Care Quality Commission

Oxford University Hospitals NHS Trust

Horton General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Good**
Accident and emergency	Good
Medical care	Good
Surgery	Good
Intensive/critical care	Good
Maternity and family planning	Good
Services for children & young people	Good
End of life care	Good
Outpatients	Good

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Overall summary

Horton General Hospital is an acute general hospital in Banbury in North Oxfordshire. The hospital has a long history from first opening with two wards in 1872. It became part of the Oxford University Hospital NHS Trust in 1998. It provides a range of services including an emergency department (A&E), general surgery, acute general medicine, trauma and orthopaedics, maternity services, a children's ward and special care baby unit (SCBU), critical care, coronary care, a cancer resource centre, and dialysis. The hospital serves a catchment population of around 150,000 people in and around North Oxfordshire and neighbouring communities in south Northamptonshire and south east Warwickshire. There were 248 inpatient beds and the hospital saw around 120,000 patients as inpatients each year. The hospital arranged in the region of 90,000 outpatient appointments each year and saw 36,000 people each year in the emergency department.

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. We spoke to more patients, carers, and staff from all areas of the hospital on our visits.

The services provided by Horton General Hospital were delivered to a good standard. Patient care in all the departments and services we visited was delivered safely, by caring staff who were well led. The hospital was delivering effective care although needed to review how patients in critical care were supported safely by consultants with the relevant training. Staff told us they were well supported by one another and their managers. The overriding comment from the nurses we met was them telling us the reason they came into work each day was the support they gave one another. Departments, wards and services were well led at a local level, but there was some concern around overall leadership of the hospital as staff told us they felt there was no one with overall responsibility. This was because the trust worked in directorates, and different senior staff were responsible for different parts or divisions of the hospital. Staff told us on occasion an issue in one department could impact another and it was sometimes hard to find a resolution without a general manager.

A number of people from the local community we met at our listening event in Banbury said they were not consulted by the trust about changes made to the provision of services. People, patients and staff were concerned specifically about the removal of emergency surgery from the hospital. The main concern of staff was feeling their voice was not heard by the trust. The trust told us about the communication exercise undertaken to inform all internal and external stakeholders about the decision and rationale to remove emergency abdominal surgery from the hospital. This involved meetings with the Community Partnership Network.

Staffing

The hospital was and had been actively recruiting staff, particularly to nursing posts. Some staff were concerned about the future of the hospital and rumours or discussions about its future. They said they knew this had deterred some staff from actively looking to work at the hospital and meant there was a high level of locum staff at times. Most staff felt the hospital was, however, well-staffed most of the time. Nurses and doctors said they felt they had enough time to spend with patients, although they said there could always be more. Nurse managers said they usually had time for their managerial duties, but would step in to direct care provision when the department or ward was short-staffed. Some staff said training was usually the first thing postponed if their area was short-staffed, but otherwise the training completion rate was high.

Cleanliness and infection control.

The hospital was clean on both our announced and unannounced visit. Staff followed cleaning schedules, paying attention to hard-to-reach areas, and most areas were organised to make cleaning as efficient as possible. We observed good infection control practices among staff. Staff were wearing appropriate personal protective

Summary of findings

equipment when delivering care to patients. There was a relatively good provision of hand gels across the site and we saw staff using them and asking patients to do the same. The number of MSRA bacteraemia infections and Clostridium difficile infections attributable to the hospital were within the acceptable range for a hospital of this size.

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. They were open and transparent when things went wrong, investigated them and made changes to avoid recurrences. The hospital was clean and infection control protocols were followed. Medicines were managed safely. Staffing levels were acceptable and departments responded well to busy times.

Emergency services were safe, although some aspects of the provision for children did not follow the guidance for paediatric emergency care. This included challenges from the environment, which had been recognised by staff. The majority of training was delivered on time, although there was a lack of specific training for staff in A&E for supporting people with dementia. Maternity and children's services were safe, and staff followed best practice guidance. End of life care was delivered well across the hospital and linking with community services to follow best practice. Medical and surgical care was delivered to ensure patients were safe. Staff said they were encouraged to report anything they felt was not safe and it was addressed.

The critical care service provided excellent care with good outcomes. But the service was not meeting guidance in relation to medical cover. There were experienced anaesthetists and consultants attached to the unit, but not all had critical care training. There was no critical care Outreach service in the hospital, although we were told this was being discussed and the service could be reintroduced.

Patients with cognitive impairments were supported to make decisions, but when they were not able to, the requirements of the Mental Capacity Act 2005 and multidisciplinary decisions acting in people's best interests were followed. Otherwise, patients and their partners were involved in decisions and made their own choices.

Are services effective?

Good

Outcomes for patients were good and the hospital performed well when measured against similar organisations. National guidelines and best practice were applied and monitored, and outcomes for patients were good overall. Pain management was done well, and patients were supported with good hydration and nutrition. Staff worked in multidisciplinary teams to co-ordinate care around a patient. End of life care was integrated across the hospital and with community services. Staff were supported to be innovative and were continually looking to improve services. Most mandatory training and appraisals were on track to be completed annually. New mothers were well supported and children and young people's services were effective.

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Are services caring?

Good

During our inspection, we observed almost all staff were caring and patients confirmed this, saying that staff were considerate, and treated them with kindness and respect. Patients and carers coming to the maternity and children's services said that staff were welcoming, caring, and kind. A&E staff, outpatient staff and ward-based staff were praised for their kindness. Staff in the critical care team provided good care and emotional support. End of life care, which was provided across the hospital where needed, was caring, professional and supportive to patients' choices.

Support for patients with mental health needs, particularly in the A&E department, was not always adequately covered. This had improved recently, but out-of-hours or weekend provision was limited.

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 usually managed well. Bed occupancy at the hospital was sometimes at a level that had an impact on the quality of care, and caused the A&E department to miss waiting-time targets for patients. The critical care unit occasionally had not met discharge targets, as there were sometimes no beds available into which to move patients who were recovering. Patients were sometimes delayed by their discharge into community care not being arranged in good time by other providers. There had been changes made to provide patients ready to go home with support in the day-case lounge to expedite discharge and release beds to the ward.

The trust said it had consulted with local people about changes at the hospital. However, people we met particularly at our Listening Event in Banbury said they were not consulted, and specifically not about the cancellation of the provision of emergency surgery at the hospital. The trust told us about the communication exercise undertaken to inform all internal and external stakeholders about the decision and rationale to remove emergency abdominal surgery from the hospital. This involved meetings with the Community Partnership Network.

Are services well-led?

Good

Staff told us they felt the hospital was well-led at a local departmental level. Staff were supported by their peers and managers to deliver good care and to support one another. Staff said they felt proud to work at the hospital, but did not feel at all times they were included and consulted in plans and strategies by the trust. Some staff described this as feeling isolated.

There was a lack of support for some newly qualified midwives and some staff in the maternity ward felt morale was low. Most staff said, however, they had good appraisals with their managers each year and could discuss matters openly and had no fear of reporting concerns.

Summary of findings

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

Accident and emergency

Good

The A&E department at The Horton General Hospital provided overall good safe care. The department had qualified and experienced staff with strong local leadership and direction. Patients told us they felt safe at the department. Systems and processes worked to keep people safe and give them the most appropriate care and treatment. Staff were caring and compassionate. Patients said their privacy and dignity was preserved and they felt treated as individuals.

Staff were dedicated to their patients and their service. They were committed to making improvements and listening to patients. There were few complaints made to the service, but those that were made were addressed and learned from. There was an open culture among staff where any care or treatment or avoidable incidents were discussed and ways to improve were recognised and implemented. The morale in the department was affected, however, by uncertainty about the future of the hospital. Staff felt this was not helping with local recruitment of nursing staff.

Patients we met described the service as “excellent”, said: “I have no complaints. They have been absolutely wonderful”, “I feel treated like a person here and like I really matter to these staff”, and: “I’ve been here a number of times and with my kids too, and the care has been first class. Nothing but praise for these staff. They work really hard and it’s not always easy for them.”

From raw data sent to us by the trust, we saw the department had breached the Government’s four-hour waiting time target on occasion. The data did not provide any detail of the reason for these breaches, but staff confirmed it was mostly due to their not being an available bed for the patient to be transferred into. There was no evidence this was due to staff in A&E not treating the patient in good time to facilitate their discharge. There had also been no specific increase in patient numbers attending A&E in the recent winter months. The busiest months in 2013 were in the summer period.

Medical care (including older people’s care)

Good

The hospital provided safe care. National tools were used to measure risks to patients and action was taken to address identified risks. Staffing levels were regularly monitored to ensure wards and departments were adequately staffed. Integrated care pathways for inpatients with diabetes were still being devised. Actions included a business case to bring diabetes inpatient specialist nurse numbers in line with the national average as well as early and comprehensive standardised assessments.

Staff were caring. Patients spoke highly about the care they received and the kindness and helpfulness of the staff. Staff worked effectively and collaboratively to provide a multidisciplinary service for patients who had

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complex needs. Patient views and experiences were sought by the hospital, by the provision of quality questionnaires, and the responses were fed back to staff on the wards. The hospital demonstrated openness to engage with patients and listen to their feedback to improve the services provided.

Surgery

Good

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. There were processes to ensure patients who moved to different wards received consistent and safe care and treatment. Staff made use of the language line facility and interpreters to ensure patients had 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 MRI imaging. Patients had to go to the John Radcliffe Hospital in Oxford to access MRI imaging; we were told that difficulties in arranging appointments meant there was a risk that some patients' treatment would be delayed.

We saw good evidence of team working at ward and departmental level. However, with some of the clinicians, there was a feeling that despite being part of Oxford University Hospitals NHS Trust, the views and opinions of staff at Horton General Hospital were not always heard.

Intensive/critical care

Good

Patients received care which was compassionate, dignified and delivered good outcomes. Clinical outcomes for patients were good. Mortality rates were below the national average and below the expected level for patients in a critical care unit. The caring and consideration of staff was excellent. The patients and relatives we spoke with praised the nursing and medical staff highly. Vulnerable patients were well supported and staff put the patient at the centre of their care.

The department was well-led at local and senior level and staff were supported and proud of their work. There were some issues with patient discharge not being timely or being delayed, but this was due to pressures on beds elsewhere in the hospital. On a national level, this problem was not significant.

However, the critical care department was not meeting the guidelines in relation to medical cover. There were skilled and experienced anaesthetists and consultants attached to the unit, but not all had critical care training. The

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lead medical consultant was trained in critical care, but this was not their substantive post and they were not available at all times. There was no evidence this had resulted in patients being put at risk, but the arrangements did not meet the national guidelines for medical care in intensive care units.

Maternity and family planning

Good

The maternity unit at the Horton provided safe care which was tailored to the needs of women receiving pre- and post-natal care.

Women received care from caring, compassionate and skilled staff. We received positive comments from women and their families about the care and support they received. They were involved in decisions about their care and received emotional support as required.

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

There were systems in place to record near misses and other events and the staff were aware of their responsibility to record and report these incidents. There was evidence that learning from incidents occurred and action plan developed.

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

Most practice was in line with national guidelines. There were concerns about the lack of support for newly qualified midwives which may impact on care delivery. The labour delivery suite had been without a manager and there was a lack of succession planning.

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

Services for children & young people

Good

We visited the children's ward on a Tuesday and a Wednesday during the daytime and again on a Sunday afternoon and early evening as an unannounced visit. During these visits we talked with around nine patients and their relatives accompanying them. We spoke with staff, including nurses, doctors, consultants and support staff. We also received information from people who attended our listening events and from people who contacted us to tell us about their experiences. We collected comment cards from a designated box set up for our visit. Before our inspection we reviewed performance information from, and about the trust.

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There was a multidisciplinary collaborative approach to the care and treatment of children across children's services in the hospital. Children's care and treatment was planned and well documented in the medical notes and nursing records in the patient's files. Staff across children's services were confident the hospital had a reliable system to alert them to risk and implement improvements. Staff told us they could express their views in ward meetings and were "confident" they would be listened to by the organisation.

Children and young people received person centred compassionate care from staff in the children's ward. We saw nursing staff delivered kind and compassionate care to a young child who was crying as their mother had gone home. Parents told us nursing staff had been "patient and kind."

End of life care

Good

Patients received effective and sensitive end of life care. Patients told us they felt safe with the staff and overall their needs were met. We were told medicines were prescribed to control patients' pain and staff were using the fast-track process for early discharge. Patients said staff respected their rights: in particular privacy and dignity. Patients and their relatives told us where there were concerns staff were available for discussions.

Patients at the end of their life were able to make decisions about the medical procedures to be followed in the event of cardiopulmonary arrest. If the decision made was not to attempt to resuscitate the patient, it was recorded and brought to the attention of all medical staff involved in the delivery of care.

Patients were treated with compassion and were not expected to wait for pain medication. Doctors prescribed medicines in advance to prevent delays in administering medicines to patients in pain. Medicines to be taken as required were prescribed to ensure patients were comfortable between other scheduled medicines.

Patients were cared for by staff with an understanding of end of life care. There were nurses on each ward who specialised in specific topics including end of life care. These staff were able to support other staff who needed guidance or advice. Doctors completed mandatory training on end of life care during their teaching.

Outpatients

Good

Patients received safe care. Staff were skilled and caring and knew their responsibilities to keep patients safe. Risk assessments had been completed and actions identified to improve the service. The clinic was clean and a refurbishment programme had started. Capacity remained a concern because demand had increased by 10% over the year prior to our inspection. The trust

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was planning to improve capacity at the Horton by providing two additional clinic rooms in the refurbishment. Audits for the “choose and book” system had taken place and the trust was in the process of re-profiling outpatients to improve the patient experience.

We spoke with ten patients and the majority had no problem getting an appointment and all tests and x-rays had been completed in a timely manner. Eight patients were complimentary about the service and two told us the service was excellent overall. Two patients had problems getting an appointment in a timely manner.

There was a culture between staff to improve the patient experience and be the best they could be. Patient views and experience had been sought to help improve the service. Staff had endeavoured to answer any verbal concerns raised with them immediately.

The trust were keen to develop directly bookable appointments that relieved pressure on staff and the time it took patients to book individual appointments over the phone. The plan was to improve the time automatic letters were sent for appointments and cancellations.

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What people who use the hospital say

The A&E department did well in the NHS Friends and Family Test with the majority of results each month much higher than the England average in April to December 2013. In July 2013, for example, the response rate was 25.3% (England average 10.4%). Of the 480 responses, 456 people said they would be "extremely likely" or "likely" to recommend the department to their friends and family. Only 6 people said they would be "unlikely" or "extremely unlikely" to recommend the department. In November 2013, the response rate was 21.5% (England average 15.2%). Of the 322 responses, 307 people said they would be "extremely likely" or "likely" to recommend the department to their friends and family. Only two people said they would be "unlikely" or "extremely unlikely" to recommend the department.

The Patient-Led Assessment of the Care Environment (PLACE) survey from 2013 rated cleanliness of the hospital 80.5%; food 85.8%; privacy, dignity and wellbeing 75.9% and facilities 74.3%. Ratings on the NHS Choices website (from between 31 and 38 ratings) rated the hospital with 4.5 stars overall, 4.5 stars for cleanliness; 4.5 stars for staff co-operation; 4.5 stars for dignity and respect; 4 stars for involvement in decisions; and 4 stars for same-sex accommodation.

Areas for improvement

Action the hospital SHOULD take to improve

- The hospital should have cover at all times from medical staff trained in critical care.
- The hospital needs to ensure it has sufficient bed capacity for A&E to meet Government target waiting times.
- Staff, specifically in the A&E department should have regular training in supporting people with dementia.
- Although all A&E staff were trained in paediatric life support, guidance said the department should have trained paediatric nurses on duty at all times.
- Clinical notes for patients in the medical wards should include a records of all agreed care given to patients.
- Patients should have access to specialist medical services when they are needed.
- The hospital trust should improve support to local staff so they feel more included and less isolated.
- The kitchen in the critical care unit should be better secured from the clinical area.
- The provision of an outreach service for critically ill patients should be revisited.
- Support for newly-qualified midwives (through their preceptorship programme) should be improved along with management of the maternity services.
- Decisions made by patients around resuscitation should be reviewed as required.

Good practice

Our inspection team highlighted the following areas of good practice:

- The care and support given to patients and their relatives in critical care was excellent.
- The stroke service in A&E followed a clear pathway and delivered good outcomes to patients.
- Staff worked well between wards to ensure safe staffing levels were maintained.
- There were good outcomes for patients in critical care. Mortality was below national averages.
- Staff were proud of their hospital and the care they provided to patients.
- Multidisciplinary team working helped to meet the complex needs of patients.
- Auditing and monitoring of care ensured improvements in practice.
- Staff spoke highly of their peers and the support they received from their line managers.

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- The services provided by the day hospital had increased to enable patients to be discharged to the day hospital while waiting for medication to take home or transport so that the medical wards could admit new patients.
- Staff were encouraged and supported to innovate and were proactive in making and promoting changes.
- Team leaders and managers focused on the skill mix of their staff to ensure services were delivered safely.
- The bereavement suite provided good support including pastoral care.
- Staff spoke highly of the consultant-led children's ward and the good outcomes for children.

Horton General Hospital

Detailed Findings

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

Our inspection team

Our inspection team was led by:

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

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

The team of 51 (of which 20 visited Horton General Hospital) included CQC inspectors, managers and analysts, consultants and doctors specialising in emergency medicine, obstetrics and gynaecology, oncology, diabetes care, cardiology and paediatrics. It also included junior doctors, a matron, nurses specialising in care for the elderly, end of life care, children's care, theatre management, cancer and haematology and two midwives, together with patient and public representatives, and experts by experience. Our team included senior NHS managers, including two medical directors, a deputy chief executive and a clinical director in surgery and critical care.

Background to Horton General Hospital

Horton General Hospital is an acute general hospital in Banbury in North Oxfordshire. It provides a range of services including an emergency department (A&E), general surgery, acute general medicine, trauma and orthopaedics, maternity services, a children's ward and special care baby unit (SCBU), critical care, coronary care, a cancer resource centre, and dialysis. The hospital serves a catchment population of around 150,000 people in and around North Oxfordshire and neighbouring communities in south Northamptonshire and south-east Warwickshire. There were 248 inpatient beds and the hospital saw around 120,000 patients as inpatients each year. The hospital arranged in the region of 90,000 outpatient appointments each year and saw 36,000 people each year in the emergency department.

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. We spoke to more patients, carers, and staff from all areas of the hospital on our visits.

The hospital is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures; family planning; maternity and midwifery services; nursing care; personal care; surgical procedures; termination of pregnancies; and treatment of disease, disorder or injury.

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 Horton General Hospital was considered to be a medium risk-level service and the trust is an aspirant Foundation Trust.

How we carried out this inspection

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

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

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

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for Children & Young People
- 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 February 2014. During our visit we held focus groups with a range of staff in the hospital including nurses below the role of matron, matrons, junior doctors and consultants. We talked with patients and staff from all areas of the hospital including the wards, theatre, outpatient departments, and the A&E department. 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 listening events where patients and members of the public shared their views and experiences of the location. An unannounced visit was carried out on the 2 March 2014 when we visited A&E, the children's ward and the critical care unit.

Good

Accident and emergency

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

Information about the service

The A&E department was open 24 hours a day, seven days a week to provide an emergency service to the people of Banbury and the surrounding areas. The department had 14 beds and treated people with both minor and major injuries and illnesses. About 36,000 patients (27,500 adults and 8,500 children) were expected to attend the department each year. The department triaged patients as they were admitted to ensure they were quickly assessed for the need for any urgent intervention. The department used the adjacent Emergency Admission Unit (EAU) for patients who needed ongoing observation or assessment before they were admitted to hospital, transferred or discharged. The matron for the Emergency Department also covered this service. Patients transferred to the EAU remained under the care of the doctor or medical team treating them in the emergency department until their care was handed over or they were discharged.

