Buckinghamshire Healthcare NHS Trust

RXQ

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXQX5	Buckingham Community Hospital		
RXQ65	Marlow Community Hospital		
RXQ62	Thame Community Hospital		

This report describes our judgement of the quality of care provided within this core service by Buckinghamshire Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Buckinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Buckinghamshire Healthcare NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

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Overall summary

We rated this core service as 'requires improvement'. We rated as 'requires improvement for providing safe, effective, caring, responsive and well led adult inpatient services.

Our key findings:

- Community in-patient services required improvement in aspects of safety, effectiveness, caring, responsiveness and leadership of services.
- We found caring staff across the three hospitals, with a commitment to helping patients on their road to recovery. However, there were some instances where caring and attention to privacy and dignity needed to improve.
- There was inconsistent reporting and learning from safety incidents. Improvements were needed in management of medicines; the access to, checking and storage of equipment; and the accuracy and secure storage of records. Nursing and therapy staffing vacancies, led to staff shortages and high use of agency staff, particularly at Buckingham hospital.
- Improvements were needed to ensure consistent use of current evidence based guidance, and person centred assessments to include the full range of individual needs. Goal setting and monitoring of outcomes for individuals was inconsistent, and participation in audits was limited. There was evidence of multi-disciplinary working but discharge planning was inconsistent at some hospitals and needed greater involvement of patients and relatives.
- There was little evidence of training or clinical supervision to support professional development. Not all staff had the experience or skills to support the more acute needs of patients being admitted. Specialist and medical support was available but was not always timely.
- The vision and strategy for community inpatient beds was not well developed, and staff in the service had not been involved in the process. There was monitoring of performance and quality using a trust wide dashboard but limited evidence of local auditing of the service. The arrangements for identifying and managing risks did not always operate effectively.
- Inappropriate admissions created longer waits for a bed for patients needing rehabilitation, or resulted in some patients needing urgent transfer back to acute services. There was little evidence of monitoring of appropriateness of admissions or the current model of medical and nursing staffing, and the skill base to meet the needs of patients. There were delays in access to specialist support for patients in vulnerable circumstances, for example, patients with a learning disability or mental health needs.
- The quality of leadership varied across the hospitals and staff satisfaction was mixed. There was a positive culture and high morale at Marlow and Thame hospitals. But there were concerns about the skills and capabilities of leaders at Buckingham hospital. Staff reported a negative culture of lack of team cohesion and respect and staff not feeling listened to.
- Across the hospitals there was some evidence of the service seeking the views of patients and relatives through 'You said, we did' initiatives. There were also examples of innovative initiatives by clinical staff to improve the quality of patient care.
- Wards were clean and infection prevention and control procedures were followed, resulting in low incidence of hospital acquired infections. Most staff were up to date with mandatory training , including safeguarding training and they knew how to report safeguarding concerns. Staff were aware of the need for openness and transparency when mistakes were made, although there had been no formal training on Duty of Candour.
- Reasonable adjustments had been made so the premises were accessible and staff demonstrated understanding of equality and diversity.

Summary of findings

Background to the service

Background to the service

Buckinghamshire NHS Trust offers a range of acute and community services, and is the main provider of community services across Buckinghamshire. Community inpatient services are provided at Buckingham, Amersham, Marlow and Thame community hospitals.

Buckingham Hospital had 16 beds and cared for rehabilitation and end of life care patients. There were 20.9 whole time equivalent (WTE) staff employed. Marlow Hospital had 12 beds and cared for rehabilitation and end of life care patients, and employed 13.2 WTE staff. Thame had eight beds and cared for rehabilitation and end of life care patients. There were 15.2 WTE staff employed.

We inspected services at Buckingham, Marlow and Thame Community Hospitals.

Our inspection team

Our inspection team was led by:

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

Team Leader: Joyce Frederick, Head of Hospital Inspections, Care Quality Commission (CQC)

The team of 35 included CQC inspection managers and inspectors. They were supported by specialist advisers, including health visitors, a school nurse, a physiotherapist, an occupational therapist, district nurses, registered nurses, a paediatrician, a GP, a pharmacist, safeguarding leads, a palliative care consultant and palliative care nurses. Three experts by experience that had used the service were also part of the team. The team was supported by an inspection planner and an analyst.

The team that inspected this service included two CQC inspectors, a geriatrician, a registered nurse and one expert by experience.

Why we carried out this inspection

We inspected this core service as part of a community inspection.

Buckinghamshire Healthcare NHS Trust had a comprehensive inspection of its acute services in March 2014. However, its community services were not inspected at that time. We therefore completed the inspection of its community services.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

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

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

Summary of findings

observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 10 and 11 April 2015.

