Oxford University Hospitals NHS Trust

Quality report

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This report describes our judgement of the quality of care at this trust. 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 acute services at this trust	Good	
Are acute services at this trust safe?	Good	
Are acute services at this trust effective?	Good	
Are acute services at this trust caring?	Good	
Are acute services at this trust responsive?	Good	
Are acute services at this trust well-led?	Good	

Summary of findings

Contents

Overall summary

Oxford University Hospitals NHS Trust is one of the largest acute teaching trusts in the UK and has four hospitals. The John Radcliffe Hospital, the Churchill Hospital, and the Nuffield Orthopaedic Centre are situated in Oxford and serve a population of around 655,000. The Horton General Hospital in Banbury serves a population of around 150,000 people in north Oxfordshire, south Northamptonshire and south east Warwickshire. The trust has around 1465 beds, 832 of which are at the John Radcliffe. The trust has around 186,000 patients who stay in hospital and it arranges around 835,000 outpatient appointments every year. The hospitals in the trust are busy with the John Radcliffe being the busiest. The trust's bed occupancy from July to September 2013 has been 92%, higher than the England average of 85.2%. The recommended occupancy rate is 85%, beyond that the pressure that a hospital is under can start to affect the quality of care given and the orderly running of the hospital.

The trust is registered to provide services under the regulated activities:

- 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
- Treatment of disease, disorder or injury

Staffing
The trust employs around 11,000 staff. It has difficulties in recruiting and retaining sufficient staff, particularly nursing staff and healthcare assistants, in all four hospitals. The high cost of living in Oxford coupled with the difficulty and cost of parking is felt to be an issue. The trust has an ongoing recruitment campaign and is exploring options to help ease the parking problems. The trust employs agency and bank staff to make up the shortfalls and permanent staff spoke positively about the skills of their temporary colleagues. At the John Radcliffe hospital the vacancy rates were particularly high in the surgical wards and theatres, 19% in nursing and medical grades in January 2014. Staff described working long days and overtime to help address the shortfalls. However staff shortages have led to the cancellation of operations. At the Horton hospital staff felt that people were deterred from applying for posts because of perceived uncertainties about the future of services there however the low turnover of staff made it the most stable of the four hospitals for staffing. Staff turnover at the trust has run at or slightly above 11% over the last two years. The trust has a clear workforce plan and has set a target to reach 10% turnover. Targeted actions at problem areas for turnover have delivered significant improvements. Staffing levels have been increased on medical wards following an audit and assessment of patients' needs.

Cleanliness and infection control
All four hospitals were clean and we observed good infection control practices among staff. Staff were wearing appropriate personal protective equipment when delivering care to patients and they cleaned their hands between patients. There were suitable hand-washing facilities in the hospitals and a good provision of hand gels. We saw staff using the gels and asking patients to do the same. Staff observed the hospital's policy on being bare below the elbow. The number of methicillin resistant *Staphylococcus Aureus* (MSRA) bacteraemia infections and *Clostridium difficile* infections were within an acceptable range for a trust of this size. Each reported case had been reviewed in detail. The trust takes action to access its own performance with its policies and practices both for cleaning and infection control.

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

Good 

We found that services at the trust were safe however some improvements were required. The trust had a good track record on safety. Performance against a range of safety measures was monitored and reported monthly. The trust benchmarks itself against other organisations and takes account of national safety performance information. This included monitoring of pressure ulcers, falls, venous thromboembolism and patients with catheter related urinary tract infections. Overall the trust's infection rates lie within a statistically acceptable range; falls rates have been consecutively lower than the England average; and, although rates of new venous thromboembolism were higher than the national average for some of 2013, latterly this has reduced. Actions were being taken across the trust to minimise the occurrence of these key areas. The trust had a good system in place to enable it to change staffing levels on a ward quickly in response to the changing needs of patients.

There were systems in place to report and learn from incidents. The quality and timeliness of investigations into incidents was monitored. We saw that changes had been made to policies and procedures in response to the findings from investigations. There were arrangements in place to share the learning from incidents. We saw that the learning from incidents had been widely shared however we also saw that this had not always happened between the four hospitals. Staff were supported to raise concerns and were encouraged to speak up. Most staff told us that they felt able to do this, but some surgical senior clinicians did not feel able to.

People were protected from abuse and staff were trained to deal with suspicions of abuse. Staff were able to describe how they would recognise the signs of potential abuse and how they would report this.

Are services effective?

Good 

We found that services at the trust were effective. The care and treatment given achieved good outcomes for people and followed current best practice. The trust's links with Oxford University meant that in some areas the trust had been involved in developing the accepted best practice guidelines. The trust took action to check that care and treatment was being delivered appropriately within the guidelines and this was reported across the trust. Feedback from patients contributed to the overall assessments of effectiveness. The trust assessed its effectiveness against known national standards and benchmarked performance against other similar organisations.