We visited the A&E department on a Tuesday during the daytime and again on a Sunday afternoon and early evening as an unannounced visit. During these visits we talked with around 20 patients and their relatives or friends accompanying them. We spoke with staff, including nurses, doctors, consultants, support staff and ambulance personnel. We also received information from our listening events and from people who contacted us to tell us about their experiences. We collected comment cards from a designated box set up for our visit. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

The A&E department at The Horton General Hospital provided overall good safe care. The department had qualified and experienced staff with strong local leadership and direction. Patients told us they felt safe at the department. Systems and processes worked to keep people safe and give them the most appropriate care and treatment. Staff were caring and compassionate. Patients said their privacy and dignity was preserved and they felt treated as individuals.

Staff were dedicated to their patients and their service. They were committed to making improvements and listening to patients. There were few complaints made to the service, but those that were made were addressed and learned from. There was an open culture among staff where any care or treatment or avoidable incidents were discussed and ways to improve were recognised and implemented. The morale in the department was affected, however, by uncertainty about the future of the hospital. Staff felt this was not helping with local recruitment of nursing staff.

Patients we met described the service as “excellent”, said: “I have no complaints. They have been absolutely wonderful”, “I feel treated like a person here and like I really matter to these staff”, and: “I’ve been here a number of times and with my kids too, and the care has been first class. Nothing but praise for these staff. They work really hard and it’s not always easy for them.”

From raw data sent to us by the hospital trust, we saw the department had breached the Government’s four-hour waiting time target on occasion. The data did not support the reason for these breaches, but staff

Good

Accident and emergency

confirmed it was mostly due to their not being an available bed for the patient to be discharged into. There was no evidence this was due to staff in A&E not treating the patient in good time to facilitate their discharge. There had also been no specific increase in patient numbers attending A&E in the recent winter months. The busiest months in 2013 were in the summer period.

Are accident and emergency services safe?

Good

Safety and performance

A&E department staff knew when and how to report and investigate incidents. All staff were trained in using the internal incident reporting system. Temporary (agency and bank) staff would be supported to report incidents if they did not have access to the electronic system. Staff at sister and above level had been trained in incident investigation, and training records supported this. There were regular staff meetings in the department where incidents were raised and discussed. Minutes were produced for staff who did or were not able to attend. Action plans from incidents were produced and staff were updated on the progress of actions. A recent analysis of incident reporting by the matron and a review of staffing levels across the trust, had determined the need for an increase in nursing staff. This had been approved and new staff were being recruited. Agency and bank staff were being used in the meantime to increase the nursing staff coverage. We saw an incident reported in February 2014 about a lack of equipment over a weekend and equipment being not clean. The incident had been reviewed; the member of staff who had made the complaint had been shown where to locate equipment, and the equipment cleaned “from top to bottom.” Staff responsible for the cleanliness of the equipment had been alerted to the issue.

People were protected from abuse. Patients who came to the A&E department were screened on arrival by the reception staff. The reception staff told us they would alert the clinical staff if they were concerned about the wellbeing or safety of a patient or anyone accompanying them who could be vulnerable. The department had a See and Treat nurse who would review patients as a form of triage shortly after arrival. Vulnerable patients were highlighted to or identified by the See and Treat nurse or by reception staff if they were known to the department already. They were then taken to a cubicle if possible or to a quieter area of the department.

Staff knew they had a duty to raise an alert if they were concerned about the safety of any patient or someone accompanying them. They had been trained to deal with

suspicions of abuse. Training records showed almost all staff, including housekeeping staff, were trained in safeguarding vulnerable adults, and this was a topic for all new staff at induction. Staff were able to tell us how they would recognise signs of potential abuse and how they would report this to safeguarding teams.

Learning and improvement

The department learned from auditing its performance against national benchmarks. We reviewed a number of audits about this hospital from the College of Emergency Medicine (CEM). We saw the hospital had improved many of its results for measures such as giving pain relief, admitting patients to hospital, and getting patients to x-ray. Most of the results for audits were in line with national averages. We asked a lead consultant how the department had responded to poor results from an audit from the CEM in relation to pain relief for patients coming with a suspected fractured neck of femur (hip). The department had initiated a pathway for these patients, which was linked to approved national clinical guidance. Audits showed the administration of pain relief in a timely way was now much improved.

Systems, processes and practices

Staff were following standard operating procedures and medicines practice guidelines. The medicine guidelines for nurse practitioners were up-to-date and available electronically on the trust intranet. Any updates were managed centrally and staff were made aware of changes or amendments.

Treatment was given in the best interests of the patient. If an unconscious patient was admitted any treatment was provided in their best interests and in accordance with the law. For patients who were not able to provide consent or did not have people to speak for them, A&E staff had access to an Independent Mental Capacity Advocate (IMCA). However, there were no advertisements for advocacy services for people who needed another person to speak for them or with them. The reception staff were not aware of how to guide people to an Independent Mental Capacity Advocate (IMCA), but the nursing staff had contact details.

Infection control

There were adequate infection control processes and practices. There were clearly indicated hand-washing facilities in the department including hand-sanitising gels placed in the right areas. Staff had enough personal protective equipment including gloves and aprons. Nursing staff were wearing standard uniforms and all staff we saw were adhering to infection control protocols (such as being "bare below the elbow", without nail varnish, and wearing minimal jewellery). We observed the cleaner in the department working to cleaning schedules in the regular but also harder to reach areas. The department was clean, well-organised to help effective cleaning, and fixtures and fittings were maintained. The chairs in the waiting rooms were showing signs of age and wear and tear. The coverings were damaged in places. This made keeping the chairs clean and preventing the spread of infection difficult. The matron told us the waiting area was due to be updated in spring 2014 and the chairs replaced.

Equipment

Where needed, areas of the department were locked and secure. Medicines, equipment and consumables were in locked rooms or cabinets. The keys were held by a senior member of staff and handed over responsibly at shift changes. Staff explained how the codes for the key-pad entry systems were changed regularly for security reasons. There was some equipment stored in corridors in a department that had little available space. However, these areas had limited footfall from patients and had been risk-assessed as being safe for this storage. Wheelchairs and trolleys were able to move safely through the department as needed.

Monitoring safety and responding to risk

Staff were supported to raise concerns without fear of reprisals. All the staff we spoke with said the matron put patient safety first. Staff said they were encouraged to speak up about any concerns and were reminded in staff meetings of the importance of this. We read the hospital trust's whistle-blowing policy dated August 2013. This policy outlined the duty of staff to report concerns, how they would be dealt with, and the support available to staff who raised concerns. The policy went on to describe the process for managers who were dealing with complaints.

Patients in the A&E department were monitored on a regular basis for any deterioration. We saw patients who needed to be were being monitored by electronic equipment checking, for example, their respiratory rate, peak flow, and arterial blood gases. Patients were also monitored for any changes to their vital signs, verbal, eye and motor response rates.

Consultant staffing levels were planned effectively. In 2013 the department had recognised additional consultant

cover was needed. This had been arranged by September 2013. Department information stated the coverage was now organised so there was emergency department consultant presence from 8:30am to 8pm on weekdays (two consultants with a five-hour overlap in the middle of the day) and 12:30pm to 8pm on weekends. We saw the rotas for five weeks of 2014 chosen at random and saw these shifts had been organised.

Nursing staffing levels were planned effectively, although the department was carrying a 12.5% vacancy rate at the end of December 2013. These shifts were being covered mostly by regular bank and agency staff, although staff told us they were not always filled, and the matron said: "we manage". Staff said they made sure they took their breaks, although sometimes they had foregone these when the department was particularly busy. The department budgeted for just under 48 nursing positions (whole-time equivalent). Nursing staff told us this had been recently increased following a review of incidents linked to staff shortages. On our unannounced visit to the department on Sunday 2 March 2014, the department was fully staffed as planned. We were told one of the staff-grade doctors (a locum) had not arrived for their shift on the previous morning and the medical team of three doctors was reduced to two. The lead consultant said the department had "coped well enough" but doctors had not been able to take breaks at times and there was little time for administration and teaching.

The department had cover from either four or five staff-grade doctors each day of the week. There were two or three doctors on shift together during the day and one overnight. There were also two or three senior house officers (junior doctors) on duty on weekdays across the hours of 9am through to 6am the following day, and 9am to midnight on weekends. The doctors were supported by a range of nursing staff and clinical support workers. The matron was in the department most days, and worked one shift on exchange with the matron from the John Radcliffe Hospital in Oxford. Either the matron or one of the senior sisters were on duty over the weekend.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

The department used national recognised clinical guidance to deliver care and treatment to meet people's needs and give good outcomes. For example, the department followed an approved pathway for hip fractures. People who had suffered a stroke were cared for quickly and placed on the agreed stroke care pathway. The pathway had been developed in line with the latest National Institute for Health and Clinical Excellence (NICE) guidelines for stroke care. We reviewed the stroke pathway and saw records showing quick identification and how the patient was managed. The stroke pathway for patients not suitable for thrombolysis showed the duties and decisions in the first and second hours after admittance to the department. This included ensuring staff did not admit the patient to the Emergency Assessment Unit, but straight to the Acute Stroke Unit.

The department recognised the need for people to maintain their nutrition and hydration, and have effective pain relief. The department had scored 91% for the most recent audit (December 2013) of nutritional assessment scores being recorded for patients. Patients we met on our visits had been offered pain relief. The charts we reviewed showed this had been done for the patients in the department. We observed staff regularly checking with patients who had not wanted pain relief if the situation had deteriorated. The patients we met had all been offered a drink and, if they had been there during a regular meal time, they had been given sandwiches. Carers were also offered a drink and there were drink and snack vending machines in the department which were in working order.

Performance, monitoring and improvement of outcomes

The department recognised the pressures it often faced and was proactive in looking for ways to be more efficient. There was a See and Treat service where patients were triaged as soon as possible after arrival. Notes were made about why the patient had come to the A&E department along with some preliminary observations and simple pain relief prescribed. People were referred to their GP where

this was an alternative solution. There was a recently introduced Rapid Nurse Assessment (RNA) system where patients who presented at the hospital who were more seriously unwell (referred to as "majors") were quickly handed over to an emergency nurse practitioner (ENP) by the ambulance team. These highly-trained nurses were able to provide intervention care to seriously unwell patients as part of the RNA system. Two ENPs covered a 15-hour period each day. We spoke with ambulance personnel and they were able to confirm the handover to the hospital team was now "a lot better" and "much improved" following the introduction of the RNA system. The rapid assessment target for the nurse team was to carry out observations and any chest x-rays if needed within 15 minutes of arrival and, records showed, for the majority of patients, this target was met.

Staff, equipment and facilities

Mandatory training for staff was up-to-date. The mandatory training required for staff in various roles was appropriate in both subject and frequency required. For example, fire safety was refreshed following induction every year, as was cardiopulmonary resuscitation (CPR) training. Health and safety and safeguarding, for example, were updated every three years. We saw records for mandatory training for nursing staff and these were clear and comprehensive. The hospital used an electronic staff record system where staff were alerted to any training due for updating. Senior nursing staff were able to oversee training and ensure staff were completing their required courses. We saw records showing nurses who were able to administer pain relief had been tested and their competency assessed.

There was good training and support for doctors within the department. We met two junior doctors who told us the teaching was good. One told us they had received "the best teaching so far" in the A&E department. Consultant cover was provided by a rotation programme for doctors working at both the Horton Hospital and the John Radcliffe Hospital in Oxford. A consultant told us there was a "good relationship" among the consultants and they had regular meetings and had organised educational support away days. There was a GP service arranged by another health care provider. Staff said this alleviated pressure on staff and the services had a good relationship.

There was a lack of specific training for supporting people with cognitive impairment in emergency departments. Staff said they had not had specific training in caring and supporting people with dementia or a learning disability. There was no automatic screening for patients to determine if they had dementia or a learning disability and may have additional needs. There was no evidence staff were not treating people with cognitive impairments without empathy and consideration, but they had not been specifically trained to recognise the signs and risks.

New and temporary staff were supported and mentored. Temporary (locum, agency or bank) staff went through an induction when they first worked at the department. We saw the induction process and approval forms were completed when any temporary staff were engaged. This included verification of their professional registration. Student nurses were able to work in the department in their second year of training and most staff in A&E had been trained to mentor and support student nurses. Due to the complexity of patients and how busy the department could get, there were a maximum of three student nurses working at any time.

Children's emergency services were effective, although did not meet some aspects of guidance around facilities or staffing. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) states there should be one or more child-friendly clinical cubicles or trolley spaces per 5,000 annual child attendances, and children should be provided with waiting and treatment areas that are audio-visually separated from the potential stress caused by adult patients. The current facilities in the emergency department did not meet this guidance. However a senior staff member told us this was under review.

Staff in the emergency department told us the department treated approximately 8,500 young people per year. There was no separate waiting area for children but there was a well-equipped play area children could use to wait for treatment. There was an area in the two-bedded resuscitation room which had appropriate equipment to treat children. There were two treatment bays in the emergency department which staff said they would "try and use exclusively for children" but they would not "delay care just to wait for one to be free." A parent with a six-year-old child told us they were "very satisfied" with the service as it meant they "didn't have to travel over an hour" to access the emergency department in Oxford. Another confirmed their child had been given timely pain relief on arrival.

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Accident and emergency

The standards also identified there should always be registered children's nurses in emergency departments, or trusts should be working towards this. Staff should, as a minimum, be trained in paediatric life support. There were no paediatric trained nurses in the emergency department, although all staff had received recent training in basic paediatric life support. The majority of medical staff spoken with were trained in advanced paediatric life support and had level 3 child protection training. However, staff had access to specialist advice and support via the paediatric nurses on the children's ward at the hospital. A senior A&E staff member told us "it can be challenging in croup season for staff like junior nurses." There was weekly paediatric training jointly between the emergency department and paediatric consultants on the children's ward. Staff told us middle grade doctors did not get the teaching sessions as they cover the emergency department. A trainee GP told us: "I have great support as have access to the paediatric resident 24-hours-a-day, seven days a week." Another staff member said they were "happy" with the level of paediatric support to the A&E Department and the service "feels safe."

In the emergency department a parent told us: "Staffing seem good here as we haven't had to wait long." They said pain relief medication was "given quickly to my daughter." Another said: "We are very happy with the service."

Multidisciplinary working and support

There was good multidisciplinary team support for and from staff of all disciplines. Shifts in the A&E department were covered by consultants who were either present during the times the department had identified as usually the busiest or most risky, or consultants were on call from other parts of the hospital.

Patients were given support from different teams to meet their needs. The lead consultant told us patients who were vulnerable or did not have support they would have needed at home would be admitted to a ward (usually the Emergency Assessment Unit) until support was organised. They would remain there under the care of the A&E doctor, and a visit from an occupational therapist would be arranged as soon as possible. There was otherwise telephone support to staff from social services 24 hours a day.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

Patients were treated with consideration and compassion. Patients we met and talked with at both our visits to the hospital and the public listening events were positive about the care they received. The attitude of staff was described as "first class", "very good", "they have been really kind", and "impressive." Many patients we met had attended the department before and said this was the case on each visit. There were cards and letters on display in the department thanking staff for their care and support. Most of the cards thanked staff for their "kindness."

Staff treated patients and one another with respect. A doctor working in the department told us the best thing about the department was "the experienced caring nurses." A patient told us they felt "like a person" at the Horton Hospital and on a number of recurrent attendees said they had always been well cared for. A parent spoke positively about the support they received in the treatment of their child. They said the consultant they saw was "willing to take the time and listen to me." Patients we met were complimentary about staff and said staff exhibited all the characteristics they would want. This included compassion, respect and a consideration of equality and diversity.

Patients were given privacy and dignity, although there were some shortcomings in this area. Some of the way the environment was arranged was not adequate for good privacy and dignity. This had been recognised by staff and plans were in place to improve this. Patient treatment bays had curtains around them, and we observed staff using these at all appropriate times. Other rooms had doors without glass to avoid people being treated being seen by others. The issues we observed were around patients entering the department from the ambulance bay and therefore likely to be on trolleys, and possibly more acutely unwell or injured. Other patients and those accompanying them sat in the main waiting area were able to see patients brought by ambulance arrive and this was not good for patients arriving or those waiting. If there were no available beds, patients would have to queue in the corridor. The matron for the department explained how new permanent screens were to be erected to obscure the view in future and a new route for x-ray patients was being designed to

Good

Accident and emergency

avoid them moving through the waiting room area. On our unannounced visit there were two patients in the corridor from the ambulance bay. Portable screens were being used around the patients and staff were present with them at all times. We observed they were only in this position for a maximum of 15 minutes.

Involvement in care and decision making

Patients and their carers were involved in any decisions about their care. The patients we met said they were asked for their consent for any procedures or tests. They said they had been able to ask questions about anything they were not sure about, and staff were patient and well informed. The department had scored 100% in the most recent audit (December 2013) of consent decisions being recorded in patient records.

Trust and communication

Patients were supported by good communication. A senior nurse we met in the department told us "communication is everything in A&E." They said: "I'm aware just how much value there was in just keeping people informed. Sometimes that's all they ask and we have to not forget that in what can be really busy shifts." A patient and their relative who had been in the department for six hours waiting for admission to a bed said they were kept informed. The patient said staff "have been checking on me all the time and I feel I'm in good hands, although I would rather not be here." We observed staff caring for this patient and they talked with them clearly and checked if there was anything they wanted to ask at that time. They told the patient when they would be coming back to carry out more observations and said the patient must "not hesitate to use your call bell if you want anything before then or don't feel well." They checked the patient had enough fluids, had been given something to eat, and made sure the relative was comfortable. We observed patients and people accompanying them being informed about waiting times and the reasons for any delays or increases to waiting times.

People with different communication needs were supported. The department had a hearing loop in the reception area. There was access to a translation service and staff on duty knew which of them spoke other languages or could communicate in different ways. The lead consultant said they had used the translation service before and it had been "very successful". There was sometimes a longer wait for more unusual languages spoken, but rarely had this been more than 30 minutes.

Information was available in writing for people to take away or see when they visited. There was a large leaflet selection in the waiting room and posters on the walls. This included telling people about any conditions they might have or be concerned about. There was information about making a complaint or how to contact the Patient Advice and Liaison Service (PALS). There were results from patient surveys displayed on the walls.

Emotional support

The department had a small room available for holding private conversations with patients and relatives. There were other rooms available for providing privacy to patients. One room was set aside as much as possible for patients who had mental health needs or were seen as a risk to themselves from deliberate self-harm. The staff had worked hard to ensure the risks of the environment were as safe as they could be with otherwise no purpose-designed room available. If a patient was at a perceived significant risk, they would be accompanied by a trained member of the security team at all times. Patients who were deliberately self-harming or had other psychiatric problems were generally admitted to the Emergency Assessment Unit overnight for their safety until they could have a psychiatric assessment. They would be admitted under the care of the A&E doctor.

Support for patients with mental health needs was not adequate at times. Staff said they had a good link to a mental health nurse between 9am and 3pm. Outside of these hours the service was provided by another provider and described as "limited at best" by one of the senior staff.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The department had adapted to meet many of the needs of the local community, although not all services were being provided. There was good physical access to the

department for people with a disability, whether physical or sensory. The department had the facilities for providing life-saving care and treatment, including a two-bedded resuscitation area which was fully equipped. There was provision in the cubicle areas for people accompanying patients to sit down. Patients said the trolley beds were comfortable and staff made sure bed rails were used with patients' permission in order to keep them safe from harm.

Some services were not available at the hospital. Patients and staff we met said they were concerned about the recent removal of emergency surgery from the hospital. Patients who arrived at the A&E department and were found to be requiring emergency surgery were transferred to another hospital providing this service (generally the John Radcliffe Hospital in Oxford). A number of patients we met at our listening event said they were not consulted about this and were concerned about the risks this may have for the community. The trust told us about the communication exercise undertaken to inform all internal and external stakeholders about the decision and rationale to remove emergency abdominal surgery from the hospital. This involved meetings with the Community Partnership Network.

There had been some changes made to improve pressure within the department. This included additional capacity created by converting one ambulatory bay into a mixed-sex assessment area with five trolley beds. The ambulatory bay was moved to another area. Additional staff were recruited and equipment purchased to enable the new bay to be operational in November 2013.

Vulnerable patients and capacity

Patients with a learning disability were supported by caring staff. The nursing staff knew some patients with a learning disability may arrive with a "hospital passport". This was a document a person with a learning disability may bring with them into a hospital to explain in writing and pictures what staff might, should, and must know about them. Staff said they knew to read and take account of the information in the hospital passport and to treat the person in a calm environment. They said they knew people with a learning disability were often scared of hospitals and they would try to put them at their ease as much as possible. They said they would be guided by the patient's carer.