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

We also looked at treatment records of patients and reviewed procedures and other documents relating to the running of the services. We spoke with kitchen staff, housekeepers and domestic assistants. Clinical staff we spoke with included healthcare assistants, staff nurses, ward sisters, occupational therapists, physiotherapists, doctors, pharmacists and ward clerks. We also spoke with locality managers and service leads. This was supported by conversations held with patients and their relatives at all three hospitals.

What people who use the provider say

- Patients at all three hospitals felt they were well looked after and treated with respect. They felt there was a good choice of food, but one patient said the mattresses and armchairs were uncomfortable, especially if they were left there for hours.
- Two patients at Thame said they were well looked after, but had not received much physiotherapy input. One patient said they were stuck there and waiting to go home but could not as they were waiting on their package of care to be set up. They were unhappy it was delayed and were keen to get home.
- On the unannounced inspection we spoke with 16 people who used the service and two relatives. People were positive about the support provided and used the phrase “very nice” to describe the nursing care they received.
- We spoke with a relative who was very positive about their experience and the care their relative had encountered. They told us that they found staff to be very caring and supportive.
- Most patients at Buckingham and Thame community hospitals said they felt able to talk to staff. One patient said “they were all very kind” and if they had any problems “they sort it for me”. Two patients said that most staff were nice but some were “sharp.” One patient at Buckingham Community Hospital said they did not want to say anything because of fear of staff reaction.

Good practice

- The ‘coppers for cupcake’s idea showed care and compassion towards patients and their visitors at Buckingham Community Hospital. This provided the patients with a pleasant tea and cake experience with visitors, which de-hospitalised the environment they were in. Patients were in a social environment and this had improved communication with their visitors and was a therapeutic distraction for some patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure

- Staff have the skills and knowledge required to care for all patients admitted to the community hospitals.
- Staffing levels and recruitment processes are effective to ensure that there are the right number of staff with the right skill mix on duty at all times.
- There are robust governance processes in place that include effective and informative audits to monitor the quality of the service provision and it must use the information to improve the service provided.

Summary of findings

- Admission criteria are adhered to for community inpatients and this is monitored.
- Admission is prioritised in accordance with clinical need and waiting times are reduced.
- All staff feel confident to report accidents and incidents and they receive feedback and share lessons learnt
- Comprehensive and contemporaneous notes are maintained at all times for all patients.
- Records and confidential information are securely stored at all times when not being used.
- Patients' privacy, dignity and confidentiality are considered at all times.
- There is effective and supportive leadership throughout the service.
- Systems and procedures for the recording of patients' and/or their relatives' consent to information sharing and care and treatment are reviewed.
- There is appropriate access to equipment at weekends.
- The National Early Warning Score (NEWS) system is used correctly and that there is early escalation of concerns if a patient's condition deteriorates.

The trust SHOULD ensure

- There is a clear system for the safe management of prescription pads.
- Staff have appropriate infection control training.
- Patient and staff engagement is used to monitor the provision of the service and to inform decision making during service development.
- The effectiveness and purpose of the multidisciplinary team meetings is reviewed.
- Relevant NICE guidance is reviewed and incorporated into local guidance and practice.
- Staff are involved and consulted in creating the new strategy, with clear messages on the trust's strategy and direction.
- The provision of clinical supervision for all staff is reviewed.

Buckinghamshire Healthcare NHS Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

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

We rated safe as 'requires improvement'.

Staff in the community hospitals did not always know how to report incidents and sometimes they were discouraged from reporting them. Reported incidents were investigated and lessons learnt shared although processes for these were not always formal.

Medicines were not always appropriately stored and the use of prescription pads was not monitored. Medicines were held in the community hospitals but there were incidents when medicines were not available. We observed this for a patient who required insulin. Staff did have training to administer medicines but new syringe drivers were being introduced across the trust and some staff had not received training. The use of a webcam was being trialled at the acute trust to reduce delays in issuing prescriptions. This was showing positive results.

The community hospital did not have access to equipment, such as pressure mattresses out of hours or at the weekend. There was a lack of storage for equipment and we found equipment being stored in sluices, bathrooms and corridors. Resuscitation equipment had not been checked regularly across all three community hospitals. Records and documentation were inconsistently stored and maintained. Medical and nursing notes were well kept at Thame Community Hospital but this was not the case at Buckingham Community Hospital where care plans were either absent or generic and not person centred.

The National Early Warning Score (NEWS) used for patients whose condition might deteriorate was not always completed. An adapted version of that used in acute hospitals was being used. This meant the actions were inconsistent with those expected in an acute care setting and this had resulted in sick patients that were not observed or escalated promptly. There were inadequate staffing levels on many shifts, and a high staff vacancy rate. This had been on the risk register for several years, and led to high use of agency staff on both day and night shifts. Agency staff had received appropriate induction. Shifts

were being managed overall to ensure permanent staff were always present. However, at Buckingham Community Hospital there were new agency staff on duty without permanent staff and this was increasing the risk to patients. There were also therapy staff vacancies, which meant that patients did not receive regular rehabilitation during their stay.