The trust had taken action to provide a comprehensive programme of mandatory and specialist training and development for staff at all levels and in all services. Staff spoke positively about the training, support, and supervision that they received. The trust generally had the facilities and equipment needed to deliver services although there are areas of the estate that need updating. Multidisciplinary working is well established and staff are proud of the integrated approach to care. The trust worked positively with local partners although the long standing issues with delayed transfers of care remained an issue that impacted on the running of services and the experiences of patients.

Are services caring?

Good 

We found that services at the trust were caring. The trust's mission statement is "delivering compassionate excellence". Across the trust at all hospitals and within all services we observed patients being treated with dignity, respect, and compassion by all staff. The feedback from patients and carers, both at the inspections, listening events and through comment cards was overwhelmingly positive. The caring

provided by staff in the intensive and critical care services at the John Radcliffe, Horton, and Churchill hospitals was considered to be good. There were some issues to be addressed at the A&E department at the John Radcliffe hospital, caused in part by the challenges of the environment they are working in. In other areas where patients and families had raised concerns those concerns were known and understood by staff and were being addressed, for example by increasing the number of staff working on a ward to ensure that there was sufficient time available to treat patients in a kind and compassionate way.

Patients, carers and relatives were involved in plans and decisions about care. Relatives and carers were encouraged to provide support, for example by supporting their relative at meal times if they wished. Training was provided to family members to support care following discharge as appropriate. People were positive about the support they had received and the difference that this had made to them.

Are services responsive to people's needs?

Good

We found that services provided by the trust were responsive to people's needs however some improvements were needed at the John Radcliffe hospital in A&E, surgery, and outpatients services. There are issues with waiting times in A&E, there is a lack of capacity in theatres and targets for referral to treatment times not being met in outpatient departments. The trust was designing and organising services to meet people's needs. The trust was aware of the areas that needed addressing, risks were captured and reported, and plans were in place. The trust engaged with commissioners and other providers of services but there were long standing problems, dating back a number of years, around the availability of onward care and support for people leaving hospital. The trust had taken some innovative steps, such as the providing personal care to patients in their homes when they leave hospital and there is engagement at matron level with social care providers in the area to improve communication and pathways.

The trust has appropriate processes in place to meet the needs of patients who are vulnerable and who may lack capacity. Most patients are able to access services in a timely way although the lack of emergency theatre capacity has meant that some planned operations have been cancelled. The trust has a dedicated discharge team who support people when they are ready to leave hospital. We observed dedicated and holistic support being given to elderly people who were ready to go home. The trust has improved its arrangements for handling and learning from complaints. Some people told us that they found it difficult to make complaints. Some organisations that support people to make complaints told us that the trust is open and honest in their dealings with complainants and that they accept responsibility when things have gone wrong. However, the trust can be slow to arrange meetings for complainants which can delay the resolution of the issue for the patient concerned and delay the learning and improvement for the trust.

Are services well-led?

Good

We found that all services at every hospital and the trust overall were well led. The trust had a clear vision that was focused on quality and safety and improving patient outcomes and care. The trust were aware of the risks and issues within services, hospitals and across the organisation. The trust was innovative in seeking solutions to long standing problems and targeted efforts in the areas most likely to make a difference to patients and staff. The trust identified and reported risk in a coherent way and planned to mitigate and remove risks where possible. The integrated clinical management structure worked well across the four hospitals with clear lines of accountability. The staff survey and human resource indicators gave a picture of a high performing and engaged staff group who were proud of the services that they deliver and of their colleagues. The trust took patient and staff feedback seriously and considered that information alongside other performance data. The trust had systems to focus on learning and improvement and the Listening into Action project gave staff a vehicle to find and implement solutions.

What people who use the trust's services say

The people that we met at the two listening events and the patients and carers that we spoke to during our inspections of the hospitals spoke highly about the services they had received and about the staff who worked there. While concerns were raised about the future of some services and there were concerns about waiting times, cancelled operations and the way that some staff have spoken to people the overwhelming majority of comments and information we received were very positive.

The NHS Choices website which scores hospitals out of five stars shows the trust is attaining an overall score of 4.5. The Adult Inpatient Survey 2012 (the last available) shows that the trust has performed within expectations compared to other trusts, meaning that patients who completed the survey have not rated it as significantly better or worse than other trusts. The trust is performing above the England average for the Friends and Family Test on both the inpatient and accident and emergency tests, this test measures whether staff recommend their hospital as a place to receive treatment. The trust performed well compared to other trusts in the Cancer Patient Experience Survey in 2012/13 with only two areas scoring poorly; these were around ease of making contact and being offered a written assessment and care plan.