Access to services

The pressure on bed space meant waiting times in A&E were sometimes not meeting targets, and this impacted on patient care. We know from evidence about the trust, the A&E departments across whole trust had regularly breached the Government's four-hour waiting target for 95% of patients to be seen and discharged from the department (to home or a ward, for example). The statistical evidence we received from the trust for the year 2013 showed just 1% of children being treated in the A&E unit breached the four-hour waiting target. However, of the adult patients coming to the department, 6% breached the four-hour waiting time target (against the government target of 5%). However, in both March and April 2013, there were 12% of all adult patients breaching the four-hour waiting time target. In January 2014 this figure was also 12%. Otherwise, the monthly data was all single-figure percentages.

The breakdown of the reasons for breaches has not been made available by the trust. We know from talking with staff and stakeholders, the reasons for the target not being met most of the time were predominantly a result of bed space being available in the hospital and therefore not attributable to the performance of A&E staff. The patients we met on our visits who were waiting over four hours confirmed they were awaiting an available bed in the right ward.

Leaving hospital

Patients were given appropriate information when they left the hospital. Patients were given a copy of the letter being sent to their GP. They were encouraged to make sure the GP had directly received the information, particularly if tests needed to be arranged. The lead consultant we met said the organisation had learned how the electronic transfer of records to a patient's GP had proved to be unreliable on occasion. Staff sent the details electronically and now gave patients a copy of the letter and a clear explanation of what they should expect to happen next. Patients leaving the department were also given information on head injury, care of sutures, and wound care advice. This information contained details on how a patient may feel and advice on what symptoms to look out for and when to seek expert advice. The department had access via the internet to other approved information for patients with unusual conditions. Patients admitted onto a ward from A&E were sent with appropriate records. This included the treatment already given and any medication administered.

Good

Accident and emergency

Learning from experiences, concerns and complaints

The department had a positive attitude towards complaints and concerns. The matron had been providing staff with a summary of complaints for just over a year. The number of complaints was relatively low, with the department receiving 32 since January 2013. Trends within complaints had been looked for and any themes were highlighted. Three staff asked independently of one another said the matron for the department would regularly inform staff at team meetings of any complaints made. These would be discussed and, if there was learning from the complaint, staff would focus on making improvements. One example of this was increasing levels of communication with patients so when waiting times became longer, patients knew why.

Concerns were listened to and dealt with. One patient we met at a listening event said they had met a member of staff on one occasion who was "less than sympathetic." They had mentioned this to a nurse before they left the department. They said they had been advised the member of staff had been an agency worker and they appreciated how the nurse apologised for their experience and said it would be addressed. They said the nurse had told them how to make a complaint but the patient said they felt reassured by the "assurance from the nurse" and didn't feel a complaint was needed. The issue with information not reaching or being seen by a GP was another example of complaints being heard. The department made sure patients (or their carers) left with a copy of any letter being sent to a GP and told what to expect if further treatment was required.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

The vision and strategy for the department at local level were clear. Senior staff, such as the matron and lead consultant had plans and strategies including, for example, improvements to the environment. Staff were proud of their department and the care it gave. Most local patients and most staff said their biggest concern was over the future of the hospital and the department. We were told the closure of the hospital had been suggested and there were many rumours about this. The trust had told us that the hospital remains as part of their plans. A local group had been formed to campaign for the future of the hospital. Patients said they were most concerned about the possible closure of the A&E department and the risks to patients of needing to travel to Oxford for emergency care. Three patients with young children said this was of particular concern with child-care arrangements. Staff said the uncertainty around the future of the hospital was affecting staff morale. They were concerned the vacancy rate for nursing staff was high as potential candidates were concerned also about the future of the hospital and coming to work in the local area as a result.

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

Governance arrangements

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

a major trauma centre, so there was good sharing among staff of information and experiences. Any actions were assigned to a member of the team and these were updated at the next meeting.

Leadership and culture

Local leadership in the department was strong. Staff told us and we observed there was strong and committed leadership and support from the matron, the consultants, and the senior nursing staff team. Staff told us they felt part of a team who cared for and supported one another. We met a range of nurses from across the whole hospital at a staff focus group who were band 5 and 6 grade. Each of them highlighted to us how the support of their colleagues and the culture within the hospital was the reason they came to work.

Wider leadership and support was not visible to all staff. A member of staff said members of the executive team were "rarely seen in the department." Most staff told us they felt their voice was not heard among the wider trust, even though their matron and senior staff spoke "loudly" and were "out there promoting us to anyone who will listen."

Patient experiences, staff involvement and engagement

Patients' views were sought and taken into account. When we were visiting the A&E department, we saw staff giving patients the Friends and Family Test response cards, and asking if they would complete them. The Horton Hospital A&E department had done well with its responses to the test with the majority each month much higher than the England average in April to December 2013. In July 2013, for example, the response rate was 25.3% (England average 10.4%). Of the 480 responses, 456 people said they would be "extremely likely" or "likely" to recommend the department to their friends and family. Only six people said they would be "unlikely" or "extremely unlikely" to recommend the department. In November 2013, the response rate was 21.5% (England average 15.2%). Of the 322 responses, 307 people said they would be "extremely likely" or "likely" to recommend the department to their friends and family. Only two people said they would be "unlikely" or "extremely unlikely" to recommend the department.

Learning, improvement, innovation and sustainability

Staff were well supported and understood their roles and responsibilities. Nursing staff appraisals were at 91% for the year to the end of March 2014, which was above the trust target. Regular and locum doctors we met said they felt well supported and part of the team.

The department responded to shortcomings in internal checks and audits. Staff had recently found there were occasions when doctors were not double-checking the prescription of medicines for patients to take out (known as TTO medicines). This was discovered when the records were audited. A new process was developed for TTO medicines and the problem had been resolved. The matron had developed an audit regime to regularly and routinely audit the department against the Health and Social Care Act 2008 Regulations. We saw the framework for audits to be undertaken each month. The department was able to benchmark itself against other departments, such as the Emergency Assessment Unit, and share learning across departments. Different staff carried out a changing variety of audits to develop and improve their skills.

Good

Medical care (including older people's care)

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

Information about the service

The Horton General Hospital provided medical care and treatment for people on three inpatient wards, a renal dialysis day unit, emergency admission unit, and a day hospital.

We visited the three medical wards and talked with 12 patients, two relatives and 10 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

The hospital provided safe care. National tools were used to measure risks to patients and action was taken to address identified risks. Staffing levels were regularly monitored to ensure wards and departments were adequately staffed. Integrated care pathways for inpatients with diabetes were still being devised. Actions included a business case to bring diabetes inpatient specialist nurse numbers in line with the national average as well as early and comprehensive standardised assessments.

Staff were caring. Patients spoke highly about the care they received and the kindness and helpfulness of the staff. Staff worked effectively and collaboratively to provide a multidisciplinary service for patients who had complex needs. Patient views and experiences were sought by the hospital, by the provision of quality questionnaires, and the responses were fed back to staff on the wards. The hospital demonstrated openness to engage with patients and listen to their feedback to improve the services provided.

Good

Medical care (including older people's care)

Are medical care services safe?

Good

Safety and performance

The hospital provided safe care to patients on the medical wards. The trust used the Safety Thermometer which is a tool to measure and monitor risks to patients. It included risks of falls, catheter and urinary tract infections and pressure ulcers. This showed an improvement in the diagnosis of patients experiencing a new venous thromboembolism. The trust was better than the national average when comparing patients who had suffered falls. The Safety Thermometer highlighted the hospital was higher than the national average for new pressure ulcers developing in patients aged over 70 years. These patients were also three times more likely to suffer a urinary tract infection compared with the national average. Nursing staff we spoke with were aware of the use of the Safety Thermometer and were able to discuss with us learning that had come as a result of the data. We were provided with reports which demonstrated the infection control lead nurse audited the numbers of urinary tract infections experienced by patients and training had been provided to staff regarding aseptic non-touch techniques and hand washing. An investigation had been carried out within the trust into the numbers of urinary catheters being used compared with the number of infections patients experienced. The Safety Thermometer demonstrated the hospital was below the England average for the number of patients experiencing harmful falls.

Staff gave us clear examples of when they had reported potential safeguarding issues. Information regarding safeguarding, incidents and near misses was reported through the trust's electronic reporting system and staff were provided with feedback. However, some staff told us they were routinely provided with feedback while others had found they had received feedback on the outcome only if they had followed the incident up and requested information. Information was provided to staff at handover and on a printed handover report regarding safeguarding issues for patients currently being cared for on the wards. This showed patients were safe from further safeguarding issues by knowledgeable staff who had been provided with relevant information.

Learning and improvement

A regular meeting took place in the hospital, attended by senior staff such as consultants, matrons and senior nurses, regarding hospital acquired infections. Electronic reports were audited and investigations commenced to provide a root cause analysis with learning actions when necessary. Such investigations had included a full review of the patients' care records, medical records and risk assessments to seek a full understanding of reported concerns and incidents. This showed the hospital strived to address any failings in previous care.

Systems, processes and practices

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 requirements of each patient. Full, written records of the assessment in the medical records were completed by the medical staff (doctors). Nursing staff were provided with a template to complete a nursing assessment which identified any care and support the patient required during their treatment. Some wound and mobility care plans had not always been completed fully to inform staff of people's needs. There was equipment available, and in use, in order to prevent and support the treatment of patients with pressure ulcers. Support from tissue viability nurses was provided from the John Radcliffe Hospital. This included support for patients with pressure ulcers. Staff reported that although the tissue viability nurses were based at the John Radcliffe, support was provided in a timely manner.

The weekly multidisciplinary meetings for two patients with dementia care needs whose records we reviewed, had identified the need for a best interest meeting. This ensured that decisions, when they could not be made by the patient themselves, were made within the legal framework of the Mental Capacity Act 2005. Relatives and representatives were included in this planning and their views were sought and respected.

Infection control

There were signs and instructions for staff, patients and visitors about hand washing to prevent the risk of cross infection. The most recent NHS staff survey noted that only 50% of staff said hand-washing materials were always available. This was worse than the national average results. During our inspection visit we saw hand-washing facilities in each area we visited and found that antibacterial hand

gel was available throughout all areas for patients, visitors and staff to use. We observed staff used the hand gel and hand-washing facilities between patient contacts. Patients confirmed the staff were thorough with this practice. The ward staff regularly audited hand-washing procedures among their peers and displayed the outcome of the audit on the ward notice board. We saw the audits showed compliance with hand-washing procedures on the wards. The infection control lead nurse for the hospital monitored these audits and also carried out their own checks of hand-hygiene procedures of which records were available for us to inspect. We were told one area of learning which had come from such an audit, was the appropriate use of antibacterial gel together with gloves. Staff confirmed their understanding of the way in which to use the gel to reduce the risk of infection.

Monitoring safety and responding to risk

Staffing levels on the wards were generally at a level to enable them to provide effective care and treatment to patients. Nurses and care support workers said they were moved between wards to cover staffing shortages. Staff said they did not always feel confident to meet specialised needs of patients on the wards to which they were moved. For example, when staff from the paediatric wards were moved to provide care to patients who had experienced a stroke. We observed a meeting, held twice each day in the hospital, which was attended by a senior staff member from each ward where the staffing levels and the dependency and complexity of patients on each ward were discussed. An assessment was made on where the priorities lay for providing additional staff cover. Ward managers told us when staff were moved from another ward or when agency staff were covering a shift, they were supported by the permanent staff on the ward. This ensured patients were safe and their care managed by experienced and skilled staff. We looked at staff rotas for some of the medical areas and found there were gaps in the duties which had not been covered. Shifts had been referred to agencies and bank staff for cover, and staff were able to update us with the progress of this. The NHS staff survey for 2012/2013 identified that 73% of staff worked extra hours. The hospital told us that recruitment of nursing staff was ongoing to meet the needs of patients by the trust's own staff.

We spent time on wards talking to patients and observing when they were provided with care. Staff monitored skin integrity, food and fluids taken, medical observations and the patient's general condition. Staff were knowledgeable about the requirements of patients' care and treatment needs and we observed they were kind, patient and demonstrated empathy and understanding of patients in their care. Staff were able to describe patients' individual risks and how they were being managed.

Staff told us they had received training in the safeguarding of vulnerable adults and children and knew the process to follow, should concerns be identified, to ensure the safety of vulnerable people. We saw information was available for patients, their representatives and the staff on how and who to report any safeguarding concerns. The training provided to staff included the Mental Capacity Act 2005, and staff were knowledgeable about how this legal framework provided protection to vulnerable patients.

Staff had a handover of information each shift when important information was passed onto the oncoming staff. Staff said these handovers were informative and enabled an opportunity for discussion regarding patients' care and treatment needs and any risk factors present. Two student nurses made positive comments about the learning from the handover sessions and how discussions took place to ensure patients were in receipt of appropriate and safe care which met their needs.

Anticipation and planning

As part of the hospital's planning, a surgical ward accommodated medical patients over the busy winter season. At the time of our inspection the majority of patients on the ward required medical care. We spoke with senior staff who were confident the medical care and treatment needs of patients were being met as this was led by the medical consultant under whom the patient was admitted. The consultant and doctors visited their patients daily although one doctor told us the visits were often later in the day as the ward was located in a separate area of the hospital to the other medical wards. One nurse said this had resulted in delays in discharges due to the obtaining of tablets for the patient to take home.

Good

Medical care (including older people's care)

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

Good

Using evidence-based guidance
The hospital provided information regarding their performance linked to outcomes for patients. We were provided with mortality indicators which were within expected range compared to similar hospitals. We also found the Dr Foster national mortality report had not highlighted areas of increased mortality risk.

We visited the ward that took the lead in how the trust provided care to patients who had experienced a stroke. Nationally recognised stroke pathways were in place which integrated the service for patients with the main stroke unit at the John Radcliffe Hospital.

Performance, monitoring and improvement of outcomes
The hospital monitored the care of patients who were admitted to the hospital having experienced a stroke. Hyper acute stroke patients were not cared for at the hospital but transferred to the stroke unit at the John Radcliffe Hospital in Oxford. The staff were confident that appropriate treatment was commenced within the four-hour target when patients attended the emergency department. Monthly audits were conducted and we found where targets were not met, an investigation was undertaken to establish the reasons for this. We saw from the audits for January 2014 and December 2013 that one patient during each month had not been directly admitted to the stroke unit as their GP had admitted them to the emergency medical unit which had delayed the process. For these patients, once a diagnosis had been made, they were immediately transferred to the stroke pathway and treatment started promptly.

Staff, equipment and facilities
Staff made positive comments about their experiences of working at the hospital. They said the hospital was a warm, friendly environment and were enthusiastic about the manner in which all staff and departments worked well together and as a team.

Clinical Nurse Specialists worked throughout the hospital and supported ward-based staff to ensure patients with specific needs, for example, stroke and diabetic care, received appropriate care and treatment throughout their stay at the hospital.

Staff on the ward which cared for patients who had experienced a stroke had been provided with additional training to be able to competently assess a patient's swallowing reflex. This meant that when the speech and language therapists (SALT) were not available patients did not have to wait for assessment. An additional SALT had recently been recruited and each ward had an allocated member of the SALT team to support the ward-based staff. Additional training had been provided to staff to enable them to support a programme of rehabilitation on the ward. There was no access to rehabilitation services in the community and therefore patients stayed on the ward for this part of their treatment.

Medical cover throughout the week was provided by two specialist stroke consultants with on-call medical cover at weekends and overnight.

Staff told us they had access to appropriate and suitable equipment within the hospital.

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. The delivery of this agreed care and treatment were not always recorded so that a written record was available to all parties to ensure continuity of care. Where nutritional intake was monitored we found fluid and food charts had not always been completed. Turning charts to support people to manage their skin integrity in line with guidelines were not always completed.

We followed the pathway of some patients through the hospital from their admission to the wards. Patients we spoke with were satisfied and confident regarding the care and treatment they had received. We also were able to evidence planning took place around the patients discharged and was discussed throughout their stay in hospital. This ensured the discharge was not delayed.

Multidisciplinary teams were involved with patients when they prepared to leave the hospital. The hospital's

discharge liaison nurse was positive in their comments about the team working both within the hospital and at the interface of community and hospital services to promote effective discharges for patients. Discharge plans were discussed during the multidisciplinary meetings to ensure appropriate action was taken at an early stage in the patient's pathway so that discharges from the ward were not delayed. For example, when setting up care packages to continue at home, contacts with external agencies were recorded and meetings set up for external care providers to visit the ward to assess the patient.

Are medical care services caring?

Good

Compassion, dignity and empathy

Staff talked with patients on the wards in a warm, friendly manner. Care was explained and patient consent sought prior to carrying out any care or treatment.

Curtains were drawn around beds when care was given ensuring patients privacy and dignity was maintained. Patients had access to call bells and when these were rung they were answered promptly. Patients confirmed their privacy and dignity were respected and most were positive about the care they had received and regarding the staff who delivered that care. Two patients informed us they had experienced one member of staff who was abrupt in manner.

The medical wards we visited during our inspection were able to provide patients with single-sex accommodation. Information was provided to patients regarding these arrangements in the hospital information booklet. One senior member of nursing staff outlined the procedure should the pressure on beds mean shared-sex accommodation would be required. Clear protocols were in place to ensure patients' privacy and dignity would be respected at these times.

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. One relative was positive in their comments about their involvement and was clear that their opinion was sought and they felt they and the patient were listened to by all of the staff.

We observed nurses explained patient's medication to them prior to administering it and obtained the patient's consent at each stage of the process.

Trust and communication

Information was available in alternative languages, on the wards for patients whose first language was not English. This included information about how to make a complaint. There was also access to an interpreter service by the provision of an interpreter to come to the hospital or through a telephone service. Staff gave examples of when this had been used.

For patients who were hard of hearing, a hearing loop system was available on some wards and information could be provided in an audio format if required. For patients with visual impairment, information was available in large print and braille. While these formats were not readily available on the ward, administration staff we spoke with were informative and knowledgeable about how to obtain these resources.

Patients and their relatives were provided with opportunities to feedback their views and experiences of the hospital through quality monitoring surveys on each ward. Several patients we spoke with told us they planned to complete these as they had been so pleased with the care and treatment they received from the nursing staff on the ward.

Emotional support

Patients and those who cared for them were given time and space to make decisions about treatment or their future. There were private rooms available for discussions about end of life or palliative care.

Good

Medical care (including older people's care)

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Staff were proactive in meeting the needs of patients in the hospital. One consultant was due to see a patient in the outpatient department, but they had been admitted to hospital. The consultant visited the patient on the ward so that they did not miss their appointment or have to attend the hospital again following discharge.

Vulnerable patients and capacity

We spoke with staff regarding the care of patients with dementia. Staff told us they nursed patients with dementia on the acute medical wards but were not always able to access additional staff to support the patient. We were given an example of how this had impacted on the patient themselves and on other patients as their level of confusion had risen. We found patients with specialist needs, such as dementia, were highlighted at the staff meetings each day and additional resources made available on the appropriate wards if possible. This showed the hospital strived to provide appropriate support and increase staffing levels when possible, although this was not always achieved. Additional training had been provided to staff on the wards to ensure they were competent and knowledgeable when providing care to patients with dementia. A link nurse had been identified on each ward to take the lead role regarding dementia care and staff were positive in their comments about the support they and the patients received from the dementia link nurses

Access to services

The hospital had taken action to meet the predicted needs of the local population. For example, one of the surgical wards was reconfigured to enable the admission of additional medical patients during the winter months when it was recognised higher numbers of medical patients required care and treatment.

A process had been put into action to increase the availability of medical beds by discharging patients to the day centre while they were waiting for medication to take home or transport. This meant the hospital was providing an earlier opportunity for someone else to be admitted to the ward. We spoke with staff in the day centre, on the wards and the discharge liaison nurse who all considered this was working well. One patient accessed this service during our inspection and they were satisfied with the service provided to them. They spent approximately two hours in the day care unit while waiting for discharge home. The nurse on the day care unit was able to spend time with them to ensure all arrangements were in place for when they got home and discussed all their medicines with them.