Wards were clean and personal protective equipment was available and used. This resulted in all three hospitals having a low incidence of hospital acquired infections. However, we did observe an incident of inadequate infection and prevention practices, with delayed barrier nursing and a lack of hand washing between patients.

At all community hospitals staff were aware of the Duty of Candour although no formal training had been received. Staff also knew how to report safeguarding concerns and had all received safeguarding training.

Detailed findings

Safety performance

- The trust collected NHS Safety Thermometer data in relation to care provided to patients. This is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls.
- At Buckingham Community Hospital, Safety Thermometer data was kept in a folder behind the ward desk but was not known by staff on the ward. At Thame and Marlow community hospitals, Safety Thermometer information was clearly on display at the entrance to the ward so that all staff were aware of the performance in their ward or department. This included information about infections, new pressure ulcers, new urinary tract infections and venous thromboembolism
- The Safety Thermometer data from January 2014 to January 2015 showed there were no falls with harm incidents reported in the months of March 2014, June 2014, October 2014 and January 2015. January 2014 saw the most reported pressure ulcer incidents, while January 2015 had no incidents of pressure ulcers. There have been no recorded incidents of catheter and new urinary tract infections since November 2014, when there were four incidents.

Incident reporting, learning and improvement

- From January 2014 to January 2015, there were five serious incidents reported at the three community hospitals inspected. Buckingham had the highest number with one grade 4 pressure ulcer and two incidents of slips, trips and falls. Marlow had two incidents of 'unexpected or avoidable death or severe harm of one or more patients, staff or members of the public'.
- Some staff across the three hospitals told us they did not know how to report incidents. Managers stated lessons learned from incidents were discussed at staff meetings . However, staff reported they did not get feedback on the incidents they reported, and only serious untoward incidents (SUIs) were discussed at staff meetings. This was after root cause analysis meetings held by the trust. At Buckingham there were two SUIs of patient falls that resulted in bone fractures. The outcome meant that the ward purchased sensory pads that were placed in patients' beds or on chairs to alert the staff when the patient was trying to get up and therefore at risk of falling. Another example was an SUI for the deterioration of a pressure ulcer from grade 2 to 4 which was identified, reported on and discussed at staff meetings.
- The ward sister at Buckingham Community Hospital introduced 'learning lunches' held to discuss serious incidents. However, only one meeting had taken place and this was not embedded into practice, which was confirmed by conversations with staff.
- At Buckingham Community Hospital some staff said incident reporting was discouraged by senior members of staff. An example of this was a staff nurse reporting low staffing numbers on duty that posed a risk to patients. They said they had been reprimanded for doing this by a senior member of staff who felt it was not necessary.
- We found that on occasions the hospitals were accepting inappropriate admissions. This was not being reported as an incident, although late night admissions which could be inappropriate were being captured. This information was captured in the trust capacity governance report.

Duty of Candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories

Requires improvement

Are services safe?

must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.

- All grades of staff were asked about their understanding of the Duty of Candour at all three hospitals. There was an overall understanding of its meaning, and examples were given on how they would address issues. However, one clinical leader had little understanding and knowledge on the meaning and implications. Senior management stated that no formal training had been given to the staff across the community hospitals.
- Nurses said they were aware of the need for openness and transparency when things went wrong and the requirement to inform patients' families of incidents.

Safeguarding

- The trust had a safeguarding leadership team. The chief nurse was the board lead for safeguarding and was supported by a lead at associate director level. There was a lead professional for child protection, a lead nurse for child protection in the emergency department, a lead for safeguarding adults and a named midwife for child protection. The children's safeguarding team was further supported by five named nurses for child protection, with four of these based in the community setting. The lead for safeguarding adults was supported by a safeguarding nurse based in the emergency department and a learning disabilities nurse. A plan was being implemented to introduce safeguarding champions at division level. These staff members would have a training role and work to ensure that staff were kept informed about guidelines and policies.
- All issues relating to safeguarding were monitored and discussed at the trust's own safeguarding forum meetings held monthly and chaired by the director of nursing. Agenda items included but were not limited to a 'safeguarding scorecard', a pathway, patients with learning disabilities, paediatric liaison/duty named nurse pilot, a domestic abuse disclosure pathway, an accident and emergency (A&E) delivery improvement plan update, the 'prevent strategy' and serious case review action plans.
- Staff received safeguarding training. Training records showed 88.7% of staff at Buckingham Community Hospital, 86% of staff at Marlow Community Hospital and 82% of staff at Thame Community Hospital had received safeguarding training.
- Staff were able to demonstrate how they would report safeguarding concerns.
- Safeguarding trust-wide policies were available to staff on the intranet.

