles applied to their role. We saw examples of meetings that had been held to make best interests decisions for patients regarding some of their care and treatment when they did not had the mental capacity to make such decisions themselves.

Anticipation and planning

In planning the safer staffing levels for medical wards the division took into account the past trend of staff sickness and high turnover of trained nurses. By anticipating this risk they ensured that a staffing level was agreed that could maintain safety even when these risks occurred. The NHS staff survey for 2012 – 2013 identified that 73% of staff worked extra hours to cover gaps in the agreed staffing levels. The hospital told us that a process of recruitment of nursing staff was ongoing to provide a higher number of available staff across the wards in order to meet the needs of patients.

Good

Medical care (including older people's care)

The medical wards had contingency plans in place to respond to winter pressures as well as emergencies and major incidences. Staff were familiar with the emergency plans. One ward had six beds closed to admissions due to insufficient staffing numbers. Though this meant a reduced number of medical beds were available, patients could be assured that action would be taken to reduce the number of medical beds if the hospital judged nursing staff numbers were not sufficient to provided safe care. When medical wards were closed bed capacity was created in surgery wards or at John Radcliffe hospital so that medical patients could continue receiving care.

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

Good

Using evidence-based guidance

The hospital had systems in place to ensure that the medical directorate was kept informed of relevant legislation, guidelines and quality standards. Staff knew how to access the hospital's intranet system and where to find information relating to national guidelines. Staff were aware of National institute for Health and Care Excellence (NICE) guidelines relevant to the medical division and the nursing care delivered to patients on the ward they worked on.

Practitioners were available to provided specialist input in line with good practice guidelines. Staff on the medical wards referred patients to specialist diabetes nurses. Records showed that patients with diabetes had been seen by the diabetic nurse who was based at the Churchill Hospital. Staff were positive in their comments about this service and the response they received when referring patients. Tissue viability nurses were based elsewhere in the trust and ward staff involved these nurses when support was required when managing pressure ulcers.

Systems were in place to ensure that patients nutritional and hydration needs were met. Patients were weighed and screened for malnutrition using the malnutrition universal screening tool (MUST) on admission and weekly.

Performance, monitoring and improvement of outcomes

Records showed that one patient saw the diabetic nurse five days after being referred by ward staff and another had been reviewed seven days before. It was not clear from records how often patients were to be reviewed by the diabetes nurse and how ward staff were to implement their recommendations. We spoke with the diabetes lead who told us that an integrated care pathway for in patients with diabetes was still being formalised.

In the trust diabetes affects 14.7% of adult inpatients (compared to a national prevalence of 15.3%). They told us that the care for inpatients with diabetes required improvement following incidents of poor diabetes care, one of these took place at the Churchill. Diabetes risk summits were held in October and December 2013 to address these concerns. The diabetes quality group would be responsible for the monitoring and delivery of the "Think Glucose" project to improve the quality of care. It would be chaired by the deputy medical director and start implementation by March 2014. Actions included a business case to bring diabetes inpatient specialist nurses numbers in line with the national average as well as early and comprehensive standardised assessments. Training was also being delivered to ensure that inpatient diabetes treatment protocols were implemented effectively and consistently in line with national guidance.

Staff, equipment and facilities

Student nurses were placed at the hospital and we heard they felt well supported by the ward staff. The hospital ensured each student had a named mentor who worked with and supported them during their placement. We spoke to two student nurses who were working alongside their mentor that day. Both told us they felt well supported, both by their mentors and the wider team.

Newly employed staff were provided with induction training to familiarise them with the trust, the hospital, and their ward base. We spoke with a newly recruited member of staff who was positive about their induction and the support received while on the ward. Staff also spoke positively of the support received and time spent in a supernumerary capacity on return from prolonged breaks such as those due to maternity leave.

Staff were provided with core mandatory training and further training relating to the medical speciality they worked within. Records provided to us showed 82%

compliance with the trust's statutory training. The lowest staff group for compliance with training was reflected as the medical division. We heard comments from staff that the levels of vacancies at the hospital made accessing training harder as it was not possible on some shifts to leave their clinical areas. An electronic training system had been introduced to enable staff to complete training on line.

Multidisciplinary working and support

Staff worked together as part of a multidisciplinary team to meet the varying levels of health, social and psychological needs of patients. Patients and staff were not always clear what the agreed response time for specialist interventions was. Most patients told us that they had received care and treatment from the multidisciplinary team promptly and effectively.

Are medical care services caring?

Good

Compassion, dignity and empathy

During our inspection we observed staff talking with patients on the wards in a warm, friendly and compassionate manner. Care was explained in a clear and effective way and the patient consent sought prior to carrying out any care or treatment.

Curtains were drawn around beds when care was given. Patients had access to call bells and during our inspection they were answered promptly. Two patients we spoke with told us that at busy times they might have to wait for their bells to be answered. Patients confirmed their privacy and dignity were respected and were positive about the care they had received and the staff who delivered that care.

Involvement in care and decision-making

The medical and nursing daily records provided evidence of the involvement of the patient and their families, when appropriate, in discussions and decisions about their care and treatment.

Patients told us they had been provided with information regarding their care and treatment and were able to make decisions about their care. They had been given sufficient information in making difficult decisions and felt their preferences and choices made were and would be respected. We saw records which showed how decisions regarding the patients' care and treatment had been reached and by who had been involved in the decisions. This had included the patient and their relatives. This ensured all members of staff who were involved in the care of the patient had access to the information about their planned care and treatment. Records showed a relative of one patient with complex care needs had been included in discussions in the planned care pathway and their views respected.

We received positive comments from one patient regarding the multidisciplinary team working particularly regarding their experiences of pharmacy. We reviewed the process to enable patients to be involved in administering their medication. The procedures for this varied from ward to ward. We found the option was not routinely offered to patients but if they asked they would be permitted to self-administer some medication like inhalers or subcutaneous insulin. We saw one patient was self-administering their medicines. A risk assessment had been completed, in conjunction with and signed by the patient, nurse and pharmacist. A review of the patient's medicines administration record showed that administration was checked and confirmed as having been self-administered.

Trust and communication

Information leaflets about a variety of medical conditions and treatment options were available to patients and relatives to support them with their care and treatment. We did not see, but were told, information could be provided in a format to suit individuals. For example in a different language, large print, Braille or audio.

We followed the pathway of four patients through the hospital from their admission to the wards. Most patients we spoke with were satisfied and confident in the care and treatment they had received. Where patients had expressed dissatisfaction we were able to see from their records that they could be reassured that action that had been taken by appropriate staff to address their concerns.

Emotional support

Relatives and other visitors were welcomed to the ward by the staff to see the patients who were supported to stay in contact with family and friends. Visiting times were detailed on the wards, although we were told by both staff and patient's that these times were flexible and relatives of elderly patients were welcome to spend long periods with patients.

Good

Medical care (including older people's care)

Patients were supported with spiritual needs by the trusts Chaplains. Information was available regarding the NHS support for different faiths.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The hospital took the needs of the community into consideration when planning and designing services. Day services had been developed to provide additional services to patients. We spoke with staff who worked in the day services department and were told patients were able to attend clinics to ensure their specific treatment and care needs were met. This included assessments for patients who required long term oxygen therapy and those who needed intravenous medication administered. This resource enabled patients to receive the appropriate treatment without having to stay in hospital overnight.

There were co-ordinated pathways of care agreed with partners to meet patients' needs. The trust was part of the Oxfordshire dementia development and implementation board and the dementia steering group led on improving care of patients with dementia. The medical wards were making improvements to better care for patients with dementia. Staff confirmed that training in dementia care was being delivered to ensure that they understood the joint working arrangements. The medical wards had a dementia champion that kept staff updated of any changes in the dementia pathway. Staff were aware that the hospital agreed to routinely undertake memory screening of patients over the age of 75 to ensure the identification and referral of patients with dementia.

Some patients with chronic illnesses, like cystic fibrosis (CF), were treated repeatedly on the respiratory ward. The rooms on the respiratory ward had en-suite bathrooms. These facilities enabled staff to meet the needs of patients who had to attend the ward regularly with comfort and convenience.

The medical wards we visited during our inspection aimed to provide patients with single-sex accommodation. However, at busy times when beds were limited wards had to accommodate mixed sex accommodation if it was clinically justified. Clear protocols were in place to ensure patients privacy and dignity would be respected at these times.

For patients whose first language was not English some information, for example how to make a complaint, was available on the wards. There was also access to an interpreter service either by the provision of an interpreter or through a telephone service. These included Polish, Cantonese, Mandarin, Urdu, Bengali, Arabic and Punjabi interpreters which were reflective of the local population. Staff gave examples of when this had been used. We saw the staff had supported one patient by ensuring important conversations and discussions took place in the presence of their relative to ensure full understanding as they had limited English.

Vulnerable patients and capacity

The hospital was sensitive to the support patients, who were in vulnerable circumstances, might require to access services. Arrangements were in place to support those who did not speak English and might need additional assistance and adjustments to enhance communication while in hospital. We saw that telephone and face-to-face interpreters were available. A text phone service was available to support deaf, hard of hearing and speech impaired patients to make appointments. Patient transport could be arranged for patients with disabilities. Wheelchair access was provided across the hospital.

Access to services

The hospital anticipated that there would be a higher demand for medical beds during the winter. Beds in surgical wards were available to ensure that medical patients could still be treated if all the medical wards were full. During our inspection we found ten medical patients who had been admitted to the surgical wards due to a lack of available medical beds on their admission. Senior staff held a bed management meeting daily which we attended. During this meeting all medical patients cared for in surgery wards were discussed. Plans were agreed for moving these patients to an appropriate medical ward as beds became available. Surgical staff we spoke with told us they ensured that they could meet the needs of medical patients before agreeing their admission to the surgery wards. If they felt that they lacked the specialist skills required to provide safe care to an acutely ill medical patient this patient would be admitted to a specialist

medical ward or transferred to the John Radcliffe Hospital. Medical patients were assigned to a named consultant responsible for their care from admission. This meant if medical patients were admitted to other specialist wards they could be reassured that they would receive appropriate clinical input. Surgical staff confirmed that medical staff attended the ward to carry out ward rounds and were available on the hospital bleep system at other times.