Where possible patients were admitted to medical wards that specialised in their condition. For example, Oak ward specialised in the care of patients with a stroke as well as acute medical conditions and Laburnum ward for patients with cardiac and respiratory conditions. When the amount of available beds were limited on the appropriate ward, patients were admitted into another medical ward and then transferred when possible and appropriate. The ward staff liaised and discussions took place at the daily staffing meetings and multidisciplinary team meetings to ensure patients were situated appropriately.

Patients with specialist care and treatment needs did not always have access to specialist services to enhance their recovery. For example, the week prior to our inspection there had been no cardiologist available at the hospital as all three consultants had been on leave. Patients requiring this service had been treated by the acute medical team on call. There had been no diabetic specialist consultant in post for a period of time which meant the acute medical teams provided care and treatment to patients with diabetes. This had been recognised by the trust and a diabetic specialist consultant had been appointed on the week of our inspection. Inpatients had access to a visiting diabetes specialist nurse while more were being recruited. Staff informed us this person was approachable and helpful but at times working under pressure.

Leaving hospital

Information for patients regarding the discharge and associated procedures was available on the wards in the form of leaflets and also specific information for individuals was provided. The staff were proactive in monitoring discharge times and each ward had a whiteboard which clearly highlighted the planned discharge date so that any delays could be seen at a glance. We heard from staff and patients that patients had been delayed in leaving the hospital for a variety of reasons. These included a lack of

appropriate placements in the community, rehabilitation placement availability, high family expectations and community care not being readily available. This led to patients remaining on the medical wards when they were deemed fit to be discharged which affected the availability of beds to admit poorly patients into.

Learning from experiences, concerns and complaints

The trust had found discharges had been delayed in a high percentage of patients, based on their auditing in the past. As a result, a discharge co-ordinator had been appointed and had been in post for almost one year. The latest audit figures indicated the delayed discharge figures were considerably lower than previously.

Information was available on the wards regarding how to make a complaint or raise a concern. The Patient Advice and Liaison Service (PALS) provided a confidential service for patients, relatives and carers. There were posters and leaflets containing their contact details available throughout the hospital.

Are medical care services well-led?

Good

Vision, strategy and risks

During discussions we had with staff it was evident they were proud of their hospital and were committed and passionate regarding the care provided to patients. Staff and patients expressed concern at the relocation of some services to the John Radcliffe hospital which was located some twenty miles away. People told us they had not felt consulted or listened to by the trust regarding these changes.

Governance arrangements

During our discussion with senior managers, ward-based staff and clinical specialist staff it was clear that monitoring arrangements were in place. We saw information on noticeboards that provided feedback to staff on the outcomes of audits and governance meetings.

The trust compiled and kept up to date a risk register which identified serious patient safety risks and those that breached waiting time targets or good practice guidance. The risk register was made available to us prior to inspection and we saw action plans to reduce the identified risks were in place together with clear dates for review. This showed the trust responded to and addressed risks to patients and visitors to the hospital while continuing to review improvements.

Staff told us they were aware that care-planning records required improvements. Work was ongoing to review the documentation across the medical wards and in the emergency admission unit to bring consistency in the templates used and improve its quality and effectiveness.

Concerns had been raised regarding falls sustained by patients in the hospital. Falls were recorded through the electronic reporting system and were audited at a senior level. As a result of the monitoring of these incidents additional equipment had been requested and provided, for example alarmed mats to alert staff to patients assessed at risk from falls. The Rowan Day Unit offered care and support in the form of physiotherapist-led group sessions to outpatients who were at risk from falls. This service had recently been available to patients from the wards to attend as part of their ongoing care and treatment. This demonstrated that incident reporting was monitored, solutions sought and good practice transferred across departments.

Leadership and culture

Medical and nursing staff were dedicated and committed to providing good patient care, and to improving care. Staff told us they felt supported by their immediate managers and could approach them with any concerns and felt they would be listened to. Staff were positive in their comments regarding the matron, who they found approachable and who visited the wards regularly.

It was evident that a clear understanding of the organisational structure was in place at the hospital. However, staff felt that support from the trust's senior management team and board, who were located at the John Radcliffe Hospital, was not as evident, with some staff expressing feelings of isolation.

Staff told us there was a lead physician in post at the hospital who was consulted when necessary regarding management issues. The lead physician was allocated two hours each week as management time for this role, out of their role as a clinician.

Good

Medical care (including older people's care)

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. Information about the ward or department was displayed in the corridors which meant it was visible to staff, patients and visitors. This demonstrated openness by the hospital to engage with patients and listen to their feedback to improve the services provided.

Good

Surgery

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

Information about the service

A range of general surgery was provided, including orthopaedic, gynaecological and general. Services were managed within five clinical services divisions. There were four surgical wards; G ward (day-case gynaecological surgery), F ward (orthopaedics), E ward (surgery) and a day-case unit which was attached to E ward. The hospital had four operating theatres.

We visited all of the wards and the pre-admission assessment unit. We also visited two of the theatres and the endoscopy unit.

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

Summary of findings

There was consensus among patients, carers and staff that staff were dedicated and provided compassionate, empathetic care. Processes were followed to reduce any risks to patients undergoing surgical treatment. There were processes to ensure patients who moved to different wards received consistent and safe care and treatment. Staff made use of the language line facility and interpreters to ensure patients had 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 patients. However, concerns were expressed about access to MRI imaging. Patients had to go to the John Radcliffe Hospital in Oxford to access MRI imaging; we were told that difficulties in arranging appointments meant there was a risk that some patients' treatment would be delayed.

We saw good evidence of team working at ward and departmental level. However, with some of the clinicians, there was a feeling that despite being part of Oxford University Hospitals NHS trust, the views and opinions of staff at Horton General Hospital were not always heard.

Good

Surgery

Are surgery services safe?

Good

Safety and performance

Safety in theatres at the 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. This accounted as a surgical directorate for 34% of all incidents reported across all specialties. Of these 192 were graded moderate, 11 abuses, 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. Never events are largely preventable patient safety incidents that should not occur if preventative measures are taken. Neither of the never events occurred at Horton General Hospital but staff throughout the surgical directorate were aware of them and included in the root cause analysis and lessons learned.

Doctor Foster hospital mortality data showed 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.

As a result of the departure of three surgical consultants in January 2014 the trust had temporarily suspended abdominal surgery at the hospital. This was done to ensure the safety of patients. Following this, a review of emergency abdominal surgery was conducted. This considered guidance from professional organisations such as the Royal College of Surgeons. As a result, to ensure patient safety was not compromised, emergency abdominal surgery was transferred to the John Radcliffe Hospital in Oxford. A clinician told us the hospital was: "a safer place than before."

The safety and wellbeing of patients undergoing surgical procedures was protected. As is best practice, the Oxford University Hospitals NHS Trust used the World Heath Organizations (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 theatres where we observed practice. The theatre staff we spoke with said the checklist was done well.

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 NHS Trust had a children's and adults' safeguarding policy. Training about safeguarding adults and children was part of the mandatory annual training that all staff completed. Staff at Horton General Hospital knew about the policy and were confident about reporting safeguarding concerns. However, some members of staff working in the theatre complex were unclear what process was completed after they reported concerns.

The security and safety of the theatre suite was acceptable. Access to the theatre was secured with the use of a key-pad system.

Learning and improvement

The hospital learned from incidents and took action to avoid recurrence. Theatre staff gave examples about changes in practice made as a response to incidents that had occurred. This included incidents that occurred locally at the Horton General Hospital and incidents – such never events – reported across the trust. Weekly and three-monthly auditing of the WHO checklists meant that processes to ensure patient safety were being monitored.

On the surgical wards, staff knew about the process to report incidents. Examples were given where practices had been changed as a result of incidents and complaints. This included on the gynaecological ward improved processes to ensure patients fully understood the information given to them, so they were fully aware about what to expect during their treatment.

Systems, processes and practices

The wards had systems and practices to follow to ensure patients received consistent and safe care. On the day-case unit standardised care plans were used to ensure patients received safe and appropriate care. On the orthopaedic ward 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 these were being used.

Track and trigger monitoring forms were used. This meant that patients had their health monitored at intervals appropriate to their health care needs.

The surgery lists of the gynaecological day ward sometimes had cases that required overnight stays. Processes were in place and followed to ensure overnight beds in the surgical ward were available for these patients prior to their surgery taking place.

Staff demonstrated a good understanding of the application of the Mental Capacity Act 2005 in relation to patients being involved in making decisions about their care and treatment. We saw, where applicable, best interest decision meetings were held, to support the decision making process. This was demonstrated on the orthopaedic ward where some patients had a degree of dementia. Decisions about care and treatment were made after recorded discussions with the patient, family members and relevant health and social care professionals.

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 they understood the application of the Mental Capacity Act 2005. To demonstrate their understanding, staff on the gynaecology ward described a situation where assessments were completed and documented about a person's capacity to make their own decisions. This assessment resulted in the decision being made that the person, despite having communication difficulties, was able to make their own decision about their care and treatment.

Patients were supported to meet their nutrition and hydration needs. Nutritional needs were assessed on admission and plans were in place. Inpatient wards had protected meal times, so patients were not disturbed when having their meals. On the orthopaedic ward, where there were a high number of elderly patients, relatives were encouraged to support their family members with eating at meal times. We observed on the same ward that drinks were available and staff supported patients with their drinks at frequent intervals. On the day-case ward, snacks, such as toast and tea, were provided after patients recovered from surgery.

Patients' pain was well managed. There were processes followed for monitoring patients' pain. Patients said that staff provided them with pain relieving medicines when they needed it.

Infection control

There were sufficient hand-washing facilities on the surgical wards and 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. We observed staff washed their hands between contacts with each patient. This practice reduced the risk of cross infection.

Monitoring safety and responding to risk

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 inpatient 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.

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.

Processes were in place to raise concerns. Staff knew how to raise concerns and were confident that concerns would be managed in an effective and confidential manner. They felt confident their line manager would respond appropriately to concerns they raised.

Good

Surgery

Anticipation and planning

Anticipation and planning for surgical procedures was done well. For non-emergency (elective) procedures the trust data showed little variance with the anticipated workload planning.

On surgical wards planning was done well to reduce any potential risks to patients. Staff assessed patients promptly on admission in order to identify risks. If patients required a higher level of observation the workload was discussed at handovers and organised to facilitate the required level of support. Staff told us that they could request additional staff to facilitate intensive monitoring.

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 NICE guidance for preadmissions when assessing patients. The WHO checklist was used in the theatre complex to ensure patient safety. On the orthopaedic ward staff were following the Falls Safe Project, to reduce the risk of patients falling. This project was supported by the following partner organisations: the Royal College of Nursing, the National Patient Safety Agency, NHS South Central, the British Geriatrics Society, and the patient safety charity Action Against Medical Accidents.

Performance, monitoring and improvement of outcomes

We found generally that patient record keeping was good. On the wards, records were good, with a few gaps, but overall well completed. 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 patients' care was reviewed daily and their care plans altered according to their needs and wellbeing.

Staff, equipment and facilities

Staff told us they were provided with suitable training to support them in meeting the needs of patients, which they were up to date with. This included training in dementia, falls, infection control. Data that we saw on wards confirmed this. Staff all said they were supported by their line managers and felt able to raise concerns. They said they were listened to and concerns were taken seriously with action taken as a result. Patients said they were confident staff had the skills and knowledge to provide the care they needed.

Generally there was sufficient equipment to meet the needs of the surgical patients. We saw equipment for procedures and monitoring of patients in the operating theatres was readily available. Staff told us 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 and moving and handling equipment available in suitable numbers. Procedures were in place to ensure all equipment was routinely serviced and checked. We saw records to demonstrate this was occurring.

Clinicians told us difficulties in accessing the MRI scanner at the John Radcliffe Hospital in Oxford meant there was a risk that patients' treatment was delayed. Patients who required an MRI scan had to be transported to John Radcliffe Hospital because there was no availability for MRI scanning at Horton General Hospital.

Multidisciplinary working and support

There was good team working and peer support. Clinicians working in orthopaedic surgery were proud of the multidisciplinary and integrated approach to caring for people with complex needs. The majority of patients were elderly and had co-existing illness and/or cognitive impairment. An ortho-gerontologist (a doctor who specialises in caring for older people with orthopaedic injuries) worked on the ward to provide medical input and ensure an integrated approach to their care and treatment. There was a multidisciplinary approach to planning the care, support and discharge for patients on the orthopaedic ward. This included the involvement of nursing, medical, physiotherapy, occupational therapy and social work staff. A liaison psychiatric service had recently been introduced by the trust. This meant support could be accessed for patients on any ward who had any form of mental-health need.

Good

Surgery

Are surgery services caring?

Good

Compassion, dignity and empathy

Patient experience of care was good. All patients we spoke with in the hospital told us staff were caring and kind. We observed good care on all wards in all interactions.

Patients' privacy and dignity was respected. We saw that curtains were drawn around patients' beds when personal care was provided. Ward accommodation was segregated so men and women were afforded privacy and dignity. Relatives told us from what they observed all patients were treated with respect and dignity. A relative told us: "Curtains are always pulled round [them] and other patients when care is being delivered." Patients had access to call bells which they could use to call for assistance. We saw 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. However the Friends and Family Test did not apply to day case services. At the time of our inspection there was a survey being completed by the anaesthetic department about the day case patient experience.

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 a manner that they could understand. They said consent procedures had been done well. They did not feel pressurised to make a decision or follow a treatment plan they did not understand or were not happy with. Patients with planned admissions had appointments with the pre-admission nurse prior to their admission. Literature about their operation or treatment and what to expect when they came into hospital was provided both in the written form and verbally at this appointment. Patients told us they felt fully informed about their admission and treatment.

On the orthopaedic ward there were some patients who had varying degrees of dementia illness. Staff involved the patients in their care by speaking with them in simple sentences and using visual aids to help their understanding.

Relatives of patients on the orthopaedic ward confirmed they were involved in the planning of their family members of care. One relative told us: "All care and treatment is explained to me and to my [parent]."

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 patients' 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 understanding 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.

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. They said their needs were being met

and that all staff were responsive to their needs. One patient said "nothing was too much trouble". Most patients who had used their call bells when they needed help said, staff always responded quickly.

Vulnerable patients and capacity

There was recognition that a large proportion of the orthopaedic ward included a high proportion of older patients, some of whom had dementia. On the orthopaedic ward we looked at three care plans for older patients. They detailed that the patient had some degree of dementia. There was a structured care plan for people with dementia that was adapted to meet the needs of the individual patient. We observed that nursing staff were following the guidelines set out in these care plans when providing support to patients.

Patients, relatives and staff said consideration for a person's mental capacity was done well. Staff on the gynaecology day ward provided an example where a patient with a learning disability had their capacity assessed to determine whether they had capacity to consent for their own treatment.

If patients had to be transferred across wards this was done in a way that ensured their needs could be met. Processes were in place to provide relevant guidance and training to nursing staff on the general surgical ward about the care of patients who had undergone gynaecological procedures. This was because in some circumstances patients were admitted to the gynaecological ward as a planned overnight stay on the general surgical ward.

Access to services

Access to services was good. Patients told us that there were no delays with their admission to hospital. Staff told us there were rarely any cancellations to the surgery schedule.

Leaving hospital

Discharges from the hospital were well planned. Patients on the general and gynaecological surgical wards told us their discharge from hospital was discussed at their pre-admission assessment and when they were admitted to hospital. A relative told us they had been fully involved in their parent's discharge arrangements, which included ensuring the appropriate health and community support was in place before they were discharged.

Staff told us that patients' discharge was planned as soon as they were admitted. 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. We saw that an estimated discharge date was recorded in patients' notes. Most patients 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 and asked about their home circumstances and the support available to them. Arrangements were confirmed about how they would get home.

Another patient had been admitted for a procedure that would normally be considered as a day case procedure. The patient told us that following discussions during the pre-admission process, plans had been made for them to be an inpatient because they did not have the required support at home for the first 24 hours following surgery.

Learning from experiences, concerns and complaints

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

The hospital routinely captured feedback using the Friends and Family Test. Staff told us 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. Some staff could not say what the vision and values were in relation to the trust but portrayed the NHS values to provide excellent patient care.

Governance arrangements

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

staff working at the hospital felt that the views and opinions of staff working at the hospital were not heard by the trust. This included the concerns among the staff about the future of the hospital.

Leadership and culture

Many of the staff we spoke with felt well supported by their immediate managers. A clinician told us the hospital was: "a great little hospital." However, a common theme running through our conversations with staff was that there was a lack of local leadership at the hospital. This was because the leadership was divided into divisions that ran across all four sites of the Oxford University Hospitals NHS Trust. Staff felt this meant at times there were delays to implementing changes at the hospital or taking hospital-wide decisions.

Patient experiences, staff involvement and engagement

Patients' views and experiences were a key driver for how services were provided. There was information displayed showing how the ward was performing and the Friends and Family Test results. Staff said they felt involved and informed about patient safety and experience. The division 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

Staff we met said they felt encouraged within their division to learn and improve. The General Medical Council reported the trust had mostly similar or better than expected in results from the national training scheme survey for doctors in the surgical services provided at the hospital.

Good

Intensive/critical care

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

Information about the service

The intensive/critical care unit at the Horton General Hospital was a six-bedded unit located a short walk from the accident and emergency department and next to the trauma/orthopaedic ward. The unit was used to care for people who needed high dependency care, intensive care or coronary care. There were two beds configured for intensive care of patients needing a ventilator to support their breathing. The unit had two side rooms which could be used for isolating patients with an infection, or providing more peace and quiet or privacy if a patient was at the end of their life.

We visited the unit in the daytime on a Tuesday during the morning and again for a brief visit on a Sunday evening. We spoke at some length with one of the three patients in the unit on the Tuesday morning and with the relatives of another patient. We spoke briefly with a patient on the Sunday evening when there were four patients on the unit. We spoke with eight members of staff. These included nursing staff, a critical care assistant, a consultant, and an anaesthetist. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Patients received safe care, which was compassionate, dignified, and delivered good outcomes. . Mortality rates were below the national average and below the expected level for patients in a critical care unit. The caring and consideration of staff was good. The patients and relatives we spoke with praised the nursing and medical staff highly. Vulnerable patients were well supported and staff put the patient at the centre of their care.

The department was well led at local and senior level and staff were supported and proud of their work. There were some issues with patient discharge not being timely or being delayed, but this was due to pressures on beds elsewhere in the hospital. On a national level data from the latest Intensive Care National Audit and Research Centre report showed this problem was not significant.

However, the critical care department was not fully effective in relation to medical cover. There were skilled and experienced anaesthetists and consultants attached to the unit, but not all were trained in critical care. The lead medical consultant was trained in critical care, but this was not their substantive post and they were not available at all times. There was no evidence this had resulted in patients being put at risk, but the arrangements did not meet the national guidelines for medical care in intensive care units.

Good

Intensive/critical care

Are intensive/critical services safe?

Requires Improvement

Safety and performance

The department had a good record for safety and performance. The unit contributed their patient data and outcomes to the Intensive Care National Audit and Research Centre (ICNARC) so they were evaluated against similar departments nationally. The unit performed well in the year April 2012 to March 2013 for unit-acquired Methicillin-resistant Staphylococcus aureus (MRSA) and outbreaks were low. This was a slight increase however, over the 2011/2012 year where rates were zero. The unit mortality rates were low and below the national average. The ratio for mortality was measured by observed against expected deaths. Scores below 1.0 meant there were less observed deaths than would have been expected. The Horton Hospital had a ratio of 0.9 for the 2012/13 year, and although this was slightly increased on the result of 0.8 for the previous year 2011/12, was a good result.

Patients and their relatives felt care was safe. Patients we met on the ward said they felt safe in the department and with staff. The ward was locked and visitors had to say who they were and be identified before coming onto the ward. Staff said they were particularly careful about identification when admitting visitors to a patient who was not able to identify them (as they were not conscious, had dementia, or were sedated). We observed care being given and saw staff following guidance in the personal protective equipment they were wearing and using. The unit was calm, well-lit, spacious, clean and tidy on both occasions when we visited. The environment was safe and well maintained. Staff were seen checking and completing charts and monitoring patients' clinical indicators as required.