Medicines management

- Monthly dashboards were used to monitor the quality of services, and these recorded medication errors at the three hospitals inspected. They listed four medication errors at Buckingham, seven at Marlow and 11 at Thame between April 2014 and February 2015. This was above the trust target of zero.
- At Thame Community Hospital, prescription pads were stored in the controlled drugs cupboard. There was no system in place to record the number of pads or serial numbers for prescription pads. This meant that the number of prescription pads could not be accounted for and there was a risk they could be used inappropriately.
- At Buckingham Community Hospital, we witnessed a staff nurse being assessed for competency to administer medicines.
- Medicines were stored securely in locked drug trolleys and controlled drugs were kept in locked cupboards. However, the controlled drugs cupboard at Thame Community Hospital was broken and waiting to be fixed. The outer cupboard lock was working so the medications were secured and out of reach, but the inner cupboard lock was missing. We were told by the ward sister that a new lock was ordered and it was due to be fixed later that week. The lock had been fixed by the unannounced inspection.
- We checked the stock levels for three controlled drugs and all drugs were accounted for. This meant the staff followed medicines management protocols and trust policies on the storage and administration of controlled medicines.
- The return and disposal of controlled drugs procedures were followed at Marlow and Thame, but not at Buckingham. Staff raised concerns that one of the clinical leads was unaware of procedures for the safe disposal of expired controlled drugs, and as a result, controlled drugs were placed in a sharps bin.

Requires improvement

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- The pharmacy technician visited regularly to check stock levels and rotate drugs. We observed that ward nurses checked the stock dates weekly.
- At Thame Community Hospital, during our initial inspection, the medicines fridge thermometer was not working and temperatures were not being recorded to ensure medicines were stored within the required temperature range. No action was in place to address this issue. This meant there was a risk medicines could be ineffective. At the unannounced inspection a temporary fridge had been installed and the minimum and maximum temperatures were being recorded daily. The ward sister informed us a new drug fridge had been ordered. The nurse said that when the fridge broke, all medicines that were in it were destroyed to protect patients against receiving medicines that were ineffective because they had been stored at an incorrect temperature.
- Staff raised concerns about agency staff on duty who were not aware of the medicines ordering process. Staff told us this resulted in patients either getting their medicines late or missing doses completely.
- Medicines administration records reviewed (drug charts) were clear and completed correctly.
- A webcam was being trialled to aid in the prescribing of medication via the pharmacy department at Stoke Mandeville Hospital. This was introduced to improve effective, timely discharge at Buckingham Community Hospital to make sure medicines were prescribed promptly. Staff reported it was showing positive outcomes in avoiding delays with prescriptions and patients getting their medication on time.
- Each bedside cabinet contained patients' own drugs. These cabinets were all locked and patients had no access. The drug trolley contained stock drugs and any named additional drugs which did not fit in patients' cabinets. We observed all drugs were in date.
- The pharmacy technician visited to check stock levels and rotate drugs. We observed that ward nurses also checked to ensure there was sufficient stock of in-date drugs.
- The treatment room at Thame Community Hospital was small, but clean and tidy. It contained a large amount of stock and equipment which was easily accessible to staff, with no issues identified.
- The treatment room at Thame was used for the storage of drugs, the checking of controlled drugs and the making up of intravenous medicines. We completed a stock check and found no issues or concerns.
- At Thame, to take out (TTO) medicines or medicines for the patients to take on discharge, were ordered when patients were deemed medically fit. TTO medicines were ordered as soon as the estimated date of discharge was identified because it took between 24 and 48 hours to receive the medicines. All TTO medicines were received by the registered nurse and checked against the order and patients' prescription sheets. All checks were labelled when completed. There was a system in place for delayed discharges of over two weeks for TTO medicines to be returned to the pharmacy and re-issued when necessary.

Environment and equipment

- The community hospitals were old buildings that had been adapted and refurbished over the years. They were not purpose-built and had areas that needed modernising.
- The treatment rooms at Marlow and Thame community hospitals were not fit for purpose. They were small and lacked space for storage and surface areas.
- A central register of equipment was held by the trust. An audit had been undertaken over the previous 18 months to ensure that the register was current. There was an established planned preventative maintenance programme for all medical equipment. The system included a facility for tracking equipment that could not be found at the time the maintenance or service was due.
- The trust had taken a risk-based approach to the testing of portable electrical appliances. This meant that some items would be tested annually and other items up to four years.
- The equipment in the sluices varied from traditional stainless steel bed pans and bed pan washers to the more hygienic and eco-friendly cardboard disposable bed pans and macerators.
- Staff told us they had access to equipment on most days apart from the weekends. If they needed an air mattress for a patient, they needed to refer them to the tissue viability nurse first. These nurses did not work out of office hours, so this could impact on patients' care, as

they would have to wait until the Monday for the mattress. Therapists did not work weekends either and this would cause delays for patients needing access to rehabilitation aids or equipment.