The trust had made arrangements to ensure patients had access to out-of-hours pharmacy to supply any additional medications required. This service was provided from the John Radcliffe hospital once the pharmacy was closed at Churchill hospital. However, we found on occasions there were delays in obtaining medication for patients. An electronic system was being introduced by the trust to improve the processing of out-of-hours medicine.

Leaving hospital

Several patients on the medical wards were ready to be discharged. Staff and patients told us that there had been delays in patients leaving the hospital for a variety of reasons. Staff explained that delays in discharge were frequently due to patients waiting for community care services. One patient told us ''I cannot go home and continue with the treatment because I am out of area and don't have any support staff to assist with treatment where I live. '' Two other patients told us that they had not been told when they were likely to be discharged.

Staff told us that patients could wait a long time for their medication on the day they were discharged. They explained that prescriptions for take home medication were not always written by the doctor and processed by the pharmacy in a timely manner.

The matron told us that the hospital was working with stakeholders to deliver the discharge improvement programme to improve the internal and external discharge arrangements. This programme included actions to improve the processing of medication for discharge. Discharge planners were being recruited on medical wards responsible for coordinating patients' discharge. They would plan patients' discharge from admission, ensuring all relevant information was shared with social services and liaised with care agencies and arranged transport. A weekly multi-agency discharge meeting took place. During this meeting all the patients reviewed by the Discharge Pathways team were monitored to ensure that appropriate arrangements were in place to meet patients' needs following discharge. The hospital audits out-of-hours discharges, and overnight discharges remain low at 0.6% of patients.

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

Learning from experiences, concerns and complaints

The medical wards captured and responded to patient feedback. This included results from the Friends and Family test, complaints and comments, Patient Advice and Liaison Service (PALS), Healthwatch Oxfordshire, National Inpatient Survey, Patient Led Assessments of the Care Environment (PLACE) and Patients Stories. Churchill hospital had received the trust's lowest score for food in the 2013 PLACE assessment. We were told the food provision had been reviewed and patients we spoke with expressed satisfaction with the choice and tastiness of food. The acting divisional head of nursing and governance told us that patients and relatives primarily raised concerns about communication, not receiving appropriate assistance and discharge on the medical wards. Actions were in place to address these concerns and to gain a better understanding of how concerns could be addressed swiftly on the wards.

Patient feedback was reviewed at monthly medical division meetings. Two Patient Stories relating to diabetes care were presented at Trust Board and Quality Committee meetings in February 2014, one of which related to Churchill Hospital. Lessons learnt from these patients' experiences were captured in an action plan which included training for staff in adhering to diabetes protocols and supporting patients to manage their anxiety.

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

Good

Medical care (including older people's care)

Are medical care services well-led?

Good

Vision, strategy and risks

The trust told us they were committed to ''Delivering Compassionate Excellence''. They described the culture and values underpinning the hospital as ''learning, respect, delivery, excellence, compassion and improvement.'' During discussions we had with staff it was evident they shared the trust's values. They were proud of their hospital and were committed to providing good care to their patients.

We spoke with staff from all levels in the medical division including the clinical director for acute medicine and rehabilitation. Systems were in place to ensure that risks were identified and understood on all levels. The concerns regarding recruitment and discharge shared by staff on the wards were the same as those captured at division and board level.

Governance arrangements

During our discussion with senior managers, ward staff and clinical specialists it was clear that monitoring and governance arrangements were in place in the division. Sisters and the matron we spoke with were clear what their responsibilities were in analysing and reporting on quality information. We saw information on noticeboards that provided feedback to staff on the outcomes of audits and governance meetings. The matron told us how they had contributed to the recent safe staffing assessment as well as compiled incident information to be submitted to the division's monthly quality meeting.

The hospital monitored risks to the delivery of care through a risk register. Several risks relating to the physical environment in parts of the Churchill Hospital had been identified and actions plans were in place to reduce the risks. Actions that had already been taken included fixing the roof for the John Warin ward which should reduce risk of leaks. The action plan noted that concerns ''have been escalated to divisional level and are currently being escalated to executive level''.

Leadership and culture

Staff told us they felt supported by their immediate managers and were able to raise concerns with them and felt they would be listened to. Many staff had lead responsibilities for enhancing patient pathways on the medical wards. This included dementia, falls, consent and safeguarding champions. Senior staff told us that the shift handover time had been reduced. This time was often used for team meetings and the matron told us that alternative time for team meetings was being sought.

The ward sisters from the Churchill Hospital rotated attendance at the John Radcliffe Hospital sisters meetings between them. This ensured management and leadership issues were identified from the wider trust and cascaded to senior staff at the Churchill Hospital. The sisters development programme was available to ward sisters to develop their leadership capabilities to solve problems, innovate and manage change was available to staff.

Human Resources' practices promoted a culture of compassion towards patients. The hospital used values based interviewing to ensure that staff were recruited that prioritised high quality and compassionate care. The matron explained to us how this had been implemented in the recent recruitment of Spanish nurses to medical wards. They also told us how the hospital's values had been incorporated in the clinical support workers academy as well as the competency bridging course for foreign workers.

Patient experiences, staff involvement and engagement

Patient views and experiences were sought by the hospital, by the provision of quality questionnaires, and fed back to staff on the wards. We saw patients had access to information about the ward or department as this was displayed in the corridors. This demonstrated openness by the hospital to engage with patients and listen to their feedback to improve the services provided.

Information from the NHS Choices website gave the Churchill hospital 4.5 stars out of 5 overall with high scoring for cleanliness, staff co-operation, dignity and respect and involvement in decision making. They scored 4 stars out of 5 for same sex accommodation. The monthly quality reports showed that the wards had been effective in increasing the completion of the Friends and Family test in both the Geoffrey Harris and John Warin wards this enabled them to understand the experience of a larger group of patients.

Posters were observed in the hospital inviting staff to share their opinions regarding the service provided through the

initiative known as 'listening into action' which was running in the hospital. This focuses on three areas of change; quality and safety, the patient experience and working together. The hospital continued to embed the Listening Into Action (LiA) project. This empowered staff to find innovative solutions to problems they identified. The medical wards were identifying their LiA champions.

Not all staff had been provided with annual appraisals or supervision. Staff were confident they could approach and talk to senior managers if they needed to. Ward managers were able to provide the up to date figures for staff appraisals on their ward and we saw these had improved since the findings of the NHS staff survey for 2012.

Learning, improvement, innovation and sustainability

The hospital took part in national clinical audits where eligible to do so and outcomes from these audits were provided to staff.

During 2012 the trust launched a five year vision for the organisation, which included the Churchill hospital, and which aimed to deliver continuous quality improvement with a focus on three key areas for 2013/14: patient safety, patient experience and clinical effectiveness. This showed the commitment of the hospital to engage with improving services to patients.

Good

Surgery

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

Information about the service

The Churchill Hospital provided surgical care and treatment for people on five inpatient wards which include the Oxford Colorectal Centre, Oxford Upper Gastrointestinal Centre, Urology Ward and the Jane Ashley Centre. There is also a day surgery unit, a theatre direct admissions unit, a complex of 10 operating theatres with a recovery and an overnight recovery unit.

We visited three surgical wards, two operating theatres, and recovery areas and talked with 12 patients and 15 staff including nurses, doctors, consultants, therapists and support staff. We observed care and treatment and looked at care records. We received information from our listening events, focus groups, interviews and comment cards. We used this information to inform and direct the focus of our inspection. Before our inspection, we reviewed performance information from, and about, the trust and the hospital.

Summary of findings

There was consensus among patients, carers and staff that staff were dedicated and provided compassionate, empathetic care. Processes were followed to reduce any risks to patients undergoing surgical treatment.

Staff made use of the language line facility and interpreters to ensure patients had a good understanding of their treatment and were able to make informed decisions.

Staff had a good understanding of the Mental Capacity Act 2005 which meant patients received the appropriate support to be able to make their own decision, or where required decisions involving appropriate people were made in the best interest of the patient.

Generally, there was sufficient equipment available to meet the needs of patents. However, concerns were expressed about access to radiology for some patients. This meant that patients had to undergo radiography procedures on the day of their planned surgery, rather having all investigations completed prior to the day of planed surgery.

There was evidence that learning from incidents occurred and that changes were being made in response to findings from quality auditing processes.

We saw good evidence of team working at ward and departmental level.

Good

Surgery

Are surgery services safe?

Good

Safety and performance

Safety in theatres at the Churchill Hospital was good. There were 206 patient safety incidents (trust wide) reported by the trust's surgical services to the National Reporting and Learning System (NRLS) between July 2012 and July 2013, accounting for 34% of all incidents reported across all specialities. Of these, 192 were graded moderate, 11 abuse, two severe and one death.

Between December 2012 and November 2013, 35 serious incidents were reported in surgical services trust-wide. Twenty were in ward areas, four in operating theatres and one in a day case theatre. Of these, two were categorised as never events.

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

The safety and wellbeing of patient's undergoing surgical procedures was protected through following best practice guidance. The Oxford University Hospitals Trust used the World Health Organization's (WHO) surgical safety checklist in operating theatres. The WHO checklist is a system designed to prevent avoidable errors. We saw good use of the checklist in the two operating theatres where we observed practice. The theatre staff we spoke with said the checklist was done well. Weekly and three monthly auditing of the WHO checks lists meant that processes to ensure patient safety were being monitored.