Staff were aware of safeguarding procedures. Staff described some events where they had contacted the safeguarding team in relation to vulnerable adults and a young person they were supporting. There was a flowchart for use when making safeguarding referrals. This described what patients would be classed as vulnerable, what matters would constitute possible abuse, and what to do. Staff had been trained in safeguarding vulnerable adults and children and their experience showed they were competent in reporting suspected abuse.

Learning and improvement

The department learned from incidents. Each incident was reviewed by a member of staff of the relevant seniority. Serious incidents were reviewed by an independent senior manager. Training in safe patient transfers was provided to all staff following an incident where staff arrived at another unit and could not get access to it. Changes had been made to medicines storage following learning from another incident.

Systems, processes and practices

Security of patient records was improved during our visit. When we visited on the Tuesday we saw the patient notes were being kept in an unlocked filing cabinet at the entrance to the main area of the ward. The drawer was also labelled as "patient records". We discussed the issues with security and safety of these records with the senior staff as although the unit was supervised at all times, we thought these records were not as secure as they should be. When we went back to the ward on the Sunday evening, the records had been moved and relocated to an unmarked drawer within the clinical area.

A checklist was available for staff to use to guide assessments of mental capacity. The admission assessment each patient was given assessed their psychological and social needs, and those of their family. Staff said patients who were not able to take 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.

Medicines management

Medicines and equipment were safely stored. All the medicine cupboards and medicine refrigerator were locked. The sluice room and equipment room was well organised and stock was clearly marked. Equipment was stored off the floor to help with cleaning routines. The pharmacist visited the department each day during weekdays to check on medicines and drug charts. The emergency resuscitation trolley and the difficult intubation trolley were checked on each shift and we saw the checks were up to date and all equipment was present and correct.

Good

Intensive/critical care

Monitoring safety and responding to risk

The unit had staffing levels that met the needs of patients. If staffing levels were not met from permanent staff, the unit used agency or bank staff to cover absences. There was a regular cohort of bank and agency staff, most of whom had experience of working on the unit before. The senior sister told us if new agency staff came to work on the department, they would be checked for their competence before they started a shift. Any staff who did not meet the standards required would not continue a shift and a replacement sought.

The skill-mix and experience of medical staff was not always appropriate. Patients who were admitted to the unit came under the care of a consultant looking after their underlying illness who was not based in the department. The unit did not have full-time dedicated intensive care doctors or consultants. The hospital provided medical care to patients using their team of anaesthetists who spent a day each week supporting the unit with two doctors on call covering the whole day. Not all the anaesthetists were trained in critical care medicine. The medical consultant lead for the hospital was trained in critical care, but this was one person who was not at the hospital at all times and had other responsibilities. There was no evidence this had affected patient care or safety, but it did not follow recommended guidelines for critical care.

There was a low level of experience of some typical patient treatment and procedures in some areas. The unit had a relatively low number of patients coming for ventilated care and treatment. In the previous year this had been around 68 patients (around 10% of total patients). The senior management of the service were aware of this and the risks of staff being deskilled from a lack of regular experience of ventilated patients and were considering how best to increase these skills or provide more exposure to this area of care.

There was an escalation policy to be used when the unit was full. Staff would initially contact the other two critical care units in the trust locations. If there were no internal beds available, staff would then contact the local area bed network to see if there was available space at other hospitals. Additional staff could be drafted in to cover increasing levels of demand or higher-dependency needs.

This would usually be a relatively low number of staff at any one time as the unit was limited to supporting a maximum of six patients, with only two needing one-to-one nursing care.

Patients had named nurses and doctors caring for them. Each patient, their relatives, and other staff knew who their nurse or doctor was. Relatives we met said staff always introduced themselves when they arrived and said who was responsible for the patient. If there were any staff the patient or relative had not yet met, they were often introduced by the senior member of the team.

Anticipation and planning

The staffing levels for patients needing critical or intensive care followed the national guidelines. Patients who were assessed as level three (for example, patients requiring advanced respiratory monitoring) were given one-to-one nursing care at all times. Patients who were assessed as level two (for example, patients requiring more detailed observation or intervention) had two-to-one nursing care at all times. The unit also looked after level one patients (for example, patients at risk from their condition deteriorating or stepping down before going home or to another ward) who also received two-to-one nursing care. This meant one nurse looked after two patients. The unit had experienced some recruitment problems recently in appointing to a band five nursing vacancy but this had now been filled. In the interim period bank and agency staff were being used from a regular cohort of local trained staff. There was also support from the teams at the Oxford sites and vice versa to cover any unplanned absences among staff.

Are intensive/critical services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

Care was delivered in accordance with evidence-based guidance and best practice. Patient records showing medicines were given as prescribed. We saw records and observed patients were turned in accordance with good practice to avoid skin damage from remaining in the same position too long. Patients' fluid and nutritional intakes were measured and recorded. Patients were asked

regularly if they were in any pain or discomfort and this was recorded. Patients were assessed for their risks of falls and appropriate management was in place to support them to move around safely.

Performance, monitoring and improvement of outcomes

The unit monitored its performance and took actions to improve against identified shortcomings. We reviewed audits for the department for four weeks in 2013 and four weeks in 2014. We saw some of the few shortcomings were as a result of agency staff not completing some paperwork fully. There was an action to discuss this with the relevant member of staff. Some of the audit results were displayed on the notice board in the unit for patients, staff and visitors to see. This included audits around hand hygiene, aseptic non-touch technique and ventilator-associated pneumonia. Scores were all above 90%. Scores for other audits such as urinary catheter care, central lines, and use of the tracheostomy care bundle were all at 100% from 25 November 2013 to 27 January 2014. There were no reports of any hospital-acquired infections (such as MRSA or Clostridium difficile during this period).

Staff, equipment and facilities

New nursing staff were given induction time, training, and mentorship. For new nursing staff, the first four weeks were spent on the unit in a role which was supernumerary to the current staff. The new nurses or critical care support workers were therefore not counted among the established staff during this time, so patient care remained provided by experienced staff. They were also able to have two further weeks in the early months of their placement to have supernumerary time and training. The senior sister delivered foundation training to new nursing staff and their competency was assessed through an approved framework of testing. College courses were available for nurses following registration and junior staff were able to spend time at the John Radcliffe Hospital or Churchill Hospital unit for further experience.

The facilities for care were acceptable. The patient area in the unit was spacious, clean, well-organised and tidy. Staff had a clear and organised area to work and observe patients. All patients were clearly visible to staff, and those in the two private rooms could be monitored but also have privacy to sleep and be quiet. There was a staff kitchen within the unit and close to the clinical area. The kitchen had no door and the wall did not meet the ceiling. Staff agreed the placement of this kitchen was not ideal. We observed a doctor wash their hands in the kitchen sink after clinical contact with a patient. There was also a mixed-sex changing room for staff, but staff said they had adapted to this. We observed the fire doors were unlocked from the inside as they should be, and were clearly marked. There was a fire escape route from the rear of the unit that required people to re-enter the building through another door, and this was also accessible and safe.

Mandatory training for the department was well managed and on track. The unit followed the trust's mandatory training programme and courses were delivered in accordance with trust policy in terms of type and frequency. We reviewed a number of mandatory training records with the senior sister responsible for the nursing staff. The senior sister's mandatory training was 100% up-to-date and the date of the expiry of any courses was clearly shown. The staff managed by the matron had completed 97% of mandatory training to date with one month still available to complete training. Staff were alerted through the electronic staffing records of any upcoming expiry of training certificates and this was alerted to their manager. Personal development opportunities were also available to staff, and this was discussed at annual reviews, or when opportunities arose.

Equipment was serviced and maintained. The unit had an agreed equipment replacement programme which staff said was adhered to. They said the equipment was maintained and serviced as required and was quickly repaired. The mattresses for patient beds belonged to the department and were not used elsewhere. The department had two high-quality mattresses designed for patients who needed additional support to prevent pressure ulceration. These would be used for patients who were expected to have prolonged stays or limited movement.

Multidisciplinary working and support

The critical care unit had effective multidisciplinary working. Patients who were admitted to critical care had support from a consultant anaesthetist during their time on the ward, and their own divisional consultant. The unit did not work with a specialist intensive care consultant. We saw from records and observation, the consultant responsible for the patient in critical care or a member of their team visited the unit each day. They met with the

patient and their relatives if they were on the unit. If the patient was not conscious, the consultant reviewed the latest charts and discussed the care with the anaesthetist and the responsible nursing staff.

The unit did not provide an outreach service within the hospital. Many critical care units in England provide an outreach service where critical-care staff either followed-up patients who had stepped down to ward-based care, or were showing signs of deterioration on a ward and would benefit from input from a member of the critical care team. This lack of outreach was overcome to an extent by the unit being able to take less critical care patients if there was capacity. There were plans being made to consider reintroducing this service in the future.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

The two patients we spoke with said the staff were kind and caring. One patient said they felt "very safe" in the unit and said they had "great, really terrific care." Two relatives of a patient said the staff had been "flexible with us and our visits" and "very caring." They said they were enabled to visit at any time and staff quickly brought them up to date with any information if they had missed the consultant rounds. They said the consultant and anaesthetist had taken time and care to update them when their visits coincided. One of the relatives said: "I can't fault the care. The whole thing is brilliant."

Involvement in care and decision making

There was good involvement of patients and relatives. Patients who were able to talk to us said they felt involved in what was happening to them. They said they were asked all the time for their consent and nothing was done before they were first asked if they agreed. Relatives of patients also said they were kept closely informed and able to make decisions for their relative when needed, but without being rushed or pushed in a direction they were not comfortable with. The relatives of one patient who had been sedated said their relative was fully involved with decisions taken about their care when they came onto the unit the previous week prior to sedation.

Decisions were taken in the best interest of patients. Any patients who were not able to speak for themselves, or take their own decisions would be treated in their best interests. Staff said decisions for patients would be taken together by staff and relatives or carers who spoke for the person. This included decisions around end-of-life care or the withdrawal of treatment. Patients who had a decision not to provide resuscitation under certain circumstances had been involved in that decision if they were able to be, otherwise their family were asked for their views and these were taken into account. Advocacy services were available if patients admitted to critical care had no one independent of their care to speak for them.

Trust and communication

Staff built up trusting relationships with patients and their relatives. One patient said staff had been open and honest and spent time with them. They said staff did not just discuss care and treatment matters, but were interested in the person as an individual. The two relatives we met said they found all the staff to be caring and sensitive. They said staff would "drop anything" to offer support and "could see when all you needed was a cup of tea and a bit of time to think or someone to listen." The relatives said staff had talked to them when they first arrived about infection control protocols; what they should and could bring onto the unit; what they might see or hear; and what to be concerned about or not if they should see the patient appear unwell. They said they were always told when they arrived who was the nurse in charge of their relative and who else was working on the ward that day. They said they were always introduced to any agency or bank staff and told generally about other patients, if there was anything they needed to know for the safety or them or the patient.

Emotional support

Patients and relatives were given good emotional support. Staff were aware of critical care units being areas of the hospital making patients and their visitors possibly nervous or scared. A patient we met said staff told them not to be concerned about the machines and monitors. They explained how they needed to beep and click, but this was just to make sure staff were alerted to any changes. The patient said they felt they could ask any questions at any time. Part of the care plan for a patient included considering their emotional support and that of their

relatives. Staff said a calm environment was important for patients. Visitors said they were encouraged to ensure the patient had periods of rest, and this was included in all care plan documentation we saw.

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

(for example, to feedback?)

Good

Meeting people's needs

Patients said care was centred on them as individuals and relatives agreed. Each patient in an intensive care bed (level three patients) had dedicated one-to-one nursing care to meet their needs and monitor them at all times. Patients in high-dependency beds (level one or two patients) had one nurse for two patients. This followed national guidelines about caring for critically ill patients.

Patient flow into and out of the department was sometimes not working well due to the availability of bed space elsewhere in the hospital or with other providers. The unit had above average numbers of patients whose discharge was delayed or not at the optimum time, but this was not statistically significant. These were patients who were medically fit to be discharged to a ward but no beds on wards were available. This may have meant beds were not released in critical care and patients who needed them were not admitted to the department. The capacity of the critical care department was, however, not always reached, so patients were usually able to access the unit.

Privacy and dignity arrangements were acceptable. The ward was a mixed-sex ward, as are the majority of critical care units. There were curtains at each bay and the beds were a reasonable distance apart to allow for space and staff and family to be comfortable around the bed. There were two private rooms. There was, however, only one patient toilet and bathroom (together) which all patients needed to share. Relatives said they were asked to leave the patient area if any personal care or medical treatment was being provided. They said they had been asked if they were comfortable with even minor checks being carried out (such as a pulse checked) and able to step away if they did not want to witness anything they were not comfortable with or the patient might not appreciate.

Some discharges were not at the optimum time. Research into critical care has shown (and hospital internal reports supported this) there was a significant increase in mortality for patients who were discharged out of hours. The latest Intensive Care National Audit & Research Centre (ICNARC) report showed the department had performed out-of-hours discharges (those between 10pm and 7am) above the national average in the 12 months from April 2012. Around 18% of patients were discharged out of hours against the national average of around 8%.

The unit performed relatively well on not delaying patient discharges and for patients needing to be readmitted. Around 27% of all discharges were delayed by more than four hours in the year from April 2012 (the national average was around 55%). This meant over 70% of patients who were assessed as fit to be discharged from the unit (either to home or a ward) were able to leave within four hours of the decision being made. The statistic on patients being readmitted within 48 hours was relatively low, although above the national average. This statistic was usually an indicator of patients being discharged too early. Just below 2% of patients discharged from the unit came back within 48 hours. This was an increase over the 2011/12 year where no patients were readmitted within 48 hours, but was not significantly of concern.

Vulnerable patients and capacity

Patients admitted to critical care were assessed to protect their rights and meet their needs. The hospital had access to other services to support vulnerable patients. There were good working relationships with the social services team. The discharge paperwork and procedures captured information about a patient's circumstances. Staff said they had recently cared for a homeless person who had alcohol dependency. Staff had ensured they had done all they could to see the patient had been supported when they left hospital and returned to the community. Staff also showed a good knowledge of working with patients with dementia and a clear empathy for them and their relatives.

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

Good

Intensive/critical care

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.

Access to services

There were no barriers to any patient accessing the service or them being supported by those who cared for them. The capacity of the critical care unit was not always fully utilised, so patients were generally able to be admitted quickly onto the unit. The unit was also able to care for patients who needed closer monitoring or a period of more intensive care to stop their condition deteriorating. A patient we met on the unit on one of our visits had been admitted for that reason and said they thought the care they had been given was "amazing" and "it feels really like first class care. I am sure I'll get better more quickly and able to get back home as soon as possible."

Leaving hospital

Patients who were discharged from the unit had appropriate records or information given to them or provided to those receiving them into their care. The inter-hospital transfer forms were comprehensive and contained all the relevant information. There was a report contained within the paperwork where receiving staff could record any issues on arrival. This included any missing medicines, or if the patient became unwell during transfer. The patient details then recorded medicines being prescribed, vital signs, ventilation needs, and what other information was needed for their ongoing care. The inter-hospital transfer checklist was used to ensure the other information to be relayed to the receiving hospital was provided. This included requirements for the ambulance transfer (such as whether a paramedic team was needed, oxygen requirements, and if the transfer was for a bariatric patient). All equipment, conversations, and contact names and numbers were then recorded.

Learning from experiences, concerns and complaints

The senior staff learned from any complaints or experiences to improve care. There were very few complaints made to the department. Any complaints, if any arose, were reported to the whole team each week. Action plans were developed if there were changes that needed to be made. The progress of changes was checked by the person made responsible for their implementation. We saw on our visit how there was an issue with the security of patient records. The senior sister considered this and addressed the problem and reported back to us about the changes made before we left the site that day.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

The patient was the main focus of the unit's vision and strategy. Staff said the senior team were inspiring in the standards of quality and safety they demanded. The nursing and medical staff we saw treated patients and their families with the values of the NHS constitution, namely compassion, dignity, respect and equality. Relatives we met agreed this was something they had experienced at all times for them and the patient. Staff were proud of the job they did and enabled and encouraged to deliver the service to a high standard.

Governance arrangements

There were good arrangements for monitoring the service at local level. The senior nurse carried out regular and routine audits, although these were often on the same day each month, which meant they were anticipated and not unannounced. The results of the audits around care and practices were good and staff were encouraged by staff to maintain these high standards. The unit was part of a larger directorate in the trust. This meant good practice, learning from adverse events and experiences, and monitoring the quality of the service was shared among a wider group. The department was represented at directorate governance meetings and this flowed through to the executive team and trust board.

Leadership and culture

There was strong local leadership of the unit. The matron and deputy matron worked across the other trust sites providing critical care. There was therefore shared learning and support for staff. The senior sisters we met on our two visits had strong support and cooperation from the staff working for them. We observed they were compassionate and led by example. In turn, they told us they received excellent support and leadership from the matron and deputy matron for the department. Where there had recently been an issue with a member of staff, this had been dealt with professionally and responsibly. All the staff

we met, both nursing, medical and ancillary (such as the housekeeper) said they felt well supported by their peers and also their managers. They felt they could report any concerns they had with anything about the service or practice and it would be listened to and addressed.

Patient experiences, staff involvement and engagement

Staff felt involved and informed about patient safety and experiences. The department held regular staff meetings where all staff could participate. The critical care assistants said they felt part of a team and were able to look after patients as part of their duties. All staff told us they attended or were represented at handover meetings when shifts were changing. They said patient safety was the main theme of handover sessions.

The national benchmarking results were not reported back to all staff. One of the senior sisters said they no longer were informed of the results from the Intensive Care National Audit and Research Centre (ICNARC) although they were aware the unit supplied the data to produce this national report. They said they felt this was a subject all staff should be engaged with and see how they compared against other similar units nationally.

Learning, improvement, innovation and sustainability

Staff were appraised and given some opportunities for personal development. Appraisals were being held with staff in accordance with guidelines and they were up to date for all available staff. Some of the opportunities for staff to have personal development were being realised, but time available for teaching had recently been reduced among a changed shift-pattern. Some staff said they felt, as one described it “a bit the poor relation” to the teams at the trust’s other locations, and not given as many opportunities due to time constraints, staff shortages, and the need to travel. The senior sister had recently attended a leadership course and learning from this had been beneficial to the team.

Good

Maternity and family planning

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

Information about the service

Horton General Hospital maternity unit served the local population and delivered around 1,600 babies each year.

The maternity service at Horton Hospital was a consultant-led unit. There were six rooms on the delivery suite, one of which had a birthing pool. There was a dedicated theatre facility which was adjacent to the delivery suite. This provided care and treatment to women for elective and emergency caesarean sections. On the first floor there was a 14-bedded ward where ante- and post-natal care was provided. The women requiring specialised care were transferred to the maternity unit at the John Radcliffe Hospital in Oxford.

As part of our inspection we sought the views of people using the service. We spoke with nine patients, six relatives and 14 staff. These included a multidisciplinary team such as doctors, midwives, consultants, midwife support workers and allied health professionals. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records. We gathered further information from data we requested and received from the trust. We undertook interviews, ran focus groups, listening events where staff and members of the public were consulted. We looked at comments cards, surveys and the process for the management of complaints by the trust. We used all the information to plan and inform our inspection.

Summary of findings

The maternity unit provided safe care which was tailored to the needs of women receiving pre- and post-natal care.

Women received care from caring, compassionate and skilled staff. We received positive comments from women and their families about the care and support they received. They were involved in decisions about their care and received emotional support as required.

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

There were systems in place to record near misses and other events and the staff were aware of their responsibility to record and report these incidents. There was evidence that learning from incidents occurred and action plan developed.

People were safeguarded from the risk of abuse. Staff had received training in safeguarding and were aware of the process to report any such issue. This ensured patients were not put at risk, as appropriate safeguards were in place.

Most practice was in line with national guidelines. There were concerns about the lack of support for newly

Good

Maternity and family planning

qualified midwives which may impact on care delivery. The labour delivery suite had been without a manager for 18 months although attempts had been made to recruit to the role.

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

Are maternity and family planning services safe?