- Due to limited storage capacity at the hospitals we visited, there were concerns with storing equipment safely when not in use. Items such as hoists were stored in the corridors or bathrooms. This reduced accessibility to bathrooms and presented a fire evacuation hazard.
- We found the resuscitation equipment at Thame Community Hospital was not checked daily. The portable appliance testing (PAT) on the resuscitation suction equipment was dated 4 November 2013. At Buckingham Community Hospital we saw resuscitation equipment was checked daily. Other equipment had PAT and calibration tests in date.
- The trust was in the process of phasing out a particular make of syringe driver in response to safety guidance from the National Patient Safety Agency (NPSA). The launch of the new syringe drivers had been delayed to 13 April 2015 because not enough staff had completed the training. During our visit to Buckingham Community Hospital on the unannounced inspection, 10 April 2015, the records showed that only three of the 12 nurses had completed their training. Staff at Buckingham told us they felt distressed and pressured because they had been told to do the on line training which they said was over a 41 pages of text, but had been given no time to do this because of staff shortages Staff knew they were required to complete training to ensure they were competent to use the replacement syringe drivers. However, there were no training schedules in place across the three hospitals to ensure all staff were trained and competent by the deadline. Some staff thought community staff were coming in to train them, by doing face to face training and giving them learning booklets. However, not all staff were aware of this. One clinical lead said they seldom used the syringe drivers, as they rarely had patients on end of life care pathways. This meant there was a risk of potential harm to patients in the use of new syringe drivers.

Records and management

- A mixture of paper and electronic notes were used at all three hospitals. Occupational therapists told us they did not have access to all required computer systems and were waiting for training on one of the trust's electronic systems. Staff expressed concerns that the use of multiple computer systems caused duplication of notes and was time consuming.
- We reviewed medical and nursing notes at all three hospitals. We looked at where they were stored, if they were filed and in order, and the quality and legibility of the documentation.
- Medical notes were stored and locked in a specific trolley at Marlow and Thame Community Hospitals, but not at Buckingham Community Hospital. Nurses' notes were either kept at the patient's bed side, or in the nurses' office. At Buckingham Community Hospital it was also difficult to locate any records as they were not kept where they should be. Nursing notes were meant to be kept at the end of patient's beds and medical notes in a trolley, but were left out at the ward clerk's desk area, the nurses station, or other places. However, at the unannounced inspection, the care plans were found at the patient's bedside at Buckingham, and the medical notes were filed in the relevant trolley at the nurses station.
- We reviewed six sets of medical notes at Buckingham Community Hospital and incomplete documentation was seen in all of them. This included records having limited admission information, and some records having no details of identified patient concerns. Some notes had no evidence that comprehensive patient assessments had been carried out. There was limited information in notes that showed discussion about care and treatment had been held with the patient and/or their family. There was detail in only two of the six notes we looked at about discussions with family members. There was no record in patients' notes about multidisciplinary team involvement. Entries in notes overall were legible, dated and signed.
- We saw patient records had generic care plans. Most of the care plans had been customised to take into account patients' needs. We found that not all care plans were easily identifiable, for example, we saw a person with a diagnosis of dementia that had a care plan in place for 48 hours but it was not used by staff. This was not easily recognised as it was written within the records' progress notes.
- During the unannounced inspection, we reviewed 10 paper records at Buckingham and Thame community hospitals. The records showed that information about the patient included their medical history and allergies

had been collected. We saw the records were updated after the patient's consultation with the therapist. There were generic care plans. Most of the care plans had been customised to take into account the patient's needs. Although we found that not all care plans were easily identifiable, for example; we saw a person with a diagnosis of dementia had in place a 48 hour care plan. This was not easily recognised as it was written within the records' progress notes.