Areas for improvement

Action the trust MUST take to improve

- The trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.
- The trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times.
- The trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.
- The trust needs to ensure that staff receive suitable induction to each area that they work within the trust.
- The trust needs to ensure that midwives receive appropriate supervision and newly qualified midwives are appropriately supported.

Good practice

- The system the trust used to identify and manage staffing levels was effective and responsive to meet the needs of the hospitals.
- There were good care pathways for patients attending the A&E department following a stroke.
- Services were innovative and professional.
- There was a strong sense of improving the outcomes for frail elderly patients and those with dementia on the medical wards. The psychological medicine service was supporting staff to understand the care and support needs of these patients. Wards on level 7 were being redesigned to make it more accessible for patients with dementia.
- Caring compassionate staff throughout the four hospitals.
- Managers had a strong understanding of the risks in service and improvements required. Incident reporting and monitoring was well managed and the learning from incidents was evident. There was a strong commitment, supported by action plans, to improve the service.
- Staff worked well between teams. The value of an effective multidisciplinary approach, in improving outcomes for patients, was understood and actively encouraged.
- It was evident that significant efforts had been being made to improve the effective discharge of patients within medical areas. The hospital was working closely with commissioners, social services,

and providers to improve the transfer of patients to community services.

- Two gerontologists worked in trauma wards to provide medical input and an integrated approach to trauma patients who were older people with co-existing illnesses.
- The nurse consultant in trauma care. This was the first such appointment in the UK and enabled the facilitation and coordination of shared care for complex trauma patients.
- The acknowledgement of excellence of junior medical staff within the trauma directorate by leaders.
- The trauma service in general was praised by patients and staff. It was well-led with well-supported staff and happy patients.
- There was good learning from incidents within critical care which translated into training and safer practice.
- The approach to caring for adolescents, within an environment designed to meet their needs and a clear team approach.
- Involvement of young people in developing art work which was made in to posters to promote the values that are important to the young people themselves.
- Patients within maternity expressed a high degree of satisfaction about the care they were receiving and the staff who supported them.
- Patients had the expertise of specialist midwives such as diabetes, breast feeding to ensure they received appropriate care and treatment.
- Patients received care in a compassionate way which included a designated bereavement suite and pastoral care in the maternity unit.
- There was good multidisciplinary team working for the benefits of mothers and their babies
- There were processes in place throughout the hospitals which took into account patients' diversity. These included interpretation service and information provided in different formats according to the patients' needs.
- The trust internal peer review process, in which over 100 clinical areas had been reviewed in a three month period across the trust.

Oxford University Hospitals NHS Trust

Good

Detailed findings

Hospitals we looked at
Churchill Hospital, Oxford
Horton Hospital, Banbury
John Radcliffe Hospital, Oxford
Nuffield Orthopaedic Centre, Oxford

Our inspection team

Our inspection team was led by:

Chair: Dr Chris Gordon, Consultant Physician, Medicine and Elderly Care, Hampshire Hospitals Foundation Trust; Programme Director NHS Leadership Academy

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

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

Background to Oxford University Hospitals NHS Trust

Oxford University Hospitals Trust is one of the largest acute teaching trusts in the UK and has four hospitals. The John Radcliffe Hospital, the Churchill Hospital, and the Nuffield Orthopaedic Centre are situated in Oxford and serve a population of around 655,000. The Horton General Hospital in Banbury serves a population of around 150,000 people in north Oxfordshire, south Northamptonshire and south east Warwickshire. The trust has around 1,465 beds, 832 of which are at the John Radcliffe. The trust has around 186,000 patients who stay in hospital and it arranges around 835,000 outpatient appointments every year.

The trust has teaching hospital status as part of Oxford University. The trust employs around 11,000 staff and had an annual turnover in 2012/13 of £822 million. The trust provides acute medical and surgical services, trauma, and intensive care and it offers both specialist and general clinical services. The trust leads regional networks for trauma, secular surgery, cancer, neonatal intensive care , primary coronary intervention, and stroke.

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, Oxford University Hospitals

Trust was considered to be a medium risk trust and 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
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 25 and 26 February 2014.

During our visit we held focus groups with a range of staff in the hospital including nurses below the role of matron, matrons, allied health professionals, junior doctors, student nurses, consultants and administration staff. Staff were invited to attend drop-in sessions. We talked with patients and staff from all areas at all four hospitals including the wards, theatres, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members. We reviewed personal care or treatment records of patients. We held two listening events in Banbury and Oxford where patients and members of the public shared their views and experiences of the location.