Good

Safe and Performance

Women and babies were protected from the risk of abuse as appropriate arrangements were in place. Assessments were undertaken in the community and information about patients who were at risk was shared with the staff at the unit. A coding system was used to ensure this information was not missed and women continued to be safeguarded on admission. Staff had completed training in safeguarding adults and children and had access to the policy on safeguarding. Staff were aware of the signs of abuse and action they were aware of their responsibilities in reporting.

Learning and improvement

The hospital had systems in place to learn from incidents. Following an incident where a patient developing a pressure ulcer following epidural, there was an action plan developed to minimise the risk of recurrence. This was cascaded to the staff on the "topic of the month" board. This included information about the observations and records to be completed and lesson learnt from the incident. Also, written information about safe sleeping arrangements for babies was made available to parents, following an incident. This was available on maternity wards.

Systems, processes and practices

There was a system in place for monitoring severely ill women, both during pregnancy and immediately post-delivery. This process was well-established and they used the Modified Early Obstetric Warning Scoring system (MEOWS). Information from the Clinical Negligence Scheme for Trusts (CNST) report from November 2013 across the trust showed these were not always consistently completed and may impact on the level of care. Action had been taken and these were complete in the records seen. This meant women were monitored and any changes in their health were identified promptly for action as needed.

Arrangements were in place for patients to be transferred to other hospitals depending on their condition. This ensured they received the correct treatment in a timely way and according to their needs.

Maternity and family planning

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

Infection control

The maternity unit wards looked clean and the cleaning of the unit was shared between the midwifery support workers and domestic staff. They were all clear about their areas of responsibilities. We observed staff and patients confirmed the staff followed the hand washing procedures and the use of hand gels as appropriate. Hand-washing facilities were available in different parts of the unit and accessible. Information about the use of hand gels was displayed and visitors confirmed they were prompted to use hand gel on entering and leaving the wards. Personal protective equipment such as gloves and aprons were available and we observed these were used as appropriate. We noted equipment was cleaned in between each patient. A recent hand-washing audit showed the unit had scored 96% and achieved compliance. This meant the staff followed their procedure ensuring good infection control measures were in place. Infection control practices were promoted to reduce the risk of cross infection.

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

Management of emergencies

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

Pain control

Women received medication and appropriate pain relief as prescribed and in line with policies and procedures. They said they had received adequate information about pain control during labour, including information about epidurals. The anaesthetist discussed pain control on admission to the hospital. For women having elective caesarean sections this was discussed during outpatient appointments.

Post-operative pain control was prescribed for women who had caesarean sections and there were systems in place to enable self-medication.

We looked at the arrangements for patients who required surgery on the maternity unit. The hospital used the World Health Organization (WHO) surgical safety checklist in operating theatres. This is a system which followed three steps in order to minimise the most common and avoidable risks for surgical patients. Records reviewed contained completed WHO checklists which demonstrated compliance with the use of this.

Monitoring safety and responding to risk

The hospital was proactive in identifying risk and ensuring patients were in the most appropriate place for their care and treatment. Women who were assessed as at high risk were transferred to the hospital in Oxford. The trust had taken the decision for diabetic patients not to be treated in the maternity unit at the Horton because there was not a nurse specialist.

Decisions about care and treatment were taken at the appropriate level. A lead coordinator on each ward was available to coordinate the overall management of the unit. This also supported other midwives and enabled practice to be monitored.

Staff confirmed they had adequate staff with the right skills to provide care and support to the women and babies. They had a system of internal support and continuous reviews were completed to ensure the staffing levels were safe. All women in the labour suite had one-to-one care. We observed a patient who was admitted in the observation suite and found they received one to one support. The midwives used a “fresh eye” process where women who were at risk were monitored. A second opinion from another midwife was sought to ensure the care remained appropriate. The staff moved between the two wards depending on the skills required and the women's needs. Staff reported this worked well and this meant women received the care and support to meet their needs.

Good

Maternity and family planning

Information from the trust indicated they had experienced difficulty in recruiting to medical posts in maternity. Medical cover was by locum doctors in the delivery suite, maternity ward. There was 24-hour consultant cover in place for the maternity unit, including theatres.

Maternity staffing across the trust was reviewed annually. A maternity staffing paper to the trust board in May 2013 stated that the midwife to birth ratio was 1:32-1:33 which was outside the national guidance (Safer Childbirth October 2007) which was a ratio of 1:28. This resulted in midwives being moved from clinical areas into the delivery suites to ensure that there was adequate staffing to ensure safe births. The paper stated "having considered the national guidance, the financial implications and the need to provide a safer service, the Head of Midwifery believed the service could currently be provided safely with a ratio of 1:30. However, if the activity and acuity should significantly increase beyond current levels, there would be a need to revisit the staffing requirements." Data from January 2014 showed the hospital was achieving a midwife to birth ratio of 1:31. At the hospital senior staff had identified issues in ensuring midwifery cover in theatre areas, although midwife support workers were being developed to support in this role.

Anticipation and planning

There were plans in place to ensure that there were adequate numbers of staff in place through the development of midwife support workers. The hospital used Birth Rate Plus for assessing and managing the midwifery workforce levels. This is a recognised tool developed for the maternity services to assess the staffing level needed. This informed the number of midwives required based on clinical needs and risk. Midwifery staffing levels were reviewed across the trust prior to our inspection. Although Birth Rate Plus does not support the replacement of midwifery time with midwife support worker time during the antenatal and birth pathway, an initiative to develop midwife support workers to provide added assistance including in theatre had been implemented. This was in conjunction with Oxford Brooks University.

Information from the trust identified concerns with the lack of out-of-hours anaesthetic cover because the anaesthetic nurse on call could take up to 20 minutes to arrive. This caused delays in emergency caesarean sections. The trust had taken action and reports in October 2013 identified that recruitment for onsite anaesthetic cover was underway. Some posts had been filled and recruitment continued.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Evidence-based guidance

There were policies and procedures in place on the trust intranet which staff confirmed they were able to access. The maternity services training policy was available to all staff at induction. There were also clear procedures and guidelines were adhered to in relation to the termination of pregnancy.

On the maternity unit the "immediate care of the new-born guidelines" has been updated to reflect NICE guidance. The trust had introduced the New-born Early Warning Score chart (NEWS). The NEWS observation chart was used to identify any deterioration in a baby's condition and reported to the midwife caring for the baby. This meant action could be taken at an early stage and appropriate intervention put in place.

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

At times National Institute for Health and Care Excellence (NICE) guidelines were not followed when considering the use of ventouse cups or forceps to enable delivery. Trust data showed a higher rate of forceps delivery than expected. Staff said this was due to a particular type of ventouse device being withdrawn from use and staff had reverted to using the means of forceps delivery.

Good

Maternity and family planning

Performance Monitoring and improvement of outcomes

A range of audits were carried out both locally and nationally. The outcome of these audits were discussed at regular meetings and action plans developed in order to improve practices.

The trust had lower rates of both emergency and elective caesarean sections when compared with other trusts in England. Similarly, the trust had a lower ventouse delivery rate, but a higher forceps cephalic delivery rate.

Data was collected about the effectiveness of epidural and spinal pain relief, where patients' views were sought. This looked at the effectiveness of pain control in order to ensure care and treatment was planned according to needs.

There was evidence that learning from incidents was monitored. Information from the trust papers showed changes in practice were implemented for perineal care. This had resulted in the reduction in third and fourth degree tears for women in their care.

Staff, equipment and facilities

There was no designated antenatal ward at the hospital and the arrangement was for the antenatal patients to be accommodated in the same bay if possible. The environment was clean and safe with a programme of refurbishment. A senior member of staff confirmed they had adequate monitoring equipment available. These included fetal heart monitoring machines. We observed the equipment in the labour unit was clean and staff told us there was a system for servicing the equipment although they did not have any records on the wards as these were held centrally.

There were systems in place for monitoring the temperature at which medicines were stored, including the monitoring of fridge temperatures. Medicines were secured appropriately in most areas. However, there was no lockable storage for medicines within the anaesthetic room in the maternity theatres. This was identified six weeks prior to our inspection and requests were made to address this but were still outstanding.

Multidisciplinary working and support

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

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

Women and their family were positive about the care and treatment they had received. They commented the staff were knowledgeable and compassionate. Some of the comments included: "since I have come here everything has been excellent". We were told the staff were welcoming and addressed them by their name. A patient said they arrived at the unit that morning and staff were "ready and waiting" for them. They felt reassured by the support they were provided.

We observed women's privacy and dignity being maintained within the maternity unit.

Involvement in care and Decision Making

Women were informed and involved in decisions about their care. Records showed women were involved in making decisions about their care and consent was sought. Women and their partners were involved in their care through ongoing consultation. This started at the antenatal stage and continued throughout their ante and postnatal care, including decisions about tests for fetal abnormalities, and the options available were fully discussed.

There was inclusive discussion between midwives, doctors, women and their partners about treatment. This included discussing the pros and cons of treatment and the provision of verbal and written information to assist women to make informed choices and decisions. Women also told us they were fully informed and consulted about the birth plan including plans about elective and emergency caesarean sections. Women were well informed about the possibility the birth plan may not be followed if they required emergency intervention.

Trust and respect

Communication between the midwives, women and their families was good. Women and their partners were

Good

Maternity and family planning

supported and able to ask questions. Women said the midwives were very good at listening and provided support. One woman said they were aware that even though they had a birth plan, this may not go to plan and they were prepared for this. They felt they had confidence in staff and trust and communication was good. We observed advice given over the phone to women and partners queries, were clear and provided reassurance.

Staff and patients described their experience of care as positive and were complimentary about the care and support they received. Staff said they worked very well as a team as this was a small area and they rotated between the labour ward, and post and antenatal work.

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

Emotional support

Women and their partners were positive about the emotional support they received from midwives and support staff. One woman said: "I was totally drained and the staff were very understanding. I received great support with breast feeding".

Arrangements were in place to provide emotional support to patients and their family in a sensitive manner. There was a bereavement specialist midwife and pastoral care service was available to support women, partners and their families if they chose. There was a fully-furnished bereavement suite with separate access with en-suite facility and a small kitchenette. This ensured women, their partners and their children had the opportunity to have private time. The suite contained a single bed and may not be appropriate for partners and children to stay overnight.

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

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

Good

Meeting people's needs

The needs of the women were assessed and care birth plans were developed to meet those needs. There was an observation ward in the labour suite where women were admitted for close observation. Women were admitted on the wards where antenatal care was provided. Women said the service was very good and they had received appropriate care and support.

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

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

Staff said delays in getting a translator had impacted on women's care particularly regarding pain management. A process was in place to ensure that information regarding the need for a translator to be gathered and recorded during antenatal care. This was to ensure arrangements for booking this service were initiated earlier.

Care plans were detailed and contained information including: fetal and maternal wellbeing, diet, hydration, pain control and mobility. All women had a venous thromboembolism (VTE) assessment to assess their risk for blood clots. Treatment plans were in place. A patient commented the staff had encouraged them to have regular pain control. They felt this had helped in their recovery following a caesarean section.

Access to services

Information indicated arrangements were adequate and there were no issues with access to care. Staff, women and their partners, confirmed this. Patients told us they felt the service was good and served the local community well.

Good

Maternity and family planning

Vulnerable patients and capacity

Patients who were at risk of domestic violence were supported and advice was available to them. Staff followed the care pathway for patients with mental health problems and were able to access support from external professionals to help and support these patients.

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

Leaving hospital

There were discharge arrangements in place for women and babies. Discharge information was faxed to women's GPs and the community midwives. At weekends staff telephoned the community teams to ensure they were aware of patients who had been discharged. Patients were also advised to ring the maternity unit if they did not receive a visit from their midwives within a specific timeframe following discharge.

The maternity unit had a procedure for take home medicines to be dispensed from the unit. This was an effective way of discharging patients without having to wait for medicines to be dispatched from the hospital pharmacy.

Learning from experiences, concerns and complaints

There were clear policies and procedures available to women and their partners about how to raise their concern. We saw leaflets were also available in different areas of the wards and labour unit. Patients could also contact the Patient Advice and Liaison Service (PALS) if they needed support about raising concerns.

We received positive feedback about the care and treatment patients were receiving. Those we spoke with were aware of the procedure to raise a concern. Staff told us they would speak with their immediate mangers if they had a complaint or concern, but, said they would not raise concerns at trust level.

Are maternity and family planning services well-led?

Good

Vision, strategy and risks

The trust achieved Clinical Negligence Scheme for Trusts (CNST) Maternity Level 2 in November 2013. The quality and audit paper from 2013 showed the trust was working with the University of Oxford and its partners in the community (including GPs and the Community Partnership Network) to formulate proposals to maintain a full obstetric service at the Horton. The proposed model involved joint clinical and research posts to support the obstetric roster. Staff and patients were passionate about keeping the local facility and had full support from the local community. The trust board members had engaged with the local community about the transfer of some services to Oxford.

Governance

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

A trust paper from January 2014 about the learning from complaints showed they were reviewed on a quarterly basis. Recurring themes were identified and action plans developed to manage the root causes.

Leadership and culture

The staff said there were good working relationships between the medical staff, midwives and other professionals. Staff felt supported in their roles and were comfortable to raise their concerns at local level. Senior management and other staff we spoke with were clear about the trust vision and values. Staff told us they were satisfied with the local management arrangements, but they felt disconnected from the organisation and trust board. They said this was due to communication.

Good

Maternity and family planning

Patient experiences and staff involvement and engagement

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

Women said they found the staff at the maternity unit very good or excellent. They felt the staff engaged with them and provided care and support according to their needs.

The staff felt the lack of senior management on site over the two years prior to our inspection had caused them to feel neglected by the trust. They felt bed closures and transfer of care to Oxford were due to financial reasons and not with patient care in mind. The staff felt there was no overall cooperation or coordination on site because most senior staff were based in Oxford. The management structure had also impacted on communication with the John Radcliffe Hospital. Staff said morale on site was poor and felt they could not openly discuss their concerns.

Learning, improvement, innovation and sustainability

Senior managers told us they had a successful recruitment drive for midwives and that this needed to continue.

The staff on the maternity unit were supported in their roles. They had a lead midwife on each shift who provided advice and support for the staff. The electronic patient record (EPR) was not fully utilised and some records were in paper form. We were told this was being addressed and would be reinstated.

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

Good

Services for children & young people

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

Information about the service

The directorate provided acute and outpatient general paediatric services at the Horton General Hospital in Banbury and the John Radcliffe Hospital site in Oxford

The service included the assessment and management of acutely unwell children, inpatient treatment and interval review of children referred by their GP or presenting to the emergency department and an outpatient service for local children requiring secondary level paediatric care.

The service included a consultant led children's ward with 17 beds for patients, the special care baby unit had space for 10 beds and there was a small outpatient service.

Facilities included a large playroom with educational facilities and family rooms for parents/ guardians to stay in the hospital.

We visited the children's ward on a Tuesday during the daytime and again on a Sunday afternoon and early evening as an unannounced visit. During these visits we talked with around nine patients and their relatives accompanying them. We spoke with staff, including nurses, doctors, consultants and support staff. We also received information from people who attended our listening events and from people who contacted us to tell us about their experiences. We collected comment cards from a designated box set up for our visit. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

There was a multidisciplinary collaborative approach to the care and treatment of children across children's services in the hospital. Children's care and treatment was planned and well documented in the medical notes and nursing records in the patient's files. Staff across children's services were confident the hospital had a reliable system to alert them to risk and implement improvements. Staff told us they could express their views in ward meetings and were "confident" they would be listened to by the organisation.

Children and young people received person centred compassionate care from staff in the children's ward. We saw nursing staff delivered kind and compassionate care to a young child who was crying as their mother had gone home. Parents told us nursing staff had been "patient and kind." Care delivered was safe and effective.

Good

Services for children & young people

Are children's care services safe?

Good

Safety and performance

Staff across children's services were confident the hospital had a system to alert them to risk and implement improvements. All staff used the same incident reporting system to ensure consistency. They told us it was "a reliable system" to address the concerns they had raised. One staff member described the reporting system as a "good" and "easy to use" and spoke positively about "quick response to concerns" by the hospital.

All staff spoken with were well aware of their responsibilities in relation to ensuring the safety of children. All paediatric nursing and medical staff including consultants had completed level three children's safeguarding training.

Learning and improvement

There was evidence of learning and improvement as a result of incidents and concerns raised by staff. For example, staff members in SCBU raised an incident on the system about the impact of the safe care for babies due to lack of access to an Ophthalmologist. They were concerned about babies receiving timely eye tests. A senior staff member said: "in two just weeks after the report an Ophthalmologist was in place."

The risk register, completed by senior staff, raised concerns about the administration of some medicines and the safety of the lift to the unit. Staff told us these had been resolved in a timely manner.

Systems, processes and practices

There were sufficient systems and practices in place to ensure children were safe in the hospital. In the children's ward there were daily nurse and consultant-led handover meetings to discuss the care and treatment of patients. We observed the hand over meeting was led by the consultant on the previous nightshift who handed over to the day staff. The handover included two consultants, a locum doctor and a GP trainee. The handover included details of the child, the diagnosis, investigations, the management of the concern and the treatment plan. In SCBU the handover included, in addition, the babies feeding plan and the gestation weight. There were details of any concerns about children discussed at the monthly perinatal meeting and the Friday morning paediatric meeting which included any "child protection forum cases." A consultant-led ward round immediately followed the handover and these included nursing staff to ensure information was shared and continuity of care for the children. A consultant said: "They ensure information about children is circulated effectively."

Equipment

Nursing staff told us they had access to equipment from the equipment library in the John Radcliffe Hospital in Oxford. They had reviewed their equipment and identified the current bathrooms could not fit a hoist to assist with the safe transfer of children as there was not enough space. A nurse said: "It is difficult as we can't bath children who cannot mobilise themselves." They told us the hospital had a plan to refurbish the bathrooms.

Infection control

The hospital provided safe care and treatment for children in a clean environment. Staff across children's services followed infection control procedures. In the Special Care Baby Unit (SCBU) infection control policies and procedures were displayed on a central notice board in the special care baby unit to ensure they were easily accessible to staff, parents and visitors. There were monthly infection control audits and results were discussed in ward meetings and then actioned by the staff team. For example, the staff team identified the clutter on the bed-side tables as a site for potential cross infection. This was because babies' dummies were too close to the bowls used for washing when changing nappies. They introduced clean and dirty areas to separate possible areas of cross infection. A senior staff member said they also completed "surprise audits" to ensure ongoing compliance and to "keep everyone on their toes."

Space in the SCBU was limited. As a consequence there was limited space between the babies' incubators and cots creating potential possible sites for cross infection. A senior staff member addressed this by moving the cots when not in use. They said: "it's sometimes not ideal and storage here is always a problem but we utilise the space we have and use it in the best possible way." A parent in SCBU said: "I feel like my baby is in safe hands here."

In SCBU staff followed infection control procedures in relation to wearing personal protective equipment like gloves and aprons. Staff were observed washing their own

hands and reminding patients and visitors. The hand washing area was in the middle of the unit staff ensured visitors used this area appropriately. A senior staff member said: "I have put the signing-in book by sink to encourage and remind people to wash their hands and it works well."

The children's ward was clean and tidy in all areas. Toilets were hygienic and staff were aware of the infection control procedures. Information was available for them in the staff meeting minutes, the infection control policies and procedures were accessible in the staff area and there was online guidance with email reminders for staff to attend mandatory training. A staff member on the children's ward said: "We know systems for following Infection control, we have cleaning schedules and equipment is tagged and dated after cleaning with 'I am clean' stickers." The playroom was cleaned by the play specialist. The toys and equipment were well maintained, clean and hygienic. Toys played with by contagious children were cleaned before returning to the play area.

Care Planning

Children's care and treatment was planned and well documented in the medical notes and nursing records in the patient's paper files. We reviewed five patient's files in the children's outpatients department. In two files it was recorded children did not attend their outpatient appointment. On both occasions the consultant followed escalation protocols and wrote to alert the child's community doctor. The medical information in the treatment plans was well structured with detailed clinical notes, details of examinations and investigations, and written evidence of conversations with parents and children about the treatment plan. In three of the five files there was a record of patient's examination findings to inform future treatment.