Assessments for the risks of pressure ulcer development, venous thrombosis and risks of falls were completed and relevant action was taken to reduce identified risks. This included the use of pressure relieving equipment and prescribed anti embolic stockings both on the surgical wards and in the theatre complex.

The Oxford University Hospitals Trust had a children's and adult's safeguarding policy. Training about safeguarding adults and children was part of the mandatory annual training that all staff were expected to complete. Staff knew about the policy and were confident about reporting safeguarding concerns.

Learning and improvement

The hospital learned from incidents and took action to avoid re occurrence. Theatre staff gave examples about changes in practices made as a response to incidents that had occurred. This included incidents that occurred locally at the Churchill Hospital and incidents such as never events reported across the trust. There was a process for informing all staff about reported incidents and action that needed to be taken to reduce the risk of similar incidents occurring.

On the surgical wards, staff knew about the process to report incidents. We were told that staff received prompt feedback about any incidents they reported.

The trust used a process of peer reviewing to assess the quality of the service being provided. The divisional nurse for surgery and oncology discussed the shortfalls identified at their recent peer review (November 2013) and the actions that had been taken to make the necessary improvements.

Systems, processes and practices

The wards had systems and practices to follow to ensure patients received consistent and safe care. Care plans were used effectively to inform staff about the care and support each patient needed which included identifying risks and implementing action to reduce the impact of the risk. Care plans for patients identified at risk of pressure ulcer development detailed the types of pressure relieving aids that needed to be used. We saw that these were being used.

A "track and trigger" system was being used on the surgical wards. The aim of this tool was to ensure the early detection of any deterioration in a patient's condition so that timely intervention could take place.

There were sufficient hand washing facilities on the surgical wards and in the operating theatre complex. Anti-bacterial gels were situated at the entrance and exit to all wards and the theatre complex and on the end of patient's beds. Patients told us that staff washed their hands between contact with each patient, and we saw them do this.

Good

Surgery

Patient education meant they were aware of the importance of hand washing. This was confirmed in conversations we had with patients. This practice reduced the risk of cross infection.

The divisional nurse for surgery and oncology informed us that it had been identified during the peer review quality assurance process that resuscitation equipment on the wards was not being checked daily. We looked at checking records for the resuscitation equipment and other emergency equipment on two of the surgical wards. They had been checked daily to ensure all equipment was in date and in working order.

There was sufficient equipment to meet the needs of the surgical patients. We saw that equipment for the procedures and monitoring of patients in the operating theatres was readily available. Staff told us that the required equipment for procedures was always available. On the wards there was sufficient equipment available to monitor and support patients. We saw monitoring equipment, pressure relieving equipment, moving and handling and other clinical equipment available in suitable numbers. Procedures were in place to ensure all equipment was routinely serviced and checked. We saw records to evidence this was occurring.

Monitoring safety and responding to risk

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

There were staff in sufficient numbers and skill mix to provide safe and effective care. The trust had completed a recent review to determine the correct level of establishment and skill mix for staff on in patient wards. We saw on each ward a chart that identified the ideal level of staffing for each shift, adequate level of staffing and details about what level of staffing would mean patients were at risk of poor and unsafe care. Staff said they used this guidance to request extra staff if for any reason staff numbers indicated patients were at risks of poor or unsafe care. Patients told us there were always sufficient numbers of staff on duty to support them with their needs. Patients and visitors commented that call bells were answered quickly.

To ensure continuity of care for patients the surgery and oncology division had employed 'long term' agency nurses while recruitment to permanent positions was completed.

A permanent night team for the operating theatres had been employed, supported by a second team of staff being on call at night. This was in response to demand for theatre activity at night due to emergency cases and organ transplantation.

Staff were effective at supporting people in making their own decisions and choices. Staff had a good working knowledge of the Mental Capacity Act 2005. Training about the Mental Capacity Act 2005 was included in the mandatory safeguarding training for all staff. Staff demonstrated in discussion that they understood the application of the Mental Capacity Act 2005.

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

Good

Using evidence-based guidance

Evidenced based guidance was being followed to deliver effective care. The pre admission nurses followed the National Institute for Health and Care Excellence (NICE) guidance for pre admissions when assessing patients. The WHO check list was used in the operating theatre complex to ensure patient safety. On the transplant ward relevant guidance for transplant procedures and check lists were followed.

Performance, monitoring and improvement of outcomes

We found that generally patient record keeping was good. On the wards records were good, with a few gaps, but overall well completed. We saw that monitoring of patients health and wellbeing was completed at the intervals as stated in their track and trigger charts or their plans of care. We saw that patients care was reviewed daily and their care plans altered according to their needs and wellbeing.

Staff, equipment and facilities

Staff we met said they felt encouraged within their division to learn and improve. Staff were appraised and given opportunities for personal development. Nursing staff on wards had specific link roles, such as palliative care and

infection control. They were enabled to attend specific training and meetings with regard to their link roles. Appraisals were being held with staff in accordance with guidelines and they were up-to-date for all available staff.

Patients were supported to meet their nutrition and hydration needs. Nutritional needs were assessed on admission and plans developed to support people to meet their nutritional needs. Inpatient wards had protected meal times, so patients were not disturbed when having their meals. Patients told us that the variety of food was satisfactory. Patients on the transplant ward told us they had access to a dietician to support them with their dietary needs. One patient said, "I get a dietician, they get me quite good food. Special diets are accounted for." A second patient on another ward said the dietetic department had supported them to gain weight so they would be fit for surgery.

Patient's pain was generally well managed. There were processes followed for monitoring patient's pain. However, one patient on the colorectal ward had experienced delays at night in receiving their pain relieving medication which had caused them distress. This, the patient told us, was a one-off situation and after they had made the ward manager aware of their experience, they were confident that action had been taken to reduce the risk of a similar occurrence happening. Other patients said that staff provided them with pain relieving medicines when they needed it. One patient said, "pain management is excellent." A second patient told us that the medical staff talked to them a lot about pain management. A third patient said they saw the pain specialist every day."

Support from the radiology department was not effective at ensuring all patients had the scans required for surgery. We were told that the radiology department could not keep up with requested scans for oncology patients. This meant that some patients had to have scans on the day of surgery rather than have all investigations completed prior to surgery.

Multidisciplinary working and support

Regular multidisciplinary meetings took place on the wards. These were attended by the medical, nursing and therapy staff together with the patient and/or their representatives when appropriate. Detailed records of the outcomes of these meetings were recorded in detail in the patient's records.

Patients spoke about the involvement of the whole team in their care. This meant the involvement of specialist nurses, physiotherapists and occupation therapists, medical and nursing staff. Patients commented that communication across all teams was good. One patient told us "The medical team have been marvellous and they have obviously been talking to each other." A second patient told us there was good communication between the two different specialists involved in their care.

Are surgery services caring?

Good

Compassion, dignity and empathy

Patients' experience of care was good. All patients we spoke with told us staff were caring and kind. We observed good care on all wards, in all interactions. Patient comments included "I feel very safe. I feel very confident about all people around me. It's a very very nice place to be if you are ill", "I feel as though I am being looked after by people who really know what they are doing and are genuinely concerned about my wellbeing. They are very happy I am getting better" and "This department is outstanding…better care all round, even the tea lady is fun…nothing is too much trouble for the staff."

Patient's privacy and dignity was respected. We saw that curtains were drawn around patient's beds when personal care was provided. Ward accommodation was segregated so men and women were afforded privacy and dignity. On some wards accommodation was all in single rooms, which aided the promotion of privacy and dignity. Patients told us they could request whether to have a male or female member of staff providing their personal care and those arrangements would be made with the staff complement to comply with their request.

Patients had access to call bells which they could use to call for assistance. We saw that these were in easy reach. Patients told us staff responded promptly when they called for help.

We saw the results from friends and family tests were displayed in each of the inpatient ward areas. This showed a high level of satisfaction with the service provided.

Good

Surgery

Involvement in care and decision making

Patients felt they were appropriately involved with their care. All patients we spoke with told us that full explanations were given to them by medical staff and nursing staff about their proposed treatment in manner that they could understand. They said consent procedures had been done well. We were told by a patient, "Everything I have ever had done has been well explained, I have always been kept in the loop." They told us "I was not pushed to sign consent, I get the last say."

Patients for planned admissions had appointments with the pre admission nurse prior to their admission. Literature about their operation/treatment and what to expect when they came into hospital was provided both in the written form and verbally at this appointment. Most patients told us they felt fully informed about their admission and treatment.

Patients were supported to manage their own medicines. Assessments were completed of patient's capacity to manage their own medicines. Patients told us that they were assessed by nursing staff before being deemed competent to manage their own medicines. Records we looked at evidence this process took place.

Trust and communication

Patients said staff were friendly, open, and sensitive to their needs. Patients said they were encouraged to ask questions if they did not understand the treatment being provided. Staff were able to access a telephone language link service to support patient's whose first language was not English. If needed interpreters were employed to assist with communication. Staff gave examples where they had used interpreters during the treatment of patients to ensure they understood and were able to make informed choices about their care and treatment.

Information about the trust and the hospital was available on the trust's website. This included easy read information for people who had difficulties understating written word, leaflets about various conditions and what to expect when undergoing surgery. The website could be translated into a number of different languages.

Emotional support

Patients and relatives told us they received the support they needed to cope emotionally with their treatment and hospital stay. There was a chaplaincy service available for people of all religious denominations. Some patients spoke positively about the support they had received both emotionally and practically from specialist nurses.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patient needs were being met. Patients told us they were happy with their care and said their needs were being met and that all staff were responsive to their needs. They said "nothing was too much trouble." Most people who had used their call bells when they needed help said, staff always responded quickly.