- At Marlow Community Hospital we also found irregularities with unsigned entries, and the 'hearts and minds' care plans only partially completed. We found little evidence that patient involvement and goal setting were documented in patients' records.
- At Thame Community Hospital all notes were comprehensive, legible and in order. The ward clerk filed the notes in an orderly fashion, and four sets of medical notes were reviewed that supported this. Nursing notes were thorough, with food and fluid charts, elimination charts and Waterlow (pressure area risk assessment) charts all completed where required. Vital observation charts were completed. We looked at the paper records of 10 patients. The records showed that information about the patients, including their medical history and allergies had been recorded. We saw the records were updated after the patients' consultations with the therapist.
- At Thame Community Hospital, the staff handover file outlining patients' details was left out on top of a filing cabinet in a public area. This was brought to the attention of the nurse in charge, as it breached patient confidentiality, and did not protect their privacy and dignity.
- At Buckingham, we found the records were difficult to track as the information was mixed between the medical and nursing records. One of the records at Thame Community Hospital identified the patient as being "confused at times" but we did not find evidence of a mental or capacity assessment.
- During our unannounced inspection at Thame Community Hospital we found the ward manager's office was unlocked and unsupervised. On entering the room we found that the filing cabinet was unlocked, which contained confidential records of staff members. This included physical information and appraisals. We also saw the pool car keys, car registration number and credit card visible to all who entered the room. This was brought to the attention of the out of hours locality manager.

Cleanliness, infection control and hygiene

- The patient-led assessments of the care environment (PLACE) 2014 overall scores for the three hospitals were 96.4% for cleanliness (the national average for community hospitals was 97.3%) and 84.2% for condition, appearance and maintenance (against a national average of 91.9%).
- Buckingham Community Hospital scored 92.6% in cleanliness and 75.6% on condition, appearance and maintenance. Marlow scored 99.1% in cleanliness and 90% on condition, appearance and maintenance, and Thame scored 99.4% on cleanliness and 87.5% on condition, appearance and maintenance.
- Staff statutory training rates on infection prevention and control was 84.5% at Buckingham, 80.6 % at Marlow and 86.8% at Thame. This was lower than the trust target of 90%.
- There were no recorded incidents of hospital acquired infections at Buckingham, one case of methicillin-resistant Staphylococcus aureus (MRSA) at Marlow and one case of Clostridium difficile infection at Thame, from April 2014 to the time of our inspection.
- The trust's Hand Hygiene Observational Audit Tool for March 2015 identified hand hygiene at the 'point of care', for example, before and after patient contact, and the bare below the elbows policy. The audit did not identify any issues or concerns. Hand hygiene results for Buckingham were 99%, Marlow 100% and Thame 96.3% overall from April 2014 to February 2015.
- Staff were 'bare below the elbow'. This meant that all staff in contact with patients could effectively wash their hands and wrists without the restrictions of cuffs, watches and jewellery.
- Hand hygiene and use of personal protective equipment such as disposable gloves and aprons, to reduce the risk of infection, were used by staff at the three hospitals. However, we observed that the changing of gloves and the washing of hands was variable among the staff. We saw staff at Thame Community Hospital not washing their hands between patients. For example, we saw staff making a bed and fetching linen from another room without washing their hands before dealing with another patient.

Requires improvement

Are services safe?

- Good hygiene was observed at meal times, with staff wearing aprons and washing their hands.
- At Buckingham Community Hospital there were no sinks outside the isolation rooms for hand washing. There were also no aprons or gloves located outside these rooms. This would pose a problem for staff that are barrier nursing a patient in isolation, as they would have difficulty adhering to infection prevention protocols.
- We observed a delay in infection control and prevention procedures where a patient was being barrier nursed due to a positive MRSA result at Buckingham Community Hospital. The isolation procedures were not started as soon as the patient arrived on the ward, but some time later. This could have posed a risk in the spread of the infection to staff, visitors and other patients.
- The wards and inpatient areas were visibly clean and well maintained. Domestic staff were seen on the wards with cleaning trolleys. We saw them cleaning lockers in rooms and side tables. Domestic staff told us they had received infection control training. A weekly cleaning schedule was used and a deep clean occurred once a week. There were colour coordinated mops and buckets. Staff told us this was to separate the cleaning equipment used for each area, such as bedrooms, toilets and kitchens. Staff also said access to cleaning equipment was easy.
- The sluices at all three hospitals were inspected and were visibly clean. All equipment had 'I am clean stickers' with current dates on them, such as wheelchairs and commodes. Daily and weekly equipment cleaning schedules were being used.
- We identified building maintenance was needed, including dripping taps and grouting on tiles, which posed an infection control concern as they could not be cleaned effectively.

Mandatory training

- Most staff had mandatory training, for example, fire safety, manual handling and health and safety. However, the uptake varied across the three hospitals. At Buckingham Community Hospital the staff had recorded figures of 70%, and at Marlow it was 78%. Despite requesting this information for Thame, we did not receive the statistics. However, the trust's quality dashboards showed uptake of statutory training was higher, for example, for Buckingham it was 95.4%, Marlow 94% and Thame 97.4%.
- Staff at all three hospitals told us they had to undertake mandatory training in their own time and they were not given protected time during working hours to complete it. Clinical leads confirmed this.