Monitoring safety and responding to risk

There was an effective paediatric early warning score system in use to try and ensure the early detection of any deterioration in a child's condition. This system was known to all staff spoken with. It ensured the early escalation of possible changes to a child's care needs to ensure they received safe and effective care in a timely manner There was a "flag" in the electronic patient records used to identify any patient of concern including children safeguarding concerns.

If children's safeguarding concerns were confirmed these were escalated to the incident reporting system. Paediatric consultants from the children's ward provided an on- call service to the accident and emergency department including out of hours cover. Staff in the emergency department described the cover as "easily accessible and "very supportive." A paediatric consultant in the children's ward told us they also worked closely with the Child and Adolescent Mental Health Services (CAMHS) for concerns like deliberate self-harm in adolescents.

In the children's ward a senior nurse was the safeguarding lead. There were close links with safeguarding link nurses in the John Radcliffe Hospital and "link" workers in social services, health visitors and school nurses in the community. Safeguarding concerns were also discussed at the monthly paediatric consultant meetings and multidisciplinary meetings. A senior nurse said: "We have a well-run service where everyone understands their role in safeguarding. It works well."

Staffing levels

The children's ward was a consultant-led ward with nursing staff and a clinical support worker. There was the consultant of the week and an additional consultant to cover the ward. There was a system of some shared paediatric consultant cover (hybrid) between the hospital and the John Radcliffe Hospital in Oxford. There were eight consultants and four hybrid posts which included out-of-hours cover. This meant there was full day-and-night consultant cover for the unit. A consultant told us cover is: "good but complicated. In effect there are two parallel services with the John Radcliffe hospital." Another consultant told us: "The second on-call consultant is useful if a child presents in the emergency department with child protection concerns. A paediatric consultant can complete a timely assessment as the child will mostly come to the children's ward." They said "the second consultant covers the rest of the ward so It works well."

In SCBU a senior staff member told us they were rarely short staffed. The duty rota showed there were sufficient nurses in the day and evening to care for the babies safely. A senior staff member said: "We have nursery nurses who work during the day to teach the parents parenting skills. There are also two paediatric consultants and a senior house officer all the time." One nurse told us: "We are well-staffed so we are not rushing around all the time."

Anticipation and planning

Staff worked closely with other agencies to ensure there was a clear plan for children's safe discharge in to the

community or transfer to other hospitals. Young people with mental health concerns were not discharged from the children's ward until a full CAMHS assessment had been completed to confirm it was safe to discharge them. A paediatric consultant told us the CAHMS service was local to the hospital so young people "benefited from timely assessments."

Records reviewed in both the children's ward and SCBU showed there were clear co-ordinated plans for children's discharge. Records included liaison with social services, health visitors, school nurses and the CAHMS service to ensure consistent working. Parents were clear about the arrangements for outpatient appointments for children and told us they were given sufficient information. Parents in SCBU confirmed they were involved in the plan for discharge and described it as well planned.

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

Good

Using evidence based guidance

Children received care and treatment in line with current legislation and national guidelines. Staff were aware how to access these on the trust's intranet. For example, a senior staff member in the children's ward told us they followed the trust's guidelines in line with the National Institute for Health and Care Excellence (NICE) guidelines about sedation of children under six years to ensure children were treated safely. The hospital monitored and audited their care and treatment of children in relation to this guidance and there were action plans to address any area of concerns to improve practice.

Other guidance and audits included Aseptic Non Touch Technique (ANNT) about the preparation and delivery of intravenous medication. A nursing staff member told us: "We make sure key parts, like the tip of the syringe, are clean." They told us additional training was put in place if the guidelines were not met. Staff also told us they followed trust guidelines, pathways, protocols and policies in relation to the "limping child" pathway. Staff accessed guidance via the trust-wide intranet under acute paediatric problems within children's services. The guidance included investigations, diagnosis and possible referral to the paediatric orthopaedic team. A nurse told us: "It's very easy to use the intranet and it means we have instant access to the guidance."

Staff told us they followed the hospital's pain management procedures and used a pain-scoring tool to assess children to ensure children had sufficient pain relief. These scores were available in the treatment files reviewed. A nurse told us: "We all use the same format so it's very clear." A parent in the children's ward told us the nursing staff had: "made sure my child was not in any pain when we arrived at the ward." A senior nurse in the Special Care Baby Unit (SCBU) told us: "We use dummies to assist pain in very small babies." An audit was currently taking place for pain relief in neonatal babies to improve and develop practice.

All staff in the hospital followed guidance called the "fluid challenge" to ensure children were sufficiently hydrated. A nurse in the children's ward told us: "It is important we ensure children have sufficient drinks as it assists in their recovery." Treatment plans included an assessment of children's hydration.

Performance, monitoring and improvement of outcomes

Staff monitored outcomes for children to ensure they received safe effective care. Staff members told us they were involved in a variety of audits to monitor and improve care for children. All staff spoken with were able to demonstrate knowledge of the "electronic patient flag" to highlight concerns about children and the "escalation stream" to protect them.

In SCBU a senior staff member told us they had regular benchmarking for consistent outcomes for children with other trusts, to compare and develop their practice. A senior nurse said: "A staff member goes into other hospital and compares what we are both doing about, for example, the positioning of babies and then we discuss the similarities and difference at ward meetings."

Staff, equipment and facilities

Children benefited from well-maintained and hygienic equipment and child-centred facilities in the children's ward.

In the children's ward there was a large play area open weekdays and occasional weekends. A teacher was available three days a week to provide education for older children and a play specialist to work across children's

Good

Services for children & young people

ages. The play specialist told us: “My role is to offer play sessions to enhance children’s experience and distract them when they were having procedures like blood tests.” We saw there was a range of age appropriate books, puzzles and toys and sensory toys with lights for children with sight impairments.

Nursing and medical staff across children’s services at the hospital confirmed they received annual appraisals which included feedback about their performance. The electronic recording system assisted with appraisals as senior staff were alerted to staff appraisals due. Nursing staff spoke positively about the appraisals as monitoring performance. One nurse said: “The new appraisals mean you can easily see what is written and sign to indicate you agree with the content.”

Multidisciplinary working

There was a multidisciplinary collaborative approach to the care and treatment of children across children's services in the hospital. Staff in the emergency department spoke positively of the consultant support they received from the children's ward. A consultant in the children's ward said: “Close links to Oxford means we have easily accessible specialist advice if required.”

There was multidisciplinary working to safeguard children in the hospital and in the community as data from the escalation process was linked to the paediatric liaison health visitor in the community, link social workers and school nurses. This meant there was a consistent system for sharing information.

Are children’s care services caring?

Good

Compassion, dignity and empathy

Children and young people received person centred compassionate care from staff in the children’s ward. We saw nursing staff delivered kind and compassionate care to a young child who was crying as their mother had gone home. Parents told us nursing staff had been “patient and kind.” One young person told us they liked the staff.

Involvement in care and decision making

Parents told us they were consulted in all aspects of the care and treatment of their children. One parent in SCBU said “staff here are great. They have kept me informed every step of the way. I feel very involved which is really important to me with a new baby.” We observed staff talked to one parent about how their baby had fed during the night and agreed a feeding plan with them for the day ahead. This showed involvement of the parent in ensuing their baby’s needs were met.

Nursing staff told us talking with parents was central to their work. We read ten patients records in children's outpatients, SCBU and the children's ward. There were recorded discussions between parents, the child, nursing staff and paediatric consultants about the content of the care and treatment plan in each file. Parents for whom English was not their first language told us staff had been clear and used “language we can understand” to ensure they knew the contents of their child’s treatment plan.

Trust and communication

Patients and their carers valued their relationships with staff. One parent in SCBU told us “I feel I can ask them anything. Once I wanted to see my baby really late at night as I was a bit anxious and they let me into the unit. My husband couldn't sleep one night because he was worried about our baby so he rang up the staff here. They talked to him for ages. They understand how concerned we get and help us to get through it.” Another parent said they trusted the staff in SCBU as they knew their baby was “in safe hands.”

Emotional support

Parents told us they were supported by nursing staff in the children's ward. One parent in the children’s ward told us “they helped me as much as my child when I was upset.” Nursing staff told us about the dual role of treating children and supporting anxious parents. A senior staff member in SCBU said “it can be a very anxious time for parents so we offer them comfort, care, food, drink and a bed here, so they can stay with their children.” One parent said: “The parent’s room is basic but I'm so glad it's there so I can be near my baby.” In the children's emergency department a parent said the consultant they saw was: “Willing to take the time to listen to me.”

Are children’s care services responsive to people’s needs?

(for example, to feedback?)

Good

Services for children & young people

Good

Meeting people's needs

The hospital planned its children's services to meet the needs of children in the local community. The hospital had developed children's outpatient service to meet the increased demand in the community. A senior staff member from the outpatient department told us: "We have reviewed our children's outpatient service as what we currently have just isn't sufficient. On clinic days (weekday mornings and Thursday afternoon) we only have space for two chairs for patients in the small waiting area. We bring out a box of toys and put them next to the chairs in an area that is only a couple of square metres. We know it is not hygienic having children playing on a carpeted area, but it was the best we could do. We don't have any paediatric nurses. We tried using paediatric trained nurses from the children's ward but it didn't work out."

In December 2013 children's outpatient provision was identified as a concern on the hospitals risk register and it was discussed at the monthly multidisciplinary children's division (CDU) meeting. A senior staff member said: "We worked closely with the Director of Operations. We identified a self-contained area close to our current site and made it into a separate unit for outpatients for children." The date for completion on the risk register was December 2014. The unit was, however, almost complete apart from some refurbishment. A staff member said the expected operable date was "in the next couple of months." The manager told us the unit would include paediatric trained nurses, paediatric consultants, a play specialist, dedicated treatment rooms and a play area. Access to the area was via a lockable entrance making it secure for children. A senior staff member told us: "this new development will mean we can offer a dedicated and separate outpatient service for children."

Access to services

A staff member in the children's ward told us they worked closely with children's services in the John Radcliffe Children's Hospital (JR) providing a joined-up responsive service to the needs of children in the community. The children's ward provided additional children's beds when children's hospital was full. Parents told us how they valued having a local children's ward. Some children had open access to the children's ward if they were known to the ward with for example a chronic condition.

Staff told us patients have timely access to the translation service which was "not on site so we book it in advance." They told us they had regular and easy access to an interpreter and sign language interpreter for parents with hearing impairments. A member of staff said: "We use it all the time."

Vulnerable patients and capacity

Staff ensured the needs of vulnerable young people were met. Staff liaised closely with the Child and Adolescent Mental Health Service (CAMHS) which is part of Oxford Health NHS Foundation Trust. This was to ensure the needs of children and young people who experienced mental health problems and needed access to specialist mental health services after discharge were accommodated. There was positive written feedback from young people about their time on the ward which stated: "staff listened to what I wanted."

A senior nurse told us "we see a lot of young people with eating disorders so we can access training and guidance from the Trust in this area." Staff told us they could access training and guidance about care pathways and needs of vulnerable young people on the trust intranet. Young people were offered leaflets with information about their illness and about prescribed medicines and possible side-effects.

Leaving Hospital

Staff ensured parents needs and wishes were taken into account when arranging discharge from the hospital. A parent in the Special Care Baby Unit (SCBU) said staff had arranged the discharge plan together at a time to suit them and the rest of their family. Children were discharged with useful information to assist parents care safely for their children at home. For example parents in SCBU were given advice about feeding their babies. Parents in the children's ward and the emergency department were given advice about medication and signs and symptoms to be alerted to of any deterioration in their child's health.

Prior to discharge all children with identified mental health concerns undergo a full CAHMS assessment. The staff

liaised with the children's health visitor and for younger children the school nurse. We were told if the child had special needs then there was also liaison with community children's nurse teams.

Children's discharge planning was also discussed to ensure it was safe and the needs of the carer and child were met. For example, one child's discharge was arranged to ensure parents could attend other hospital appointments. Information discussed at the handover was included in the treatment records in the patient's files.

Learning from experiences, concerns and complaints

The trust monitored and analysed complaints from patients in children's services. They established 0.08% of patients who used women and children's services across the trust last year complained, in the main, about communication. In response to this the trust employed additional staff.

In the children's ward we read written feedback from patients who described their interactions with staff as "helpful." Parents told us communication with staff working with children in the hospital was good. Staff in the children's ward told us parents complained about the standard of food available on the ward. Staff told us dishes like shepherd's pie was sometimes available twice a day and wasn't always child friendly or a healthy option. In response the ward reviewed the options available to them to assist them to provide additional healthy food.

Are children's care services well-led?

Good

Vision, strategy and risks

Nursing and medical staff told us the strategy in children's services in the hospital about the delivery of high quality compassionate care to patients was in line with the trust's strategy and vision. Nursing staff in the Special Care Baby Unit (SCBU) and the children's ward had access to the information and guidance about the trust strategy on the intranet. Nursing staff told us workforce planning and care delivery was regularly discussed at ward meetings and at the children's services clinical governance meeting. Nursing staff in SCBU told us they regularly discussed and followed trust strategies like the neonatal strategy. A staff member told us: "It means we work consistently towards shared goals. Following strategies like delivering compassionate care is embedded in our day to day work."

Risks inherent in the delivery of safe care for children were clearly identified on the hospitals risk register. For example in SCBU they identified the need to ensure the correct prescribing, administration and dosage of antibiotics given to babies, following a recent incident. As a consequence the protocols and checklists were reviewed. Three additional checks were put in place to ensure the safe administration of the medicine. Two monthly audits and spot checks were also put in place.

All risks to safe care for children were discussed at ward meetings with the ward managers. These were then escalated to senior staff in the children's services including the director for divisional risk and then to the executive board for the trust. A nurse in the children's ward told us: "If risk was high then the corporate risk team in the John Radcliffe Hospital would also be involved." They told us: "It is a very thorough system."

Governance arrangements

Staff members in all parts of children's services across the hospital were clear about the monitoring arrangements and the feedback about performance. Clinical governance meetings were held monthly. The children's service unit (CSU) monthly meetings included the ward manager from SCBU, paediatric consultants from the hospital, the clinical director, staff responsible for the maintenance of the risk register and paediatric staff from the John Radcliffe Hospital. These meetings discussed clinical incidents and incidents on the reporting system. The ward manager said they invited colleagues across the trust for shared learning on microbiology. A senior nurse in the SCBU and the children's ward went to monthly children's divisional meetings..

Leadership and culture

The leadership and culture in the hospital encouraged supportive relationships in staff teams. A senior member in SCBU said it was their role to ensure staff felt supported. They said: "we have an open supportive culture here. It is important staff feel supported so we have regular ward meetings to discuss any issues about the ward and share any information from the trust." They said every two months senior staff from children's services in the hospital met with senior staff at the John Radcliffe Hospital "where

we can voice our opinions and make changes." They told us they benefited from the unit being small so they could affect change quickly. For example, they introduced a system where staff were responsible for cleaning certain areas in the unit with a designated checklist. They said: "I then know in a 24-hour period everything has been cleaned."

A staff member said they felt involved in decisions about the future of the unit. The staff duty rota and discussions with staff members confirmed staff turnover in the SCBU was low. A staff member said: "People only leave if they retire or go on maternity leave."

A senior staff member in the children's ward spoke positively about the consultant-led unit. They described it as: "a close knit department with a strong team of consultants who have very close links with John Radcliffe Hospital as some of the team are on a rotation to work there." Nursing staff spoke of these close ties and consistent working across the trust which assisted children who moved from the John Radcliffe Hospital to the Horton Hospital.

Patient experiences, staff involvement and engagement

Staff were involved and engaged in service delivery and the views and experiences of patients impacted positively on changes in children's services. All staff including paediatric consultants told us they felt supported by the hospital nursing staff and patients were positive about the consultant-led children's ward and the strong links with the John Radcliffe Hospital. A staff member told us: "it means we have easy access to speciality advice."

Staff told us they could express their views in ward meetings and were confident they would be listened to by the organisation. We were told parents complained about the effective working of the lift to both the children's ward and SCBU and it had been repaired quickly.

One parent told us: "The children's ward has a good reputation locally. We wouldn't want it to close." Another parent told us at our listening event: "I had all my children at the hospital and we are thankful we have a good emergency department for children. I couldn't drive all the way to Oxford if my child had an accident. We worry about it closing so I take every opportunity to make my views known." A member of the local Healthwatch told the hospital was "held in high regard."

Staff in the children's ward said children and carers can use the feedback forms or comment cards to tell them about their service. In the children's ward the staff told us they listened to parents' concerns about healthy eating options not being available for children and a review was in process.

Learning, improvement, innovation and sustainability

Staff in children's services in the hospital told us they felt included in the development of children's service across the trust. They talked about the "Safe and Sustainable" programme and the increased demand for paediatric subspecialty services. Information from the trust predicted annual growth for both paediatric endocrinology and for paediatric neurology. The trust worked in partnership with other trusts to develop a model which intended to provide as much care as possible locally. Staff spoke positively of opportunities for learning both in the trust and from work with other trusts.

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 visits if clinically indicated to patients. Specialist link nurses on each ward supported staff with day-to-day good practice and updating them with recent guidance.

Summary of findings

Patients received effective and sensitive end of life care. Patients told us they felt safe with the staff and overall their needs were met. We were told medicines were prescribed to control patients' pain and staff were using the fast-track process for early discharge. Patients said staff respected their rights: in particular privacy and dignity. Patients and their relatives told us where there were concerns staff were available for discussions.

Patients at the end of their life were able to make decisions about the medical procedures to be followed in the event of cardiopulmonary arrest. If the decision made was not to attempt to resuscitate the patient, it was recorded and brought to the attention of all medical staff involved in the delivery of care.

Patients were treated with compassion and were not expected to wait for pain medication. Doctors prescribed medicines in advance to prevent delays in administering medicines to patients in pain. Medicines to be taken as required were prescribed to ensure patients were comfortable between other scheduled medicines.

Patients were cared for by staff with an understanding of end of life care. There were nurses on each ward who specialised in specific topics including end of life care. These staff were able to support other staff who needed guidance or advice. Doctors completed mandatory training on end of life care during their teaching.

Good

End of life care

Are end of life care services safe?

Good

Safety and performance

The hospital responded to changes in guidance for the delivery of care. In June 2013, the Oxford University Hospitals Trust responded to guidance from the independent review of the Liverpool Care Pathway and phased the use of this pathway across the trust. Advance care planning forms developed with the Oxfordshire End of Life Reference Group followed on from previous end of life strategies. This was devised to capture essential information based on the wishes of the patient at the end of their life and act on it. Advanced care planning listed the professionals involved in the patient's care, the diagnosis, the patient's wishes for the future, and if a decision not to resuscitate had been taken.

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 said they felt safe when staff delivered their care and treatment. One patient said: "Yes, my care is very good."

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 procedure and directed the patient's consultant to complete do not resuscitate forms for the patient. Consultants were directed to document the decision which ensured all staff involved with the patient knew not to resuscitate the patient in the event of cardiac or respiratory arrest.

Forms for resuscitation decisions were in place for patients at the end of their life. Nursing staff knew it was the consultant's responsibility to discuss resuscitation with the patient and, where appropriate, their relatives. The resuscitation decision forms (DNACPR) we looked at were signed by the consultant and included the reasons for the decision and the people involved in taking it. Staff told us patients were able to take a copy of their DNACPR forms on discharge and some patients on readmission returned with their form.

Medicines management

Patients were prescribed medicines to manage their pain. One patient said: "I have morphine and the staff say if you are in pain you must take it. I can have it every hour." Another patient told us their pain was not being managed. We spoke with the ward sister who explained the pain management plan in place and explained there had been an increase in the strength of prescribed pain medicines. The palliative team had recorded in the patient's notes the difficulties that may be encountered with managing the patient's pain. The medicine chart we looked at confirmed pain medicines had increased and were administered according to the doctor's directions.

Medicines for symptom control were prescribed in advance to prevent delays in administering medicines to patients in pain. Nurses on two wards told us it was usual for doctors on their wards to prescribe pain relief early to make sure patients had their medicines over weekends. Medicines to be given as required (known as PRN medicines) were prescribed to ensure patients were comfortable between other scheduled medicines. A link nurse (a nurse with responsibilities in specific areas) for palliative care told us doctors had access to information on the range of medicines that could be prescribed to patients at the end of their life.