Vulnerable patients and capacity

Patients admitted to the surgical wards were assessed to protect their rights and meet their needs. Staff said patients who were not able to make their own decisions due to a lack of mental capacity would have care and treatment given in their best interests. The family or an advocate for the patient was involved in any decisions along with the patient's medical team. This process was confirmed in a conversation we had with one patient who had been very unwell and decisions about treatment had to be made on their behalf. They told us that the decision that had been made was the decision they would have made had they been well enough to make that decision. This showed that the team making that decision had a good insight into the wishes and beliefs of the patient and were therefore able to make the appropriate decision on behalf of the patient.

Staff had experience of supporting people with a learning disability. Staff knew about the 'hospital passport' which was a document people with a learning disability usually brought with them to tell health and social care providers more about them. The document said what the person liked, did not like and how to treat them. Staff said the carers for the patient were closely involved with their care and staff took advice from them to help support the patient.

Good

Surgery

Access to services
Access to services was good. Patients told us that there were no delays with their admission to hospital. Staff told us cancellations to surgery lists were primarily due to patients having not received admission letters.

Leaving hospital
Most of the patients we spoke with had been given information about their discharge from hospital and they knew when they were expected to be discharged. If needed they had been assessed by physiotherapists and occupational therapists about their home circumstances and the support available to them. Arrangements were confirmed about how they would get home.

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

However, one of the 14 patients we spoke with expressed concerns with their previous discharges. They felt they had not received sufficient information to enable them to manage their illnesses and condition on discharge, This they believed had resulted in re-admission to the ward. However, they said that they now felt they had sufficient information to manage independently when they were discharged from hospital.

Learning from experiences, concerns and complaints
The divisional nurse had told us that the peer review process had identified a lack of patient information on the wards. Most patients had received this information during pre-assessment processes. We were told that as a result of that finding processes were being implemented to make sure the information patients had received prior to admission was understood before they were discharged. Other patients spoke how good the discharge process was and that if they had any concerns they were given the number of the ward to ring for advice and support.

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

The wards we visited had received few complaints. As a result, most staff we asked could not identify any themes within the complaints received.

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

Are surgery services well-led?

Good

Vision, strategy and risks
There was a clear trust vision and a set of values, which were patient focused. Many staff did not know what the vision and values were but portrayed similar values and passion and motivation to provide excellent patient care. Senior management and other staff we spoke with were clear about the trust mission and values.

Governance arrangements
There was a clear governance structure with reporting lines from departments through directorates and divisions, ultimately to the trust board. Quality and performance were reviewed with the peer review process and any concerns or problems identified were discussed and strategies developed to address them. There was a system for learning from incidents.

Leadership and culture
Staff said they were well supported. There was a mixture of new staff and others with many years of experience. New staff said they had been made to feel very welcome and there was a planned induction programme to follow.

The staff said there were good working relationships between the medical staff, nurses and other professionals. They felt supported in their roles and were comfortable to raise their concerns at local level. Staff told us they were satisfied with the local management arrangements, and from information on the trust's internal website and email communications were aware of the leadership of the organisation and trust board.

Good

Surgery

Patient experiences, staff involvement and engagement

Patients' views and experiences were a key driver for how services were provided. There was information displayed in wards showing how the ward was performing and what the friends and family test results were telling them. Staff said they felt involved and informed about patient safety and experience. The divisions that each ward was aligned to held regular staff meetings where all staff could participate. Staff on wards said that attended or were represented at handover meetings when shifts were changing.

Learning, improvement, innovation and sustainability

The surgical and oncology division had recently introduced new nursing roles with the aim of improving outcomes for patients using the service. This included the introduction of enhanced recovery nurses and nurse practitioners. Links had been made with local higher education establishments to support training for operating department practitioners.

Good

Intensive/critical care

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

Information about the service

The critical care unit at Churchill Hospital has eight beds. There were arrangements to provide 24 critical care beds between the adult intensive care units at John Radcliffe hospital and Churchill Hospital. This allowed for flexibility of how many beds were available at each hospital but would not exceed a collective bed number of 24. At the Churchill Hospital the beds organised as six bays and two side rooms.

Critical care covers both intensive care and high dependency care with level 2 being high dependency and level 3 being intensive care beds. The critical care department at Churchill Hospital had level 2 and level 3 beds and which were considered as critical care and not high dependency beds.

We visited once during the day and talked with one patient, this low number was due to the difficulties in communicating with some critically ill patients. We spoke with 14 members of staff. These included nursing staff, consultants, junior doctors, and management of the units. Before our inspection, we reviewed performance information from, and about, the trust and listened to comments from people at our listening events. We also reviewed data from the Intensive Care National Audit & Research Centre (ICNARC) for April 2012 to March 2013.

Summary of findings

Alert systems were in place to escalate patients with deteriorating health from the wards to intensive care. However, most patients at Churchill on the critical care unit were planned as surgical post-operative care. No trauma or accident and emergency admissions came directly to this unit. A patient follow up system was in place to ensure patients leaving critical care and returning to the wards were well supported. There was consultant cover on all of the departments 24 hours each day.

Patients received safe care. Clinical outcomes were monitored and demonstrated good outcomes for patients. Care provided was effective with a multidisciplinary approach taken and good standards of facilities to meet patient's needs. While staff recruitment and retention was recognised by the trust as an issue, the levels and skills of staff on a day-to-day basis were consistently managed by using staff from John Radcliffe Hospital.

Patients told us the kindness and care of staff was good. The unit was responsive to the needs of the patient and learned from safety events or incidents. The departments were well led and demonstrated a positive leadership and open culture to enable staff to feel involved in changes.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety and performance

Monitoring took place to promote patient safety. Each the critical care units in the trust used a standardised record for measuring their performance and so all safety data was comparable. This increased the learning available to each critical care unit. Saving lives data was collected and the audit results were visible in the staff room. Safety audits included a monthly check on infection control assessments, falls, urinary tract infections and incidents relating to pressure damage. Churchill intensive unit had not had any falls or urinary tract infections in the most recent audit. The hospital trust contributed their data to the Intensive Care National Audit and Research Centre (ICNARC) in order that they could be evaluated against similar departments nationally. The results of this and all monitoring was reviewed and discussed at divisional meetings each month. Monitoring of mortality included comparisons to other trusts. We saw that ICNARC data from the first two quarters of 2012/13 showed the Churchill Hospital Intensive Care Unit units had a Standardised Mortality Ratio (SMR) that lay comfortably on or below (better than) the mean value. Further data was also monitored monthly which related to the views of patients and their relatives. The comments made by patients and relatives were used when needed to change practice on the units.

We saw that patient's safety was considered and well managed. The unit had security arrangements in place to ensure the safety of patients on the ward and anybody entering the ward was checked and when needed prepared before visiting their relatives. Patients who were unconscious or unable to comment were protected from inappropriate people on the unit.

Learning and improvement

Staff told us and records showed they learned from untoward events. All serious incidents were recorded through the incident reporting system and were investigated and discussed at the divisional governance meetings. Staff told us that they received feedback from those meetings and learning from all of the critical care units was shared to develop and improve practice.

The unit had developed its own focus group which afforded staff the opportunity to discuss the challenges of working on the intensive care unit and about how to deliver compassionate care to families and carers.

Systems, processes and practices

Systems for patient records were managed safely. Nurses used an electronic system for care records and information. Medical and nursing staff told us this system was suitable for purpose and secure access was maintained by staff using passwords to access patient notes. The electronic records excluded do not attempt resuscitation records. All electronic stored information was backed-up and could be transferred into paper records in preparation for transfers to other wards when patients were discharged. Electronic prescribing systems had been implemented and medicine records could be reviewed by the unit pharmacist either on the unit or remotely.

Infection control and hygiene was monitored and the results made public on each unit. The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) lay within a statistically acceptable range, taking into account the trust's size and the national level of infections. We observed good hand hygiene taking place in all areas. An infection control lead nurse worked on the unit and undertook regular audits. The current hand hygiene audit had an overall score of 84% compliance. This was broken down to doctors 82%, nurses 92% and visiting doctors 29%. Resulting learning from this meant that further training would be planned for visiting doctors. An equipment cleaning audit was done monthly and daily cleaning included bed areas. We observed that side rooms were used when patients presented with any kind of potential infectious symptoms. While empty, a negative pressure system was used to ventilate those rooms to reduce spread of airborne particles.

Medicines and equipment were safely stored. All medicines and equipment was stored securely and were only accessible by the staff on the unit. Stock medicines were checked and good stock levels maintained. The storage of equipment was well managed and all equipment needing collection for repair was clearly marked.

Facilities in the intensive care unit were of a high standard and the unit had been purpose built. It was clean, spacious and suitable for purpose. Staff told us that they had sufficient equipment to meet the needs of the patients. All

equipment was stored above floor height and systems were seen for the repair/replacement of equipment. Equipment was standardised and made available across the two hospital sites.

Accommodation was available on all of the units for relatives to stay overnight. There was also a sitting room available for staff to explain to relatives what was happening and a room available for the delivery of bad news.

Monitoring safety and responding to risk

Monitoring systems were used to make improvements to safety and work practice. Bed allocation meetings were held throughout the day. This allowed the opportunity for discussion about the need for intensive care beds or the timing of discharges from intensive care to the wards. This enabled staff to communicate earlier with theatre staff to plan the theatre lists and promoted a more effective way of working. This was also an opportunity for staffing issues to be raised and addressed if possible on site. Systems were in place to access extra staff if needed. There was access to a contingent workforce, most of whom had experience of working on the unit before.

The critical care departments recognised and understood risks. The managers for each critical care unit decided what risks were escalated to the service risk register and how they were to be managed. Issues related to pressure sores, medicine errors and capacity of the unit were high areas of identified risk.

All deaths on the critical care units were reviewed to inform and direct current practice. These were discussed by the medical teams to ensure learning from outcomes.

There was a surge escalation plan in place in preparation for any emergency requiring critical care beds.