An unannounced visit was carried out on 2 and 3 March 2014.

Are services safe?

Good 

Summary of findings

We found that services at the trust were safe however some improvements were required. The trust had a good track record on safety. Performance against a range of safety measures was monitored and reported monthly. The trust benchmarks itself against other organisations and takes account of national safety performance information. This included monitoring of pressure ulcers, falls, venous thromboembolism and patients with catheter related urinary tract infections. Actions were being taken across the trust to minimise the occurrence of these key areas. The trust had a good system in place to enable it to change staffing levels on a ward quickly in response to the changing needs of patients.

There were systems in place to report and learn from incidents. The quality and timeliness of investigations into incidents was monitored. We saw that changes had been made to policies and procedures in response to the findings from investigations. There were arrangements in place to share the learning from incidents. We saw that the learning from incidents had been widely shared however we also saw that this had not always happened between the four hospitals. Staff were supported to raise concerns and were encouraged to speak up. Staff told us that they felt able to do this.

People were protected from abuse and staff were trained to deal with suspicions of abuse. Staff were able to describe how they would recognise the signs of potential abuse and how they would report this.

Our findings

Safety and performance

Overall, the trust had a good track record on safety although some improvements are required in maternity and surgery at the John Radcliffe hospital. Staffing levels in maternity, operating theatres and on surgical wards were not always sufficient to meet people's needs. The trust has recognised these issues and has plans in place to recruit additional staff and reduce turnover. Some areas at the Churchill Hospital and Nuffield Orthopaedic Centre looked old and worn and presented a potential risk to safety. These risks had been identified and are on the relevant risk registers.

The trust has effective arrangements in place for reporting patient and staff safety incidents and allegations of abuse and these are in line with national guidance. There are clear accountabilities for incident reporting. There was some variation in the robustness of these arrangements between the four hospitals and between services within individual hospitals.

People were protected from abuse and staff were trained to deal with suspicions of abuse. Training records showed that staff at all levels were trained in safeguarding vulnerable adults and this topic was included on induction training for all new staff. Staff were able to describe how they would recognise the signs of potential abuse and how they would report this. Staff were aware of their duty to raise a safeguarding alert of they were concerned about the safety of a patient or somebody accompanying them.

Learning and improvement

Overall the trust had a good approach to incident reporting and was committed to capturing and sharing the learning from incidents and complaints. Staff received training in health and safety and incident reporting. The learning from incidents and complaints related to safety was variable. In some areas there was clear learning which had been shared and disseminated to staff. We saw some good examples, for instance, the A&E unit at the John Radcliffe hospital reported a higher number of incidents compared to trusts of a similar size. We saw that incidents had been analysed and action had been taken. In the medical wards at the same hospital we saw that the lessons following the investigation of a fall that had led to harm was shared with staff at ward meetings. However, in others it was not clear that learning from or awareness of incidents had occurred. This included learning from never events in operating theatres with some staff

working in surgery at the John Radcliffe hospitals being unaware of the never events in surgery at the Churchill hospital.

Systems, processes and practices
The trust had effective systems, processed and practices in place in a range of areas that were key to patient safety. These included effective systems for cleanliness and infection control. The layout of departments was safe with clear routes through and between wards and departments. There were clear processes for the storage of medicines, equipment, and consumables.
The trust monitored the investigation of incidents at a monthly quality meeting to help ensure that these were completed promptly and to a good standard and that the learning from them was shared.

Monitoring safety and responding to risk
Safety is monitored throughout the four hospitals through a programme of regular reviews and risk based audits. Areas monitored included pressure ulcers, falls, venous thromboembolism, and patients with catheter related urinary tract infections. Actions were being taken across the trust in all relevant service areas to improve safety. The trust used the "safety thermometers" as part of their measurement. Action had been taken in response to fluctuations in trust performance against this. Each of the five clinical divisions produces a monthly safety report. Wards displayed their information about individual performance.
Staff were supported to raise concerns and were encouraged to speak up. Staff told us that they felt able to do this.

Staff spoke highly of the system for responding to the need for an increase in staffing when the needs of patients in a particular ward changed. Green, amber, and red staffing levels had been set for each ward. The model was used to identify risks and changing needs and enable staff to be redeployed and for extra staff to be brought in if needed. This system worked in real time and made the changes needed quickly.
Staff across the trust demonstrated an awareness of the Mental Capacity Act 2005 and we saw examples of applications that had been made in line with the deprivation of liberty safeguards.