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 for improvement identified by the hospital trust in 2012/13. The safety and security of medicines was identified as needing improvement and audits were undertaken to assess the levels of risk. Staff ensured medicine rooms were locked and only those staff with responsibilities for the administration of medicines had access to the medicine room. Systems were in place for controlled drugs (CD) which included, as legally

Good

End of life care

required, the maintenance of a CD register. Staff recorded the CDs held, directions for administration and details of their administration. The pharmacist audited the CD register on a three-monthly basis to ensure safe systems of medicine management were maintained.

Staff knew the principles of the Mental Capacity Act 2005. Staff knew where patients lacked capacity to make a decision a formal assessment had to be undertaken. If a patient was assessed as lacking mental capacity, decisions were taken in their best interests and involved the patient's medical team and relatives or carers.

Anticipation and planning

Some decisions were not recorded to reduce the risk of error. The "do not attempt cardiopulmonary resuscitation" (DNACPR) forms kept in the front of patients' files did not indicate where indefinite decisions were made. A consultant told us indefinite DNACPR was assumed where there was a blank section with no review date in the patient's form. This meant there was no clear information to ward staff for readmitted patients on end of life care.

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

Good

Using evidence-based guidance

The standards of care evaluated in the National Care of the Dying Audit Hospital (NCDAH) Round 4 2013/14 were 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.

Patient care was delivered to patients as individuals. Specific end of life care pathways were not used at the hospital since the Liverpool Care Pathways (LCP) was phased out. The nurses we spoke with told us an individualised approach was now used for all patients on the ward. For example, patients received support with their physical, emotional and cognitive health. The nursing assessment incorporating activities of daily living care records form replaced the LCP monitoring tools. The forms were not appropriate for all situations, as there was limited space for recording information about palliative care. The staff used stickers to identify the nature of the record for example, nursing procedures and palliative care. The notes showed staff received guidance on how to meet the needs of patients on end of life pathways.

Performance, monitoring and improvement of outcomes

The trust participated in national clinical audits, reviews of services, benchmarking and clinical service accreditation. The trust participated in the National Bowel Cancer Audit and various respiratory disease audits; however, there was no overarching auditing of the end of life care service.

Staff, equipment and facilities

The hospital made sure that it had the right skill mix of staff. One patient told us the nurses had explained the care and treatment to be delivered when they were admitted to the ward. We were told the ward staff were "busy but good," they knew how to care for them and "yes the staff are qualified."

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 the 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.

Ward staff told us people on end of life pathways were able to continue their care in the ward. Another nurse said, where possible, patients at the end of their life were moved from four-bedded bays to side rooms to preserve patients' dignity. Where it was not possible to move patients to side rooms they were moved to quieter bays with full consideration given to the patients in the bay.

Multidisciplinary working and support

Ward staff told us there was a fast-track process for patients whose wishes were to be discharged home when they were at the end of their life. Palliative care staff told us the medical team co-ordinated the patient's discharge home and ensured information about the person's care was relayed to community teams. The two patients we spoke

Good

End of life care

with were on fast-track discharge and explained the reasons for their onward admission to nursing placements. One patient and their family told us the delay in their discharge was caused by funding.

Are end of life care services caring?

Good

Compassion, dignity and empathy

Patients' rights were respected by staff. Patients said staff made sure they pulled curtains when providing personal care to ensure privacy and dignity were maintained. The family of a patient told us the staff cared for their relative by providing personal care and monitoring their food and drink. Another patient and their relatives said the staff were not always respectful. The ward sister explained meetings with the family had taken place to resolve some of the conflicts that had arisen.

Staff were aware of the rights of patients. A nurse said they had attended equality and diversity training. They gave us examples on how patients' rights were respected. For example, keeping the ward calm and treating patients in the same way "we would like to be treated."

Ward staff ensured patients and their relatives were cared for with compassion. One nurse gave us examples of the care delivered to end of life patients from other ethnic or cultural backgrounds. This included patients who were travellers and patients with other religious beliefs. Staff told us visiting times were more flexible for patients at the end of their life to ensure patients had as much time with their relatives as they wanted.

Involvement in care and decision making

Patients made decisions about their care. One patient told us: "I don't like people making decisions for me." Another patient told us they wanted to be better informed by their consultant and they knew to make an appointment with the consultant to discuss their treatment. The ward sister knew of the concerns this family had. The family of a patient at the end of their life told us they were involved in the decisions of no further treatment being given to their relative. They told us their views not to resuscitate had been sought by the consultant and they had agreed with the consultant's decision.

The staff on the wards knew the patients who were on an end of life pathway. Nursing staff said consultants made the decisions on the status of patients. Once the consultant and multidisciplinary team (including ward staff) had agreed the decision, the consultant discussed this with the patient and/or their relatives. The consultant explained to the patients and their relatives the emphasis of the care was no longer to cure the patient, but to make them comfortable at the end of their life. One nurse gave us an example when joint decisions not to resuscitate were made for patients who experienced readmissions due to their medical conditions. We were told it was common for patients with chronic obstructive pulmonary disease (COPD) to experience a number of readmissions and the decision not to resuscitate was reached jointly with the patient. The specialist palliative team told us they were then informed of the patient once the decision was made by the consultant and the patient's notes clearly indicated this decision

Trust and communication

Information on palliative care was available to patients and their families. Ward staff told us information on palliative services was available on the hospital website. The hospital website had online advice and information linked to hospices and other NHS websites. Staff from the palliative team told us patients had access to direct contact from the community team for support following their discharge. Written information was also available to patients on Living with Life-Limiting Illnesses which gave key information on services and facilities available to adults in the Oxfordshire area.

Emotional support

Patients had emotional support from trained staff. The bereavement officer helped families and carers with arrangements following their relative's death; helped with family conflict; and counselling. Ward staff asked the bereavement officer to visit families and carers, and they had strong working relationships with the palliative care team. Patients and families had access to chaplaincy and clergy from their religious denominations. Staff ensured the viewing room available to families was arranged in accordance with the patient's and family's belief or culture. For example, appropriate books and religious symbols were made available.

Good

End of life care

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 with an understanding of end of life care. There were nurses on each ward (referred to as "link" nurses) who specialised in specific topics including end of life care. These staff were able to support other staff who needed guidance or advice. Palliative care link nurses had a strong working relationship with the palliative care team and attended meetings arranged by the team. The meetings discussed good practice which they used on the wards. For example, link nurses had provided information on the types of medicines suitable for patients at the end of their life and we saw this information was on display in the medicine room. Two nurses told us although they had not attended end of life training, they worked alongside link nurses who offered advice. We spoke with a junior doctor who told us end of life teaching was mandatory during their training.

Vulnerable patients and capacity

Staff were aware that patients at the end of their lives were particularly vulnerable and took extra care to ensure that these patients understood their care and treatment..

Access to services

Patients on end of life had access to specialist staff from the palliative care team. Staff from the palliative care team offered advice and guidance to patients, their families and health and social care professionals. Once discharged, patients at the end of their life had access to community palliative care staff. The patient's care and treatment was reviewed weekly at multidisciplinary team meetings. Patients' notes we saw recorded advice given on pain management and symptom control. One family confirmed their relative had home visits from specialist palliative nurses.

Leaving hospital

The hospital had a fast-track process for patients at the end of their life who wished to be discharged home or to other care providers such as a hospice or nursing home. The staff from the palliative care team told us the fast-track process was co-ordinated by ward staff. An end of life care checklist was completed and contained essential information for discharging the patient to the community palliative care services.

Learning from experiences, concerns and complaints

Patients felt confident about raising concerns. The two patients we spoke with told us they felt confident to raise concerns to the staff. One patient told us they had been on the ward for five weeks and had no concerns. The other patient told us they had complained in the past. The ward sister told us when patients have concerns a discussion takes place to resolve issues promptly. A meeting had taken place with the patient and family to discuss their 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. 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 multidisciplinary team. The patients we spoke with were part of the decision about their care and treatment. Ward staff and staff from the palliative care team told us the systems in place to provide community services following patients discharge. Patients told us they had a palliative nurse involved in their care when they were in the community. The two patients we spoke with were on fast-track discharge as they had made the decision not to stay in the hospital.

Governance arrangements

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 and 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.

Good

End of life care

Leadership and culture

Hospital staff were proud to work for the trust. One nurse told us: "I am proud to be part of the team. We work well together." A link specialist palliative care nurse told us: "I am proud of what we are doing." Another nurse told us: "We do end of life care well." They told us there were strong links with members of staff from the palliative care team.

Patient experiences, staff involvement and engagement

Patients' experience was sought through surveys and feedback to staff. There were Friends and Family test surveys for patients to give feedback about their experiences. These views were used by the trust to improve services for patients. One family of a patient on end of life told us they were aware feedback forms were available.

Learning, improvement, innovation and sustainability

The organisation wanted to learn and improve. Lack of information at the discharge stage had been identified by the trust as needing improvement. The Quality Account report 2012/13 accepted some people returned to hospital because they were not given enough information on their discharge. The trust identified two areas for improvements to reduce readmission to hospital which included providing better quality of information to patients on what to expect following their discharge. The trust also was to introduce a helpline managed by specialist nurses offering advice on symptoms people may experience following their discharge.

The key findings in the NHS staff survey for the Oxford University Hospitals were reported in the trust's Quality Accounts 2012-13. It was reported 77% of the staff had an appraisal in 2012 and 81% job relevant training and learning development.

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 Horton General Hospital in 2012/13 was 87,610 which accounted for 11.6% of the total trust-wide activity in the Outpatients division. There were 26 different speciality clinics including: neurology, ophthalmology, dermatology, oral and maxilla-facial, gynaecology, general surgery and medicine, paediatrics, breast care, rheumatology, urology, gastroenterology, vascular, ear nose and throat, haematology, oncology, chest, diabetic and endocrinology and one access department for planned surgery. Fracture clinics were provided at the weekend to enable patients from A&E to be seen the following day.

Summary of findings

Patients received safe and effective care. Staff were skilled and caring and knew their responsibilities to keep patients safe. Risk assessments had been completed and actions identified to improve the service. The clinic was clean and a refurbishment programme had started. Capacity remained a concern because demand had increased by 10% over the year prior to our inspection. The trust was planning to improve capacity at the hospital by providing two additional clinic rooms in the refurbishment. Audits for the "choose and book" system had taken place and the trust was in the process of re-profiling outpatients to improve the patient experience.

We spoke with 10 patients and the majority had no problem getting an appointment and all tests and x-rays had been completed in a timely manner. Eight patients were complimentary about the service and two told us the service was excellent overall. Two patients had problems getting an appointment in a timely manner.

There was a culture between staff to improve the patient experience and be the best they could be. Patient views and experience had been sought to help improve the service. Staff had endeavoured to answer any verbal concerns raised with them immediately.

The trust were keen to develop directly bookable appointments that relieved pressure on staff and the time it took patients to book individual appointments over the phone. The plan was to improve the time automatic letters were sent for appointments and cancellations.

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

There were effective arrangements in place for reporting patients or staff safety incidents and allegations of abuse, which were in line with national guidance. In the last 12 months 54 incidents forms had been completed and there were no red alerts that identified an extreme risk.

We were informed that all staff completed life support training annually and there was resuscitation equipment available. The sister in charge told us there was adequate staff due to staff being "flexible, helpful, positive, and supportive". The staff rotas were different every week to match the clinics. Staff had been matched to their skills and additional staff would be provided when required. The sister in charge managed staff skills and competencies that related to the specialities in each division.

There was an adult and child safeguarding procedure for staff to access from the computer and staff had completed safeguarding e-leaning training every three years.

Learning and improvement

The incidents reported were mainly minor accidents to staff and patients for example: slips or trips and there had been no actions required. The results from a recent patient questionnaire were mainly positive and the results were posted on the wall for patients to see. Individual negative comments were mainly about waiting times. An audit had been completed to assist an outside company with re-profiling. This was a review of the way that outpatients was organised and managed, to ensure the capacity within clinics met increasing demand.

Systems processes and practices

There were systems to help keep patients safe. These included risk assessments which had been completed for moving and handling and hand washing. When patients waited for transport at lunchtime they had a free lunchbox provided and snacks when doctors were delayed.

The clinic was clean. There was a cleaning schedule for all clinic rooms and staff checked them three times a day and recorded the result. There were hand gels available for both staff and patients placed at entrances which were being used.

Monitoring safety and responding to risk

There were no major risks to patients. There was a local risk action plan for outpatients which included three issues for improvement. These were to replace carpeted areas to improve infection control, update the clinic couches and replace a wooden baby changing station. We were informed two clinic room floors had been replaced but there were other areas to finish. All 20 pump action couches need updating to electronic couches. The League of Friends were providing two new couches but they had not arrived. The trust had agreed to replace the baby changing station and the replacement couches were outstanding.

Administration staff were concerned that the corridor they used to access their office had water was leaking through the ceiling and electric cables were visible. We observed this during our inspection.

Anticipation and planning

Some problems with capacity were anticipated in advance because the department was generally notified six weeks before a clinic was cancelled. The sister in charge had kept a record of when there was no notification. The majority of changes to clinics without notification were cancellations. Changes made to outpatient clinics without notification from the beginning of August 2013 until end of January 2014 numbered 100. The majority of reasons for clinic cancellations were the doctor was on annual or study leave, even though they were required to give six-weeks' notice. When clinics were cancelled in advance other clinics were scheduled to clear the backlog of patients waiting for an appointment.

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 was working with Oxfordshire CCG because they were concerned the trust had a Choose and Book breach rate of over 50% and in some specialties over 95%. The hospital had recently provided additional capacity to see patients in the ear, nose and throat (ENT) clinics to help with the breach rates.

Good

Outpatients

Performance, monitoring and improvement of outcomes

The trust participated in national clinical audits, reviews of services, benchmarking and clinical service accreditation. Staff told us that all appointments were managed by different teams. The Choose and Book system did not take all referrals. Some were arranged by each department and consultants managed some of their own referrals. A member of staff told us that sometimes patients got multiple letters for appointments at the hospital. This was a fault of the system and was under review. We were informed ophthalmology clinics were full with first appointments which meant follow up appointments caused an overload in the clinics.

The trust planned to improve capacity at the hospital by providing two additional clinic rooms in the refurbishment. Audits for the Choose and Book system had taken place and the trust was in the process of re-profiling outpatients to improve the patient experience.

We spoke with ten patients and the majority had no problem getting an appointment and all tests and x-rays had been completed. Eight patients were complimentary about the service and two told us the service was excellent overall.

Staff, equipment and facilities

Risk assessments had been recorded for facilities and equipment. Actions had been recorded and timescales for improvements had been agreed with the trust. The outpatients department was old and drab but the trust had started a refurbishment programme.

Multidisciplinary working and support

There was a good working relationship within the patient access centre where appointments were booked at the hospital. Local GP's would refer through the Choose and Book system and 90% of patients had an appointment after they had called the centre in Oxford at the arranged time. If an appointment was not booked then a referral was logged in the electronic patient record and the patient was added to breach list. These were triaged by the consultant to consider whether any tests were required first. Staff contacted the patient by phone or letter to explain the plan and all appointment letters were sent by the Oxford team. Pre-operation information and dates were sent from the Horton. A member of the administration staff told us there was usually a queue on the 'Choose and Book' telephone line but 90% of patients had their choice of time and occasionally hospital site.

Are outpatients services caring?

Good

Compassion, dignity and empathy

We spoke with 10 patients and the majority were pleased with the service. We observed that the reception staff were welcoming and treated patients with respect and kindness. A recent patient survey of 44 patients recorded that 31 patients told them communication with support staff in outpatients was excellent and 12 said it was good.

Involvement in care and decision making

Patients told us that they had investigations in a timely manner and one patient told us: "Banbury has always been good". Patients knew what their appointments were for and the reason investigations were required.

Trust and communication

Patient records arrived the day before a clinic and investigation results were printed from the computer where required. Records arrived on time for the clinics. The sister in charge told us the electronic patient record was in different stages in each department and currently they only had access to patients' investigation results.

Nurses were usually able to chaperone patients and ensured that they understood the consultant and repeat the information if required. Occasionally, a nurse supported four consultants in one clinic and was unable to chaperone everyone. This may mean that patients did not get always get the support they needed. Leaflets were available about treatment and diseases and the doctor asked staff to give them to patients. Consultants had recorded medical history, medication, treatment, advice and follow up appointment in the patient record. Letters to GPs were recorded and sent out within a week with a duplicate to the patient. Patients were able to make further appointments in outpatients which was easier and quicker for them.

Emotional support

Staff checked the results of investigations required and were mindful should the news be negative and a patient

Good

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may require additional support. The sister's office could be used for privacy when required. The staff were experienced in providing support to patients as most of them had worked in outpatients for a long time and the sister in charge was confident in their ability.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The recent outpatient survey in February 2014 identified that 40 patients out of 44 were satisfied with the care they received in outpatients, three did not respond. The majority of patients indicated that the verbal and written communication was either excellent or good. A white board outside each clinic room indicated to patients how long they had to wait to be seen. Generally, the staff told patients how long they would be waiting. Staff told us that 5-10% of patients had waited two hours to see the consultant.

Vulnerable patients and capacity

A telephone interpretation service was used to support staff and patients when required. Staff told us it worked well and was used a lot. Braille and large print leaflets were available. Information in other languages could be provided. There was no learning disability trained nurse in the hospital to support patients and staff should the need arise. The trust told us there was a learning disability nurse who worked across all sites where required. The sister told us that staff had been trained to support patients with dementia care needs.

Access to services

A patient told us they travelled from north of Banbury to Oxford for an MRI scan because there were no facilities for this at the hospital. We spoke to the manager in radiology and they told us there were no plans to install MRI facilities there. There was some capacity to use the MRI scanner at a treatment centre nearby but access was difficult for inpatients.

Leaving hospital

Patients were given information they required before leaving the department. Patients waiting for transport over lunchtime were provided with a free lunch box.

Learning from experiences, concerns and complaints

The sister in charge told us they did not have many verbal complaints and mostly they were about waiting times. There had been issues raised with the Patient Advice and Liaison Service (PALS) about waiting times for outpatient's appointments. The trust had taken action by conducting an audit of outpatient's capacity and demand to introduce re-profiling of clinics. This is a review of the way that outpatients is organised and managed to ensure that the capacity within clinics meets increasing demand. There was a plan to create a four-room paediatric clinic which will free up two rooms in the outpatients department at the hospital. This would enable additional clinics to take place and improve appointment waiting times.

Are outpatients services well-led?

Good

Vision, strategy and risks

The trust Quality Account recognised waiting times were not reduced and were working with Oxford Clinical Commissioning Group (OCCG) to ensure that capacity of outpatients was managed well.

The radiology department had a refurbishment plan in place and changes were being made to rearrange and improve facilities. All safety precautions had been identified and we were told there were detailed plans to ensure patient safety at all times.

Governance arrangements

Issues raised in the outpatient department were escalated to the lead nurse in the operational and service development directorate. Outpatient clinic bookings were made in Oxford for each division. This made it a difficult exercise to follow up the cancelled clinics for each division. Staff felt they were sometimes the poor relation of the trust when improvements were required.

Leadership and culture

There was a culture between staff to improve the patient experience and be the best they could be. The staff we

Good

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spoke with were proud of the hospital and worked together to maintain a good quality service. Staff felt supported by senior staff but sometimes felt they rarely saw divisional or executive staff. A member of staff told us that they had completed an audit about patient waiting times and clinic demand and capacity to aid the review in progress by the trust to improve patient experience.

Patient experiences, staff involvement and engagement

Patients' views and experience had been sought to help improve the service. Staff had endeavoured to answer any verbal concerns raised with them immediately. Patients had completed surveys about outpatients and the results had been posted on the wall for patients and staff to see. The results had been mainly positive.

Learning, improvement, innovation and sustainability

The trust set out their transforming patient experience strategies for 2014 to 2016. 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.

The finance and performance committee met on 12 February 2014 to review the progress of the outpatient re-profiling project. The project aims to match demand and capacity to secure a maximum six-week wait for new outpatient referrals and to secure savings. The review completion is behind plan, but the end of May for implementation was still in place. Patients, staff and GP communications have been developed and circulated.