There were sufficient medical and nursing staff available on the unit. Staffing levels followed national guidelines about caring for critically ill patients. This meant that for a level three patient they received one-to-one care. For level two patients they would share one nurse between two patients. This was because they had less critical care needs. Further staff were also available to assist with tasks including moving and handling and transferring patients. The staff rotated between three hospitals and a system was in place whereby staff rang a taped message each morning to find which unit they were working on that day. Staff told us that this system was not a problem to them.

Medical staff and consultant staff was available 24 hours per day and seven day cover was provided at all times. There was one consultant and two junior doctors each day and one consultant and one junior doctor overnight. Medical cover was rotated three to four weekly over the John Radcliffe and Churchill Hospital adult intensive care units and all doctors were intensive care trained. Doctors felt well supported and had unlimited access to senior medical staff. Medical staff told us that they found the handovers of information to be well organised.

Patients who lacked the mental capacity to make a decision were supported to ensure that their best interests were served by using the Mental Capacity Act and Deprivation of Liberty Safeguards. A checklist was available for staff to use to guide assessments of mental capacity. For those patients who lacked the capacity and temporary ability to make decisions, decisions were made by medical staff in their best interest. This was recorded to include the rationale for the decision and who was involved including family members/representatives or advocates for the patient.

Anticipation and planning

There was not an outreach team available in the hospital to visit and assess deteriorating patients with a view to admission to the critical care beds. A system was in place to alert staff to the level of deterioration considered to be in need of critical care. Staff told us that the “track and trigger” tool to ensure early detection of any deterioration, monitoring in place on the wards was effective. There were systems in place to review how this alert system was undertaken and its level of success. Churchill Hospital admissions were mostly planned for post-surgery critical care.

As part of the discharge planning a follow up team was in place available seven days per week. This altered to cross site cover at the weekends. We spoke with the follow up nurse who advised that as part of discharge planning this service supported the patient and staff on the ward for transfer.

Good

Intensive/critical care

Are intensive/critical services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

Patient's received care in line with national guidelines. We saw that the management of skin damage by pressure or moisture damage was effective. The role of a unit-based tissue viability nurse had been allocated and this nurse visited twice each week and ensured staff were kept up to date with new methods and equipment. Trolleys of dressings were being implemented to enable staff to access the equipment they needed quickly and easily. All grade 2, 3, and 4 damage was recorded as a notification to inform the hospitals auditing process. These were also discussed at clinical governance reviews to consider if the current methods of management were effective. The tissue viability lead audited all pressure damage daily which showed a reduction in skin damage. In the previous month the unit had only one reported incident of pressure damage. Any learning outcomes were shared across all of the critical care units. However, it was noted that the high health risks of patients receiving critical care often meant that pressure damage could not always be avoided.

Performance, monitoring and improvement of outcomes

Outcomes for patients were good. The adult intensive care department was equipped for up to eight patients with a flexible arrangement with John Radcliffe Hospital to accommodate up to 24 patients between them. The trust's bed occupancy average for July to September 2013 had been higher than the England average and above the recommended rate of 85%.

We were told by staff that there was an issue with delayed discharges and this had impacted on planned admissions following elective surgery. Information received showed that in January 2014 two elective surgeries had been cancelled. However, for critical care beds, the trust's occupancy rates have been lower than the England average for the period of September to November 2013

Mortality rates at Churchill Hospital had not been raised as an area of concern. The ICNARC data for the first quarter of 2013 showed that there were a number of unplanned readmissions within 48 hours. The number is higher than would be considered the normal rate and had appeared to have doubled in the past year. This may be related to the type of patient admitted post-surgery or the lack of high dependency step down beds available to meet the needs of level 2 patients. Further information supplied to us showed that in January 2014 two patients had been readmitted within 48 hours. Since August 2013 to date nine patients had been readmitted. The unit manager told us that any re-admission was reviewed to identify the reasons for the readmission as part of the governance arrangements. Any issues identified would be addressed.

The management of deep venous thrombosis was recorded electronically and staff reviewed equipment and medication needed routinely to reduce the risks to patients of thrombosis. A warning on the electronic recording system reminded staff to complete this area or reminded them if a review was due.

There were no reports of any hospital-acquired infections such as MRSA or Clostridium difficile for the previous month to our inspection.

Staff, equipment and facilities

The trust continues a foundation training programme for all nursing staff to ensure sufficient training in critical care. This included competence assessment and observation of care being provided. An induction programme took place for all new staff. These staff were extra to the planned number of staff to afford them time for learning. Further specialist training packages were available to support staff and time was made for mandatory training to take place. A mentorship programme by band seven nurses provided further support to new and existing staff. There was a colour coded name badge system which allowed new starters to be recognised by the broader team and therefore supported more effectively. We were told that 96.2% of Churchill staff had completed all mandatory training areas. These included, safe moving and handling, infection control and fire safety. Further training to develop competencies were available to assist band five staff prepare for band six roles.

Multidisciplinary working and support

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

We saw the input from therapists included physiotherapy, a dietician and occupational therapy to promote the health and welfare of patients. The unit had two dedicated

physiotherapists each day with only one working at the weekend as most admissions were for elective surgery and this did not take place at the weekend. We saw that the allocated dietician used to support the nutritional needs of patients had been cut back and was now available by referral. The follow on team worked with ward staff to support critical care patients who had improved and moved on to wards. The management of organ donation was managed within the critical care unit. Organ donation staff visited the unit twice weekly to ensure staff were aware of the procedures to follow and the access to contact information for transplant

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

Patients and relatives spoke in the highest terms about the staff and the care they had received. They said staff had explained to them at each stage what was happening and treated them at all times with dignity and respect. One patient, who was a planned admission following surgery, felt totally prepared for the admission to the intensive care unit. The patient had been given a mobile telephone to maintain contact with relatives and felt they had received "five-star care."

The unit was a mixed sex area but curtains were provided to ensure the dignity of the patient. Each bed had 2.5 m-wide unobstructed circulation space provided at the foot of each bed space in line with HBN 04-02.This allowed for the use of equipment and also enabled staff and family to be able to discuss quietly and have a degree of privacy.

Involvement in care and decision making

Patients who were able to talk to us said they felt involved in what was happening to them. Decisions were taken in the best interest of patients. Consent was actively sought on all levels including consent to provide personal care and consent to change position. Pre surgery consent was received in a signed format. For planned post-surgery admissions the manager told us that patients were visited and supported to understand what to expect on the unit. At the time of this inspection no patients needed a Do Not Resuscitate decision made about them and as such we could not see documents relating to this. Policies relating to this issue were available on computer for staff to follow. Staff explained what action would be taken should the patient not be able to participate in the decision process. Recently a decision about resuscitation had taken place and staff described time spent sitting and talking with the people concerned to gain an understanding of how the situation should be managed.

Trust and communication

Patients and relatives had the opportunity to speak regularly with doctors and nurses about their care and treatment. When patients stayed for a period of time on the unit staff took time to get to know the patient and their relatives. For those patients who had specialist communication needs, information about how best to communicate was obtained prior to admission to support both the patient and staff to communicate better. Staff told us that recently following a particularly long admission staff developed trust and friendship with relatives who later visited the unit to see the staff and left a gift for staff to remember their relative. We observed staff sitting with patients and chatting, taking time to talk then through the procedures and discuss the day. We saw staff assisting a patient to sit out into a chair. This was done slowly with full explanations given to support the patient and staff stayed with the patient to ensure they were safe and confident.

Emotional support

Emotional support was provided both during admission and after discharge from the critical care units. Staff took time to explain procedures to patients and their relative to try and allay any anxieties and fears associated with an admission to the unit. Prior to elective surgery staff would prepare the patient for admission to the unit with explanations of what to expect. A room was available for the delivery of bad news which enabled relatives to have time and privacy to discuss news with doctors and nursing staff.

A focus group of patients had been developed to discuss issues that had arisen following discharge. Information was available about life after intensive care and information for relatives. Visiting at Churchill Hospital Intensive care unit was open and a pleasant waiting room was available with facilities for them to rest when visiting.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

Intensive/critical care

Good

Meeting people's needs

Patients said they felt well cared for. Meetings took place earlier in the morning on the unit to assess each patient and decide if they would leave the unit that day. This also enabled the availability of beds to be assessed earlier. This information was then passed to the theatre department to inform the theatre list for patients who required post-surgery critical care beds to establish if they would have a bed or not. Those patients who had a tracheotomy in place were only considered for discharge early in each week to ensure sufficient medical cover was available. These patients were sometimes cared for a little longer on the critical care unit while they waited for a bed on the respiratory ward. This was because they had specific and specialist nursing needs, Delays of four hours or more to transfer did however take place and three patients had delayed discharges in the last month. The ICNARC data showed that delayed discharges were higher than expected. We were told by staff of some cancellations in elective surgery due to bed capacity not being available and some delays in discharges. Information provided to us by the trust showed that no cancellations took place in December 2013. However, 27 cancellations took place in between August 2013 and January 2014.This information was recorded through a notification process to enable this data to be discussed at divisional governance meetings to try to establish the reasons for delay and how this could be avoided.

Once a patient was discharged to another ward the critical care unit had a follow up nurse from the critical care unit who visited patients on the ward. This follow up took place to ensure that the ward staff had the specialist support they needed and ensured a continuity of care for the improving patient. Initially patients were seen by the follow up nurse within 24 hours and depending on their health needs may continue to be visited by the follow up nurse daily. After that the follow up nurse would review and assess what support the patients and nursing staff needed. Should a patient be transferred to John Radcliffe Hospital, the follow up nurse would contact the follow up nurse at that location and ensure a continuity of care.

Vulnerable patients and capacity

For those patients who had a carer at home, for example patients with a learning disability, carers were involved with their care and staff took advice from them to help support the patient to ensure a continuity of care and to meet the patient's needs.

Visits could take place by the hospital Chaplain to support the spiritual needs of patients, relatives and staff regardless of their beliefs and a 24-hour on call service was provided. A place for prayer was also available for relatives and visitors.