Assessing and responding to patient risk

- Patients had individual risk assessments, for example, on the risk of developing pressure ulcers. We saw the risk assessments had not always been regularly reviewed and updated. Therefore it was not always clear, when a risk did exist, if action was taken in a timely way.
- The trust collected NHS Safety Thermometer data in relation to care provided to patients. This is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls. We saw that VTE assessments had been fully completed. We saw wound assessments completed but the records did not identify any review of the wounds.
- During our announced inspection in March 2015, we found that services did not always assess and respond to patient risks. For example, National Early Warning Score (NEWS) documentation was not always recorded effectively and consistently at Thame and Buckingham hospitals. NEWS observation charts are designed to identify changes in patients' observation and wellbeing that indicate a deteriorating condition. This resulted in deteriorating patients not always being identified and cared for appropriately. We saw evidence of this at Buckingham Community Hospital where staff had to call an ambulance to take two patients to the emergency department at Stoke Mandeville Hospital. However, at the unannounced inspection on 10 April 2015, we found the records at Buckingham and Thame identified that routine changes had been actioned. This meant that staff had taken the required action when a NEWS observation indicated a patient's condition was deteriorating.
- There was lack of decision making and escalation, with patients suffering from poorly controlled diabetes, the effects of cancer and anxiety. There was a lack of evidence of escalation of concern when their condition deteriorated, and their medical needs could not be met in the community hospitals. One patient at Buckingham Community Hospital urgently required short-acting insulin, and this was not available. The incident was not

escalated and the patient did not receive the insulin they needed. The patient was left overnight on the ward with a high blood glucose level which would have put them at risk of harm.

- At the unannounced inspection at Buckingham Community Hospital we observed a patient in a wheelchair using the fire exit to go outside. We reviewed their records and found there was no assessment of the risk of falls due to the uneven surface. We asked staff if they had assessed the risk to other patients who may leave the ward via the open fire exit. The staff nurses confirmed no risk assessments had been done. This was brought to the attention of the nurse in charge who immediately closed the fire exit doors.
- The trust had a protocol that if a patient became unwell, they had a direct line to the out-of-hours emergency call centre. Staff told us this could result in a doctor's visit, or advice to call an ambulance.
- Comfort rounds to relieve patient's pressure areas were completed, although this was inconsistent across the three hospitals. At Buckingham Community Hospital, staff felt comfort rounds were a tick box exercise and that they did not always complete the rounds as trust policy required. The time stated on the forms clashed with meal times and when patients were washing.
- Patients were referred to the relevant therapists, for example speech and language therapists when risks relating to swallowing were identified.

Staffing levels and caseload

- There were high levels of nurse vacancies at Buckingham and Marlow Community Hospitals with a 32% and 40% vacancy rate respectively. This was seen on the nurses' off-duty rota, and recorded on the risk register. The vacancies were filled with agency staff on short- and long-term contracts, and the clinical leads and locality managers covered shortfalls. Staff at Buckingham Community Hospital told us the trust had recruited new staff but that they had not yet started in post.
- The trust's quality dashboard demonstrated that NICE guidance on staffing levels were being met. There was a nurse to patient ratio of 1: 8. The use of agency staff was 20% at Buckingham, 20% at Marlow and 4% at Thame, from April 2014 to February 2015. This was above the trust target of 3%. We spoke with agency staff who confirmed they had received an induction and that their mandatory training was up to date and provided by the agency.
- The ward sister and locality manager told us that most night shifts were covered by agency staff, which was seen on the nurses' off-duty rotas. Staff told us that at Buckingham Community Hospital it was not unusual to see an agency registered nurse and healthcare assistant working together, with no permanent staff. On occasions, they were both new to the ward, which had the potential to place patients at risk, because staff new to the environment would not know the patients.
- Senior management at Buckingham Community Hospital said they were developing a new staffing model. They recognised a need to increase staffing levels and explained that the current establishment of staff was based on 12 beds but there were actually 16.
- Staff told us the caseload of patients had changed as they were now receiving patients who required more clinical input because of bed pressures in the acute trust. Although the three hospitals still received patients for rehabilitation, they now looked after patients with more complex care needs, especially at Buckingham Community Hospital. This placed more demands on what was described as a "stretched and short-staffed team" .
- There were also vacancies in therapy staffing. A locality manager told us they were looking at training healthcare assistants to cover this shortfall. Therapy services did not work out of hours and there were no therapy services at weekends to support rehabilitation. There was one part-time occupational therapist at one hospital and a physiotherapy vacancy.
- We observed a nursing handover at Marlow Community Hospital which was detailed and professional. Each patient's previous and current care was discussed and information sharing took place between the staff. All staff had prior knowledge of the patients details, and some discharge planning took place at handovers.
- At Marlow and Thame there was a good team spirit, and staff appeared content and organised. At Marlow, the staff nurse on duty was competent in running the ward and making decisions, and did not appear stressed or flustered due to her junior status and being new in post.