Anticipation and planning
Although the trust did not have any explicit headline references to safety in its strategic objectives for 2013/14 it is implied under the umbrella aim of "delivering compassionate excellence". The monitoring and reporting arrangements that sit underneath the objectives included safety as a component of quality. The trust benchmarked itself against other trusts in assessing performance. Plans are risk assessed and the impact on patient safety is monitored. The monitoring arrangements were at set at divisional level rather than by individual hospital. It was not clear how long issues specific to a hospital would take to emerge through this route.

The trust had plans in place to respond to major incidents and emergencies. The A&E departments worked as part of a network with other trusts and had detailed plans for transferring and redirecting patients in the event of a major emergency.

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

Good 

Summary of findings

We found that services at the trust were effective. The care and treatment given achieved good outcomes for people and followed current best practice. The trust's links with Oxford University meant that in some areas the trust had been involved in developing the accepted best practice guidelines. The trust took action to check that care and treatment was being delivered appropriately within the guidelines and this was reported across the trust. Feedback from patients contributed to the overall assessments of effectiveness. The trust assessed its effectiveness against known national standards and benchmarked performance against other similar organisations.

The trust had taken action to provide a comprehensive programme of mandatory and specialist training and development for staff at all levels and in all services. Staff spoke positively about the training, support, and supervision that they received. The trust generally had the facilities and equipment needed to deliver services although there are areas of the estate that need updating. Multidisciplinary working is well established and staff are proud of the integrated approach to care. The trust worked positively with local partners although the long standing issues with delayed transfers of care remained an issue that impacted on the running of services and the experiences of patients.

Our findings

Using evidence-based guidance

The trust systematically identified relevant legislation and current and new best practice. This was achieved through the trust's audit, governance, and clinical review committees. Pathways of care had been developed in line with latest guidance from the National Institute for Health and Care Excellence (NICE).

The trust monitored practice to ensure that care and treatment was delivered in line with the practices agreed for the trust. This was monitored within the clinical divisions by designated leads and reported on a trust wide basis through the governance systems. Some pathways of care were under active review, for example an integrated care pathway for patients with diabetes was being formalised.

The trust has taken part in research in conjunction with Oxford University that has led to the development of best practice guidelines that have been adopted nationally and internationally, for example, around the increased risk of mini strokes in the aftermath of a stroke.

Patients were provided with information and support to make choices about their care and treatment. Staff demonstrated an awareness of the processes in place when a patient was considered to lack capacity to consent. There was evidence in services across the trust that these processes had been appropriately followed.

Performance, monitoring and improvement of outcomes

The outcomes for patients receiving treatment at the trust were good and compared well with similar organisations. This was determined through participation in national clinical audits and through independent audits commissioned by the trust. Performance against an agreed set of patient outcomes was monitored on a monthly basis. Shortfalls in performance were identified and improvement plans put in place and monitored. The risks to patients identified through the NHS Safety Thermometer process were being managed. Mortality rates are within expected levels.

Patients were included in the process of evaluating the effectiveness of their treatment. Patients asked to report on the outcomes of their surgery showed they had achieved good outcomes. Comment cards from patients and other feedback described the improvements they had experienced in the control of pain and the improvements such as mobility and quality of life.

Staff, equipment and facilities

The trust had a programme of mandatory training for staff. Specialist training was provided appropriate to the roles performed by staff at different levels. The trust provided skills and language classes for staff who

had trained abroad. The trust had an academy for care support workers that provided support from practice development nurses. Student nurses praised the support and development that they received. There were develop and leadership programmes available. Refresher training was available to ensure practice remained up to date. The trust had developed training in response to identified needs, for example a dementia training programme for doctors, medical students, nurses, and ward staff had been developed in response to the findings of a national audit.
The trust generally had the appropriate equipment and facilities to support safe and effective care across the range of its services. There were some significant exceptions to this relating to the condition of the main theatres at the John Radcliffe hospital. These risks are reflected in the trust's risk registers. The experience of surgeons in obtaining specialist equipment was mixed. The spinal team said their requests for equipment had not been met while other specialist teams said they had everything that they needed. The trust were aware of the concerns and plans were in place to refurbish the theatres at the hospital. Equipment was maintained as needed. Some parts of the estate, particularly at the Churchill hospital, are in need of updating and refurbishment and these issues are appropriately captured on risk registers and plans.

Multidisciplinary working and support
Multidisciplinary working was well established within and across different services and hospitals. Treatment and care plans reflected the multidisciplinary approach. Staff were proud of the integrated approach to caring for people with complex needs. End of life care was integrated within the hospitals and with community services. Patients and staff were very positive about this service. The trust worked positively with local care and transport providers in the best interests of patients. The long standing problem with delayed discharges in Oxfordshire remained an issue and impacted on the wellbeing and experience of patients. The trust had sought solutions, for example, by supporting patients on their return home through the provision of personal care and working with local social care providers to improve communication and discharge arrangements.