Access to services

Over 1,200 critically ill adults were admitted to the two adult intensive care units at John Radcliffe and Churchill Hospital per annum. Facilities were available for relatives/carers to be able to stay overnight. The accommodation was pleasant and suitable for an overnight stay. Information available to relatives and carers informed them about what to expect from each unit, information relating to visiting times and facilities and how to raise a concern.

There were some links with the palliative care team for end of life support but this was not routine. Staff said that they had experience of transferring patients to the hospice for specific palliative care.

Leaving hospital

Patients were discharged with appropriate information. It would be very rare for any patients to be discharged home from the critical care units. Patients who left the unit for other wards or hospitals had a paper record of their electronic notes produced to accompany them. Should it be needed staff would go through the notes to explain any critical care records being provided. Any issues around discharge would be raised with the staff team to promote learning. The electronic systems in other parts of the hospital were not compatible with the electronic system on the critical care units and so printed notes were provided. Should the patient be sent to another hospital, sufficient information was provided to inform the receiving hospital. Training in transferring patients had been provided to all staff and so any inter hospital transfers would follow the hospital policy and equipment and transfer information would be recorded.

The hospital maintains a policy that no patients will be transferred between inpatient areas for non-clinical reasons between 8pm and 8am. This included transfers

from ward to ward and transfers to other health providers outside of the trust. Staff told us that every effort was made to adhere to this policy and a notification was made to record when these transfers took place. All transfers were planned to take place as early as possible in the day to enable handover communication to be effective.
Re-admissions to critical care units took place as a response to deteriorating critical conditions. The level of re-admission for each unit was measured against other units across the country using ICNARC data. The data for the early part of 2013 would indicate an increase in unplanned readmissions within 48 hours.

Learning from experiences, concerns and complaints

Each critical care department captured patient feedback. This included results from the Friends and Family test, complaints and comments. Each unit also requested information via their own questionnaires. We saw that all information received from the questionnaires had been reviewed and when areas for change had been identified, planned actions to make changes was posted on notice boards. Feedback provided to the unit was used to change practice. This included information about noise, the need for clocks and waiting times for relatives. Staff told us that they received feedback from notifications, complaints and patient experience feedback. No complaints had been received about the unit at the time of our inspection.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

Staff were clear about the trust vision for the future. They explained they had been involved in the development of the vision and felt involved in the strategy and future of the trust. These values included learning, respect, compassion and improvement. Some staff felt the executive board were more visible than others. Some staff did not know who their divisional lead was or who to contact with any board level questions. Staff were confident to contact the unit manager or matron to raise any issues or make suggestions on their behalf.

Governance arrangements

The critical care departments monitored the quality of its service. There were good arrangements for monitoring the service at local level and the results of the audits around care and practices were good. The critical care leads from each department met monthly. This was an opportunity to discuss any issues and feedback from complaints, review notifications or areas of concern. The divisional governance meetings were attended by managers from each unit. Risks were also discussed at this time and review of critical areas which may need escalating to the trust risk register. We reviewed the trust risk register and saw that risks around staffing were recorded, with an action plan in place to address the shortfall.

Leadership and culture

Staff told us that they were proud of the units they worked on and had felt supported as new members of staff. They told us they enjoyed working across the three sites of Churchill and Horton Hospitals and John Radcliffe Hospitals and had no concerns about the unit. The senior care team of band six and seven nurses provided a continuity of leadership at the Churchill Hospital.

Staff teams from each critical care department were well-led. Staff told us that they had “great leadership” and a supportive management team. Senior staff and managers were visible on the unit daily. Staff told us they felt able to approach the unit manager or matron with any issues or questions and that their views would be listened to and feedback given.

Board walk around took place and staff felt able to approach board members at this time to raise any questions or views. Management staff told us they felt listened to an involved in decisions which changed the service.

Patient experiences, staff involvement and engagement

Staff felt part of the hospital and wider trust. Complaints were managed via Patient Advice and Liaison Service (PALS) and staff told us that there were very few complaints but they were included and informed of broader organisational complaints. We observed a staff member explaining to a relative the complaints process and also making an effort to ensure that the concerns raised were also managed locally within the hospital.

Learning, improvement, innovation and sustainability

Staff were appraised and given some time for personal development. Staff appraisals were undertaken to support

and develop staff practice. Where areas of support were needed this was being implemented. This included the opportunity for staff to discuss with a psychologist when there had been challenging or distressing incidents at work. Staff we met said they felt encouraged to continue with learning and development of their practice. All policies and procedures were available on the electronic system on the unit to support and guide staff and ongoing learning was provided weekly on the unit.

Staff also told us that a recent peer review exercise had taken place. This had involved visiting each unit and reviewing the standards and practices taking place. Staff told us that this had been a valuable learning experience and one staff member felt this should be done more often to continue with the learning opportunities it presented.

Good

End of life care

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

Information about the service

End of life care was not provided in a single setting, but integrated in wards and departments across the hospital. The hospital had a palliative care team providing support to staff caring for patients at the end of their life or needing palliative care. The hospital also provided 24-hour palliative care advice to patients nursing staff and doctors by phone or by visits to patients if clinically indicated.

Sir Michael Sobell House Hospice offers expert care and support to those suffering with advanced or progressive life limiting illness. Multidisciplinary care and support is provided in the 18-bedded inpatient unit, day centre, patient's homes, and in the acute Oxford Radcliffe Hospitals.

We spoke to two patients on in haematology and oncology wards and the relatives of a patient in Sobell House. We spoke with five ward staff across Churchill Hospital and Sobell House.

Summary of findings

Patients received effective and sensitive end of life care. Patients told us they felt safe and their needs were met by skilled staff. Patients knew the reasons for their admissions and had made decisions about where to have their end of life care. Patients' pain was well managed by the clinical staff and they did not have to wait for their medicines. Staff respected patients' rights and, in particular, their privacy and dignity.

Palliative patients were able to make decisions about the medical procedures to be followed in the event of a cardiopulmonary arrest. If the decision was not to resuscitate in the event of a cardiopulmonary arrest, the decision was recorded and professionals made aware of the decision.

Patients were cared for with compassion by staff who knew how to care for patients at the end of their life. Hospital staff attended palliative care training and were able to attend study days on end of life care to update their knowledge.

Palliative patients had access to a centralised helpline which offered advice and referrals for admissions. End of life patients arriving on the emergency medical unit were assessed and transferred to the most appropriate ward to meet their care and treatment needs.

Systems were in place to provide sensitive care to patients on end of life pathways and their families. Haematology palliative patients were able to receive treatment as day patients in a recently opened

Good

End of life care

ambulatory room enabling them to remain longer in their own homes. A four-bed flat was available on site for families who wanted to be close to their relative during their end of life pathway.

Are end of life care services safe?

Good

Safety and performance

The hospital had responded to changes in guidance for the delivery of care. The trust had phased out the Liverpool Care Pathway (LCP) in line with recommendations from the Independent Review Panel. Advance care planning forms developed with the Oxfordshire End of Life Reference Group followed on from previous end of life strategies. The forms were designed to capture information and the wishes of the patients. Essential information included the professionals involved; their diagnosis; if a do not attempt cardiopulmonary resuscitation (DNACPR) form was in place; and the patient's wishes for their future.

Learning and improvement

The hospital learned from incidents and was continuously learning. The Quality Account reports 2012/13 for the trust stated incident reporting had improved with the introduction of the electronic reporting system across the trust. This system had allowed for "real-time assessments of clinical incidents" which gave the trust an opportunity to identify trends and improve patient safety.

Systems, processes and practices

Patients felt safe with the staff who delivered their care and treatment. The patients we spoke with told us they felt safe with the staff. One patient said: "I feel completely safe with the staff." The family of a patient in Sobell House told us their relative was safe and the staff ensured they were pain was controlled.

The care needs of patients were assessed. The nursing assessment, incorporating the activities of daily living care records form had replaced the LCP monitoring tools. The nurses we spoke with told us an individualised approach was now used for all the patients on the ward. For example, patients received support with their physical, emotional and cognitive health. One ward nurse told us the forms were good but there was limited space to evaluate patient's needs. We looked at the notes for two patients at the end of their life. Risk assessments were completed for moving and handling, malnutrition universal screening tools (MUST) and pressure ulcer care. Where risks were identified

Good

End of life care

further action was taken to prevent deterioration and maintain the patient's comfort. The notes showed staff received guidance on how to meet the needs of patients on an end of life care pathway.

Policies were in place to ensure staff followed correct procedures for patients considered not suitable for resuscitation in the event of a cardiopulmonary arrest. The "do not attempt cardiopulmonary resuscitation (DNACPR) and child and young person's advance care plan (CYPACP)" policy explained the hospital's procedure. The policy required staff with direct patient contact to discuss advanced decisions with the patient and/or their carers in a timely manner. The roles and responsibilities of staff were detailed in the policy and directed the patient's consultant to complete do not resuscitate forms for the patient if this was appropriate. Consultants had to then document the decision to ensure the staff and other external professionals involved with the patient knew not to resuscitate the patient in the event of cardiac or respiratory arrest.

Monitoring safety and responding to risk

The hospital responded to identified risks. The safety of patients in relation to the delivery of medicines was another key area identified by the trust for improvement in 2012/13. Audits were undertaken to assess the levels of risk. Staff ensured medicine rooms were locked and only those staff with responsibilities for the administration medicines had access to the medicine room. Action plans were devised from the audit undertaken by the pharmacist with the ward sister. A ward sister showed us the actions taken from the recommendations made by the pharmacist following the audit carried out in January 2014. The medication room was relocated to a quieter area of the ward, and better security systems were introduced.

Staff knew the principles of the Mental Capacity Act 2005. Ward staff knew where there was doubt of the patient's capacity to make decisions, mental capacity assessments had to be undertaken. One nurse gave us an example of when a patient's capacity was assessed to ensure they were able to make decisions about their discharge before packages of care were put in place. Another nurse told us the multidisciplinary team which included the consultant made "best interest" decisions on behalf of patients assessed as lacking capacity to make decisions.

Anticipation and planning

Codes for resuscitation orders differed from ward to ward. The use of different codes for the same outcome could be confusing to staff. Codes were used to inform staff of the medical procedures to be followed for specific patients in the event of a patient having a cardiopulmonary arrest. We noted from the handover sheets (summaries of patients care and treatment for staff coming on duty) that each ward had different codes for resuscitation orders which may have been confusing to staff not routinely deployed to the same wards.

Are end of life care services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

Pain was well managed. One patient told us their pain medicine was administered through a syringe pump to maintain a consistent level of pain relief. One member of staff told us there was support from the pain management team and they offered advice on prescribing medicines to control patient's pain.

Staff ensured patients were free from pain in between scheduled times of other medicines. Staff from Sobell House told us patients were prescribed with medicines which could be used when required (also known as PRN medicines) for symptom control and for pain relief. They had pain medicines through a syringe pump. We were told discussions had taken place with consultants to be more proactive in prescribing medicines early to prevent delays in managing patient's pain.

Performance, monitoring and improvement of outcomes

Where decisions had been made around resuscitation, the forms confirming this were completed. A patient confirmed they had signed the form and another said they were involved in the decisions about their care and treatment. The ward staff told us patients were assessed on admission and decisions were made about their care pathways. There were conversations with the consultant and ward staff about patient's treatment. The consultant and nursing staff from the palliative care team met with the patient and family to discuss the best supportive care.

Good

End of life care

Staff, equipment and facilities

The hospital ensured the staff had the right skill mix**.** Patients knew the reasons for their admission and the care and treatment they were to receive. One patient told us they were seen by a healthcare specialist for their care and said: "The expertise is amazing. I have been seen by top consultants and by nurses." The patient's notes we looked at showed a multidisciplinary team was involved in the care of the patient. Staff from the palliative care team recorded the advice given on symptom control and ward nurses documented when treatment changed to supportive care.

There were safe handovers between shifts. Ward staff were updated on the patient's condition when they came on duty. They told us there was an overlap of staff for handovers where all patients were discussed. There were pre-populated handover sheets given to staff when they came on duty. These sheets included a summary of a patient's history, diagnosis and essential information. Essential information included patients identified for fast-track discharge, those who did not wish to be resuscitated, and patients receiving palliative care.

Multidisciplinary working and support

Patients received care and treatment from a multidisciplinary team. One patient told us specialist palliative care nurses visited and they focused on aspects of their medical condition. A ward nurse told us there were strong links with staff from palliative care services. They told us the team were quick to respond and offered direct support to patients and staff. Palliative care staff helped patients plan where they wanted to be. The notes we read showed patients had access to health care professionals. We saw when staff from the palliative care team visited they documented the advice they offered. For example, advice around pain management. Staff from Sobell House told us there were social workers and physiotherapists working at the hospice. This was to ensure patients had access to social care support for them and their families, and for equipment they may need as in patients or in the event of their discharge.

Are end of life care services caring?

Good

Compassion, dignity and empathy

Patients were well cared for. The patients we spoke with made positive comments about their end of life care and their families agreed with the patient's views. One patient said: "the care here is second to none" and explained how treatment provided was to help with their end of life care. Another patient told us their privacy and dignity was respected. They said it was excellent. Ward staff told us where possible patients on end of life care were transferred to a side room to respect the patient's dignity. We were told visiting times were more flexible for patients at the end of their life. One relative told us: "The staff care about me too." Another family told us: "They have been fantastic from the moment we got here."

Involvement in care and decision making

Patients were involved in the decisions about their care and treatment. One patient told us their consultant had told them when their treatment was no longer curative. We were told they were given the choice to move to the hospice, but had decided to remain on the oncology ward. Another patient told us they were involved along with their family in the decisions about their care.

Trust and communication

The staff understood when providing end of life care consideration must be given to patient's diversity and equalities. A member of staff gave us an example to show patients religious beliefs were respected. We were told: "We felt strongly we needed to respect the patient's faith and we did their personal care correctly."

Patients were able to maintain links with family and friends. Patients receiving end of life care told us visiting times were more relaxed. Ward nurses told us the arrangements they made for families to spend as much time as possible with their relative. For example on one ward there was a sofa bed for families to use when they wanted to stay overnight to be with their relative.

Good

End of life care

Emotional support

Support was available to patients. Sobell House staff told us there was counselling support from the chaplaincy; patients had access to psychiatry and there was external bereavement counselling for children and young people. Ward staff told us the Chaplin was available at all times

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patients were cared for by staff who knew about end of life care and who had been trained to provide end of life care. One member of staff told us they had end of life training during their induction and attended study days to maintain their knowledge and skills.

The staff at Sobell House told us there was a strong multidisciplinary team. The multidisciplinary team documented their information in the patient's notes which ensured the social and health care professional involved were aware of the care and treatment patients were receiving. We were told there was an admission booklet which gave a good history of the patient's palliative care history.

Vulnerable patients and capacity

Patients received care that supported family arrangements, culture and beliefs. The staff we spoke with knew how to access support for patients. A ward nurse gave us an example where social care support was provided for a patient at the end of their life who chose to have their care in the community. Another ward nurse told us they had accessed websites to support a patient with their finances.

Access to services

There was a single point of access for patients. Patients on end of life care arriving at Churchill Hospital on an unplanned basis were assessed at "triage" to determine the priority for treatment based on their medical condition. A triage nurse told us there the multidisciplinary team were able to refer patients for care to wards, other hospitals and hospices**.** Sobell House staff told us referrals to the hospice for care and treatment came through triage for patients on unplanned admissions.

The identification of patient's reaching their end of life was an area for improvement by the trust. The staffs told us decisions to determine when patients were reaching the end of their life were made by the consultants and the multidisciplinary team. The patients we spoke with were part of the decision about their care and treatment.

Specialist teams were involved in the care of patients at the end of their life and receiving palliative care. We were told there were good working relationships with the palliative care team. We were told they were quick to respond. They visited the patient and developed a plan to support the patient's wishes.

Leaving hospital

Fast-track discharge procedures were available for patients on an end of life care pathway. Ward staff knew there was a fast-track discharge process and said patients were able to have their end of life care at home, in the hospital, at Sobell hospice or in the community. Ward staff co-ordinated fast-track discharges. A discharge check list had to be completed to ensure community teams had essential information to deliver care to patients at the end of their life. Sobell House staff told us fast-track discharges were available to patients wishing to have end of life care at home.

Learning from experiences, concerns and complaints

Patients knew there was a hospital complaints procedure. The family of a relative in Sobell House said ward staff listened to their concerns and passed their feedback to the manager of the ward. We saw information on The Patient Advice and Liaison Service (PALS) on display for patients to contact in the event they wanted to discuss concerns.

Are end of life care services well-led?

Good

Vision, strategy and risks

The hospital had a strategy for end of life care. The Oxford University Hospitals Trust Quality Account report 2012/13 featured patients experience as a key objective specifically care of the dying.

Governance arrangements

The standards of care evaluated in the National Care of the Dying Audit Hospital (NCDAH) Round 4 2013/ 2014 were

Good

End of life care

based on the End of Life Care Strategy (DH, 2008) and reflect National Policy Guidance. Compassionate care of the dying patient was an essential aim for NHS Trusts, and commissioners wanted evidence of the provisions of quality care. The audit report for the National Clinical Audit was expected in 2014.

The Oxford University Hospital Trust reports on mortality rates as part of their clinical excellence. The Health and Social Care Information Centre (HSCIC) were commissioned to gather mortality rates across trusts in England. The Oxford University Hospitals stated in their quality account report that their mortality rates were approximately 10% higher because of their inpatient palliative services.

Leadership and culture

The staff were proud about the way end of life care was provided to palliative patients. One member of staff said: "We are very good at providing end of life care." A member of staff at Sobell House told us: "We are good at accessing support."

Patient experiences, staff involvement and engagement

Patients were able to refer themselves to the specialist palliative care team and were able to speak with the doctors responsible for their care. Patients were involved in discussions about their discharge and treatment plans and were informed about the progress of their illness. Discussions with patients and/or their relatives around Do Not Attempt Resuscitation (DNAR) decisions were recorded in patient's records.

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

Learning, improvement, innovation and sustainability

Services were in place to provide sensitive care to patients on end of life and their families. Haematology palliative patients were able to receive treatment as day patients in a recently opened ambulatory room enabling them to remain longer in their own homes. A four-bed flat was available on site for families who wanted to be close to their relative during their end of life pathway.

Good

Outpatients

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

Information about the service

The level of outpatient activity provided at the Churchill Hospital 2012/13 was 191,124 which accounted for 25.3% of the total trust-wide activity. The hospital is a centre for cancer services and specialities including renal and transplant, oncology, dermatology, haemophilia, infectious diseases, chest medicine, medical genetics and palliative care. The outpatients services are located in separate areas within the specialities provided. We visited oncology/ haematology outpatients, respiratory outpatients and the respiratory day service. We spoke with ten patients and four staff.

Summary of findings

Patients received safe and effective care. Some outpatient and day services were in an old part of the hospital not well suited to the delivery of modern day healthcare. We saw that this was recorded in the risk register and that temporary actions had been taken to mitigate the risk. Identified remedial work had not been undertaken and genetics and cystic fibrosis services affected had not been relocated as planned. We were not able to establish when this would be completed. The clinics we visited were well led and patients told us that the care was excellent

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

We were unable to get a full view of the staffing because outpatients clinics were spread throughout the hospital in each department. We visited two clinics and spoke with four staff. In the oncology/haematology outpatients a member of staff told us there were no trained staff to run the clinic but this would change. There were specialist and research nurses working in the clinic that provided patient support. There were 21 clinic rooms and 21 consultants where 300 patients were seen daily. We observed a patient queue that stretched into the corridor and meant the fire door in the corridor was constantly open. Frail patients and patients on crutches had to stand and wait to be booked into the clinic. There was insufficient room to ensure patients' health and safety at all times.