Are services caring?

Good 

Summary of findings

We found that services at the trust were caring. The trust's mission statement is "delivering compassionate excellence". Across the trust at all hospitals and within all services we observed patients being treated with dignity, respect, and compassion by all staff. The feedback from patients and carers, both at the inspections, listening events and through comment cards was overwhelmingly positive. The caring provided by staff in the intensive and critical care services at the John Radcliffe, Horton, and Churchill hospitals was considered good. There were some issues to be addressed at the A&E department at the John Radcliffe hospital, caused in part by the challenges of the environment they are working in. In other areas where patients and families had raised concerns those concerns were known and understood by staff and were being addressed, for example, by increasing the number of staff working on a ward to ensure that there was sufficient time available to treat patients in a kind and compassionate way.
Patients, carers and relatives were involved in plans and decisions about care. Relatives and carers were encouraged to provide support, for example, by supporting their relative at meal times if they wished. Training was provided to family members to support care following discharge as appropriate. People were positive about the support they had received and the difference that this had made to them.

Our findings

Compassion, dignity and empathy
We observed, and people told us, that they were treated with compassion, dignity and empathy. In each service at all four hospitals people described the way in which staff had been kind to them and had taken the time to make them feel safe and supported.
Some people told us they were concerned about the way their elderly relatives had been treated, that they were not always helped in a timely way, and that some staff were not patient with them. Staff at all levels in that service were aware of the concerns that had been raised and additional staff had been provided. Staff understood that disrespectful behaviour would not be tolerated. We observed kindness and consideration on the part of staff across all the services.
The exception to this overall positive picture was the A&E department at the John Radcliffe hospital. The staff there were observed to be caring in many ways and had been motivated to improve the way that the service was designed and delivered for patients. However, at busy times some patients did not feel safe or comfortable. The physical environment contributed to the challenges of delivering care in a dignified way. The Atrium was in effect a corridor, vulnerable to extremes of heat and cold, separated from the main entrance by a screen and overlooked by office windows from above. Patients who have been admitted waited here for a bed to become available. Some patients were not assessed in a way that respected privacy or confidentiality, conversations could be overheard, and doors were not closed.

Involvement in care and decision making
The trust was able to demonstrate that patients are considered partners in their own care. This was apparent in the plans and assessments that preceded decisions and in the assessments made of the effectiveness of the care and treatment given. Patients and relatives told us that they had felt as involved as they could be in decisions. Conversations included discussions of the pros and cons of treatment options and the provision of verbal and written information to help people make choices. Patients were able to refer themselves to the specialist palliative care team and to speak to a member of staff when they wished. Relatives and carers were given the opportunity to be involved in patient care. The trust welcomed carers to support patients with their meals and we observed this taking place. We saw examples of relatives who had been provided with training to enable them to provide support and care once the patient had been discharged.

Trust and communication
Patients and their relatives described staff as kind and caring in the way that they communicated with them and this included housekeeping and cleaning staff. Nurses who worked as part of the palliative care teams completed a course in advanced communication skills. Parents of sick children and babies described how

staff took the time they needed to support them and what a difference that had made to their ability to cope. The trust website provides online support and guidance and provides links to relevant sources of further information and a variety of relevant written information is provided.

Emotional support
Patients were supported by trained staff to cope emotionally with their care and treatment during their stay in hospital. People told us about the good support that had been provided by the chaplaincy team. Patients were encouraged to stay in contact with family and friends. Visiting times were flexible, the relatives of elderly patients were welcome to stay for longer periods, and we observed staff supporting patients to make telephone calls. In areas with single rooms communal areas had been provided to enable patients to have some social contact. Additional and targeted support was given to patients and their families when a diagnosis of dementia was given. Psychiatrists were providing ward staff with guidance on how to meet the emotional needs of patients with dementia. People who spoke to us in every service at all four hospitals wanted to tell us about the support they had received and the difference that this had made to them.

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

Good

Summary of findings

We found that services provided by the trust were responsive to people's needs however some improvements were needed at the John Radcliffe hospital in A&E, surgery, and outpatients services. There are issues with waiting times in A&E, there is a lack of capacity in theatres and targets for referral to treatment times not being met in outpatient departments. The trust was designing and organising services to meet people's needs. The trust was aware of the areas that needed addressing, risks were captured and reported, and plans were in place. The trust engaged with commissioners and other providers of services but there were long standing problems, dating back a number of years, around the availability of onward care and support for people leaving hospital. The trust had taken some innovative steps, such as the providing personal care to patients in their homes when they leave hospital and there is engagement at matron level with social care providers in the area to improve communication and pathways. The trust has appropriate processes in place to meet the needs of patients who are vulnerable and who may lack capacity. Most patients are able to access services in a timely way although the lack of emergency theatre capacity has meant that some planned operations have been cancelled. The trust has a dedicated discharge team who support people when they are ready to leave hospital. We observed dedicated and holistic support being given to elderly people who were ready to go home. The trust has improved its arrangements for handling and learning from complaints. Some people told us that they found it difficult to make complaints. Some organisations that support people to make complaints told us that the trust is open and honest in their dealings with complainants and that they accept responsibility when things have gone wrong. However the trust can be slow to arrange meetings for complainants which can delay the resolution of the issue for the patient concerned and delay the learning and improvement for the trust.