In respiratory outpatients there were several staff running the clinic. We briefly spoke to a nurse at the end of a morning clinic. The clinic was very busy in the afternoon and we were unable to speak to a trained nurse. There were three consultants in the clinic. The administration staff told us they had the equipment they needed including resuscitation equipment. The staff felt that the environment was safe but old.

A review of staffing and nursing roles for outpatients started in January 2014. The Churchill outpatient project plan, dated 21 January 2014, highlighted that Band five nurse interviews were taking place on 27 January 2014 to ensure sufficient staff were available. We were unaware of the outcome.

Learning and improvement

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Systems, processes and practices

We spoke with ten patients and two were concerned they had waited a long time in the oncology clinic. Two patients told us that car parking was a big problem and they had taken more than forty minutes to park. One patient had been given a parking permit because they had frequent appointments. A patient told us their GP had not received a hospital discharge letter, so no outpatient referral was made. An urgent referral to oncology was made on 6 December 2013 and an appointment was given for 26 February 2014. The patient had not received an apology and was told by their GP to go to A&E. The patient told us they would be writing to the Patient Advice and Liaison Service (PALS) about the delay as they had lost two stone in weight while they waited.

Monitoring safety and responding to risk

Some outpatients and day services were in the old part of the hospital. We spoke to a member of staff in the respiratory day service and they told us the environment was not fit for purpose. There was no piped air and only emergency suction was available. The areas were used for assessment and gym facilities for patients with cystic fibrosis, sleep studies, patients with chronic obstructive pulmonary disease (COPD) and outpatients. Corridors that linked areas were extremely dilapidated and cold. Staff following the 'bare below the elbows' rule felt uncomfortable, and morale was poor as a result. Staff told us there was a plan to move services from there two years

Good

Outpatients

before our inspection. A comment from a patient survey carried out six months before our inspection for the day unit said, "building in need of a refurb". There were plans indicated in the response to the survey for sleep study patients to be moved on 28 February 2014.

The risk report said "infrastructure which does not meet modern healthcare needs and cleaning standards. Windows fall out of the frames, radiators burst and power failures are common occurrences". The trust had put some temporary measures in place, but the risk remained for damage to equipment, records, and patients' perception of sub-standard care. We were unable to visit genetics outpatients where concerns had been raised with us as it was not operational that day. However, we visited the respiratory day care services, which were next door to genetics outpatients and saw that the environment was poor. There were rusting windows in the corridor, the area had an unpleasant odour, and there were visible electrics on the floor near a reception desk.

Staff said they were unsure as to when the physical environment would be improved. We saw that this was recorded in the risk register and that temporary actions had been taken to mitigate the risks. Heaters and fans were available to support staff with extreme temperatures. At the time of our inspection we identified remedial work had not been undertaken and all services affected had not been relocated. We were not able to establish when this would be completed.

Anticipation and planning

The outpatient services were under review to ensure clinics have the capacity to meet increasing demand for appointments. The trust had employed a company to collate audits from outpatient clinics to plan the improvements required and improve the patient experience.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment was delivered in line with evidenced based guidance. The trust participated in national clinical audits, reviews of services, benchmarking and clinical service accreditation. A patient told us they thought the consultants they had seen were the best in their field and they were confident about their care and progress

Performance, monitoring and improvement of outcomes

The trust participated in national clinical audits, reviews of services, benchmarking and clinical service accreditation. Customer care workshops attended by 50 clinic nurses and administration staff took place in January 2014 as a response to patients surveys and complaints. There were recurring themes from patients that were discussed at outpatient steering group meetings. The themes related to late running and delays in clinics (including blood tests); lack of or poor information about the running of clinics or delays; the availability of car parking and no timetable in bus shelter. It was reported that the themes were being addressed. We spoke with ten patients and two were concerned they had waited a long time in the oncology clinic.

Staff, equipment and facilities

We were informed that an additional senior band six nurse was to be recruited to help run outpatients and provide the necessary support for both staff and patients.

Multidisciplinary working and support

We observed good multidisciplinary working in one outpatients department we visited. Specialist nurses and research nurses supported patients. Patients told us they had their MRI scans and x-rays done quickly within a week and the care was excellent.

Are outpatients services caring?

Good

Compassion, dignity and empathy

Patients told us they felt safe and that the staff were polite and approachable. We observed that staff treated patients with compassion and dignity while they received their care and treatment. Consultations took place in private rooms and staff did not discuss patients in public places.

Involvement in care and decision making

Patients told us they were involved in their care and so were their relatives. The patients were able to give informed consent to treatment and nurses had provided

Good

Outpatients

any additional information to help them. A patient told us that the nurses would print information for them from the computer if they need it. Patients told us there was sufficient time to discuss options with the consultant.

Trust and communication

We observed that staff greeted patients with respect and warmth. The majority of patients told us the experience and care was very good. A patient in the oncology department told us that they would get immediate care without going to their GP or the A&E department.

Emotional support

Patients received support from specialist oncology nurses and research staff. Patients told us that the staff culture was good and they said the environment in oncology was lovely and welcoming. A patient in respiratory medicine had been well supported by the staff on many occasions and had confidence in the care and treatment at the hospital.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The provider actively engaged and worked with local commissioners of service, the local authority, other providers, GP's, patients and those close to them to co-ordinate and integrate pathways of care that meet the health needs of the local population.

Patients' needs were assessed at each appointment and care planned and delivered to meet their needs. A patient and their relative in respiratory medicine were able to access the department from a nearby car park at the back of the hospital near the clinic. They used a hospital wheelchair to ensure the patient was comfortable. There was a calm atmosphere in the two outpatients we looked at.

Some clinics were in the old part of the hospital and were not as spacious as the new clinics. There was little space to walk around in one clinic we visited but staff supported patients and there was a calm atmosphere.

Vulnerable patients and capacity

Staff were trained to protect vulnerable adults and children who may or may not have the mental capacity to make decisions. Safeguarding training was mandatory throughout the trust and staff had access to the trust safeguarding policies and procedures for adults and children. We did not test staff knowledge but patients told us that they felt safe and that staff were kind and approachable.

Access to services

Waiting time guidelines and performance issues were monitored by the trust and there had been some breaches of national waiting times for appointments. The administration staff told us that the choose and book system for appointments worked well for most patients. Most of the ten patients we spoke with were able to book an appointment easily. There were some patients that had to wait a long time in the clinic when consultants were busy and arrived late. We spoke with ten patients and two were concerned they had waited a long time in the oncology clinic. Two patients told us that car parking was a big problem and they had taken more than forty minutes to park. One patient had been given a parking permit because they had frequent appointments.

Leaving hospital

Patients' needs and wishes were taken into account so that they left the department with appropriate information.

Learning from experiences, concerns and complaints

Patients told us they knew how to make a complaint if they were not satisfied with their care. There were leaflets in the hospital that described how to make a complaint and how to feedback their views. From August to December 2013, 38 (61%) of patients indicated they would be "extremely likely" to recommend the service to a friend. There was no mention in the patient information leaflet about contacting the Health Service Ombudsmen for further support if required by patients. Patients we spoke with told us the care was excellent or good. There were concerns raised about car parking, waiting times in the clinic and two patients had not been referred in a timely manner. Action was being taken with regard to these matters as the trust were reviewing the way that outpatients was organised and managed to ensure that the capacity within outpatient clinics met the increased demand. The trust were having discussions with the county council about car parking.

Good

Outpatients

Are outpatients services well-led?

Good

Vision, strategy and risks

Quality drives the trusts strategy and the board is aware of potential and actual risks to quality. There was a monthly outpatients steering group meeting where best practice was shared and risks were identified. At the meeting in January 2014 there had been discussion about patient questionnaires and providing a regular view of all outpatient departments on a specific week each quarter. One outpatient clinic had already used a monthly questionnaire for patients. Other initiatives were being trialled to find out what patients want. One was the use of a hand-held computer notebook device for patients to use in a survey.

Governance arrangements

Any issues raised in the outpatient departments would be escalated to the service development directorate and the board where necessary. We asked patients about the issue of timely appointments and waiting times in the clinics, which remain an issue for some. There was significant work being completed to improve patient experience in this area.

Leadership and culture

Part of the trust vision is to deliver excellence and value in patient care. There was a clear responsibility within the trust when issues were raised. Outpatient sisters and the trust project manager were involved in the outpatients steering group monthly meetings. This meant that there was communication from and to the trust to effect changes to benefit the patient experience.

Patient experiences, staff involvement and engagement

The patient experience programme had included the “Friends and Family test” (FFT) and would be implemented across all outpatients by the end of 2014. We saw an example in the hospital where a poster displayed “you said” and “we did” as a service improvement for patients and carers from their feedback.

Learning, improvement, innovation and sustainability

The trust had set out their transforming patient experience strategies for 2014 to 2016. We looked at recent meeting minutes to see what innovation had been started. Staff we spoke with told us that the hospital was currently going through a re-profiling of outpatients. This is a review of the way that outpatients is organised and managed to ensure that the capacity within clinics meets increasing demand to improve targets. The trust used Royal College guidelines to inform the work, for example; on the number of patients seen and appointment duration. This was work in progress and had not been rolled out to all outpatients departments yet.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider had not ensured that patients on John Warin and Geoffrey Harris wards were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each patient. Records did not contain all the required information to ensure care was delivered safely to meet the patient's needs. Risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed. Regulation 20 (1) (a)