Our findings

Meeting people's needs
The trust worked with stakeholders to assess the needs of the local community and to plan and design services to meet those needs. Commissioners commented that there is an open dialogue with the trust that involves both clinicians and managers. Co-ordinated pathways of care had been discussed and agreed with partners. Services and related support was planned to meet the needs of different groups of people using services. This support included arrangements for the visually impaired, hearing loops, translation services, and support for people with a learning disability. Equality impact assessments were undertaken There were some challenges, particularly at the John Radcliffe hospital, because bed occupancy ran at about 92%. This meant that patients admitted from A&E sometimes had to wait for a bed to become available and patients were delayed leaving critical care for the same reason.

Vulnerable patients and capacity
The trust had a process in place to decide if a patient had the capacity to consent to care and treatment and where a patient lacked that capacity staff followed a process to make sure the patient's best interests were assessed and recorded. Staff had received training in the safeguarding of vulnerable adults and demonstrated a good understanding of the Mental Capacity Act 2005 and the deprivation of liberty safeguards. The responsibility for applications rested with ward sisters who were supported by the psychological medicine service for complex applications. Patients with fluctuating capacity were supported to manage their confusion.

Access to services
The trust performance on access and waiting times was variable with the most pressure experienced at the John Radcliffe Hospital. A&E targets had been missed and targets for referral to treatment times had not been met in outpatient departments. The trust had anticipated a higher demand for medical beds in the

winter months and escalation plans were in place. The trust had a major project underway to reprofile outpatient clinics to improve access and this was on target but has not yet delivered the improvements needed.

Leaving hospital
The trust had processes in place for the planning of discharges and transfers of care that met patients' needs. There were long standing issues within the health economy which means that every month there were delayed transfers of care. These delays contributed to pressures throughout the hospitals. The trust had been innovative in seeking solutions and this included the provision of personal care in people's homes and engagement at matron level with social care providers. We observed a holistic approach to planning for leaving hospital. Extra care and preparations were provided for elderly people who lived on their own to return home.

Learning from experiences, concerns and complaints
The trust has arrangements in place to capture and learn from patient feedback, concerns and complaints. During 2012/2013 the top three themes from the 860 formal complaints received related to delays and difficulties making appointments, poor and uncoordinated discharge and staff attitude, behaviour and communication. The trust board received a report on the themes from complaints and feedback and divisional and trust wide learning and actions were identified. The trust had work in progress to address the issues raised. The outpatient reprofiling project, the discharge oversight group and the implementation of the patient experience strategy were all in response to issues that had been identified through monitoring and feedback. The commitment shown by management and staff to improve the effectiveness of complaint handling was impressive. Organisations that supported people to make complaints considered that the trust performed well in comparison to other organisations that they dealt with.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Good

Summary of findings

We found that all services at every hospital and the trust overall were well-led. The trust had a clear vision that was focused on quality and safety and improving patient outcomes and care. The trust were aware of the risks and issues within services, hospitals and across the organisation. The trust was innovative in seeking solutions to long standing problems and targeted efforts in the areas most likely to make a difference to patients and staff. The trust identified and reported risk in a coherent way and planned to mitigate and remove risks where possible. The integrated clinical management structure worked well across the four hospitals with clear lines of accountability. The staff survey and human resource indicators gave a picture of a high performing and engaged staff group who were proud of the services that they deliver and of their colleagues. The trust took patient and staff feedback seriously and considered that information alongside other performance data. The trust had systems to focus on learning and improvement and the Listening into Action project gave staff a vehicle to find and implement solutions.

Our findings

Vision, strategy and risks

The trust had a clear vision, captured in the phrase “delivering compassionate excellence”. This was underpinned by a set of strategic objectives that in turn influenced the detailed objectives within divisions and services. Risks were identified and captured and this was a significant exercise given the size of the trust and the range of services. There is a clear connection between the concerns raised by patients and staff and the trust risks and related plans. The trust had launched a five year vision in 2012 which aimed to deliver continuous quality improvement. The focus on 2013/14 was patient safety, patient experience, and clinical effectiveness.

Governance arrangements

The trust had an integrated clinical management structure with a single point of accountability for services across all four hospitals. The trust is organised into five clinical divisions, 17 clinical directorates and 74 clinical service units. There were clear reporting lines. The members of the board and executive team that we met were clear about their roles and responsibilities and the extent of their authority. The divisional structures had enabled a consistent approach to be taken across the different hospitals and reinforced the intention to take a whole trust approach. Some staff felt that this approach made them feel that there was no one in overall charge at the individual hospitals. The trust did not have performance information readily available at hospital level and this raised a question about the ability of the governance and reporting arrangements to pinpoint areas of concern. The governance arrangements had brought a sense of cohesiveness to a large and dispersed organisation.

Leadership and culture

The leadership strategy is one that focuses on excellence and high performance. This was articulated in discussions with executive and non-executive members of the board. The trust was found to be performing better than expected for the majority of the 28 NHS 2013 Staff survey indicators. Staff are motivated and satisfied with their jobs and experience proportionally less bullying and harassment compared to the England average. With the exception of the midwifery staff group sickness absence rates between April 2011 and September 2013 were consistently below the England average. The trust’s ratio of nurses to bed days is above the England average.

The trust had a strong medical culture. Medical staff were proud of the trust and of the association with Oxford University. Medical staff talked positively about the quality of their colleagues at all levels and about their pride in the outcomes for patients. There were some pockets of significant discontent among the consultant body. These consultants talked about their frustration when they raised issues that were not

dealt with in a timely way although they remained proud of the work that they were doing. There was also a sense of some disconnection between the John Radcliffe hospital and the other hospitals and between the hospitals based in Oxford and the Horton General hospital in north Oxfordshire. Perceptions about the future of services at the Horton were impacting on the way that staff there felt about the leadership of the trust.

Patient experiences, staff involvement and engagement
The trust recognised the importance of patient and public views. Patient and staff feedback was a standing agenda item and monthly governance and board meetings. This feedback was considered alongside other performance information. Staff felt involved and informed about patient experiences. The clinical governance committee received reports on the concerns raised by whistleblowers. Action plans were in place at ward and service level to improve practice and patient experience. Positive feedback was shared with staff and displayed in ward areas. The trust's Listening into Action project empowered and encouraged staff to find innovative solutions to the issues they had identified.

Learning, improvement, innovation and sustainability
The trust had systems in place to enable learning and improve performance. Risk reporting systems were reviewed and an improved integrated risk reporting system was in development. Staff teams in different services were able to take time out for focused and in-depth reviews of performance and pathways. Board away days were focused on improvement and sustainability. Staff felt encouraged to continue with their learning and development.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and outpatient care to meet their needs and ensure their welfare and safety. This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The accident and emergency department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively. The outpatient department was failing to provide an effective booking service, failing to meet national standards for timely referral to treatment and failing to provide suitable information. In some surgical specialties waiting times for surgery were too long and operations were cancelled too often. There was not suitable attention paid to the identification, assessment and planning of care needs for vulnerable people, particularly those with dementia in surgery and A&E.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Family planning Maternity and midwifery services Termination of pregnancies	The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the maternity department and on surgical wards and in operating theatres.

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider had failed at times to deliver care to patients that ensured their privacy, dignity and human rights were respected. This is a breach of Regulation 17(1)(a) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The use of the accident and emergency triage room, the atrium area, and layout of the reception did not give patients privacy and dignity

Regulated activity	Regulation
Treatment of disease, disorder or injury.	The provider had failed at times to take proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment arising from a lack of proper information about them, by means of the maintenance of an accurate record in respect of each patient, including appropriate information and documents in relation to that care and treatment. Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 There was no suitable information within care records to inform staff about the individual care patients needed. This was particularly in relation to the needs for vulnerable people, particularly those with dementia and patients requiring complex wound management. Records did not contain all the required information to ensure care was delivered safely to meet the patient's needs. Risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed.

Regulated activity	Regulation
Treatment of disease, disorder or injury Maternity and midwifery services	The provider did not have suitable arrangements in place in order to ensure that all staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard through receiving appropriate training, professional development and supervision. This is a breach of Regulation 23(1)(a) the Health and Social Care Act 2008 (Regulated Activities)

	Regulations 2010. Some of the new nursing staff coming to work at the hospital did not have sufficient induction into the A&E department. Newly qualified midwives did not always receive adequate preceptorship. Not all nurses qualified overseas working in A&E and newly qualified midwives were appropriately supervised to ensure they were competent and trained to deliver all care and treatment procedures to the appropriate standard.