Requires improvement

Are services safe?

At Thame, due to the good staff to patient ratio since closing beds, nurses told us they had ample time to give patients personal care and service, and it was now a lovely place to work.

Managing anticipated risks

- Evacuation procedures were in place for responding to emergencies. Staff at Buckingham Community Hospital gave us an example where a fire alarm was sounded accidently and they had to evacuate the ward of patients and staff. They said this evacuation went well.
- Staff at Thame Community Hospital had risk assessed their fire evacuation procedure due to the narrow doors on the ward that stopped them from evacuating patients on beds. This had been assessed by the trust's fire safety officer and a number of ways of managing the situation considered. In order to be able to move patients, 'ski' sheets had been provided and the staff had been trained in how to use them. In addition to this, a sprinkler system had also been fitted.

Requires improvement

Are services effective?

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

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

We rated 'effective' as 'requires improvement'.

There was not consistent use of current evidence based guidance, and best practice. The indiscriminate use of supplement food, without evidence base or dietetic advice, was a cause for concern.

Care assessments were not always person centred so did not include the full range of individual needs. Goal setting and monitoring of outcomes for individuals was inconsistent, and participation in audits limited, so outcomes of treatment and care could not be adequately monitored. Pain management needed to improve at Buckingham Hospital.

Patient nutrition and hydration was supported by a varied menu, and there was monitoring of patient food and fluid intake at Marlow and Thame hospitals. However at Buckingham Hospital there was incomplete monitoring of nutrition and hydration and delays in referral for dietetic advice and support.

There was evidence of multi-disciplinary working, with weekly meetings attended by nursing therapy and social services staff at all hospitals. However, the effectiveness of these meetings varied. Therapy input was limited by staffing vacancies and was not provided seven days a week. There was access to a range of specialist staff, but there were delays in the referral process and provision of support. Multidisciplinary decisions, and discharge planning, were not always clearly documented or communicated to the patient or their relatives, particularly at Thame and Buckingham hospitals. There were delayed discharges at all hospitals.

All staff had received an annual appraisal, but it was not clear this had led to a full understanding of their learning needs. There was little evidence of training or clinical supervision to support professional development. Not all staff had the experience or skills to support the wider range, and more acute, needs of patients being admitted.

Consent was not always obtained for example for the use of bedrails or alarms. In discussion, staff showed awareness of the Mental Capacity Act 2005, and there were some examples of its use.

Local policies and tools were based on national guidance, but these were not always correctly followed.

Evidence based care and treatment

- Some care plans and tools that were used to assess a patients' needs were evidence based although staff had limited knowledge of National Institute for Health and Care Excellence (NICE) guidelines.
- The therapists and nurses used the Malnutrition Universal Screening Tool (MUST) to assess patients for the risk of malnutrition. This tool was used during the initial assessment of a person entering the hospital. This was in line with the NICE clinical guideline 32 'Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition'.
- Venous thromboembolism (VTE) assessments were also completed in accordance with NICE clinical guideline 92 'Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital'.
- Diabetes control charts was completed in line with NICE clinical guideline 15 'Diagnosis and management of type 1 diabetes in children, young people and adults'. However, patient records at both Buckingham and Thame Community Hospitals did not identify the patients' target range in order to maintain an even blood glucose level. This should be agreed by their doctor or diabetes consultant as set out in the NICE guideline.
- National Early Warning System (NEWS) charts were used in line with NICE clinical guideline 50 'Recognition of and response to acute illness in adults in hospital' and the NICE guidance supported the 'Surviving sepsis campaign' (2004) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines on 'Acute kidney injury' (2009) by including prompts and guides. The NEWS score had been adapted, however,

and expected actions were different for that of the acute inpatient. There were different instructions as to when to refer to medical staff for patients who would have the same clinical risks.

Pain relief

- We found that pain was well managed at Marlow and Thame Community Hospitals. At Buckingham Hospital, patients' pain was not regularly assessed and managed. Patient notes confirmed pain assessments were not always completed regularly. We observed one multidisciplinary team meeting where staff failed to identify alternatives when the pain relief that was being provided was ineffective in managing patients' pain.

Nutrition and hydration

- We observed lunch being served by the clinical lead at Buckingham Community Hospital while other staff were giving out medicines and doing other duties. The staff member said this was a 'standard operating procedure', and allowed them to monitor what patients were eating. However, we then saw a healthcare assistant collecting a patient's tray of uneaten food and throwing the food away without reporting it. This was not noticed by the ward sister giving out the lunches.
- At Marlow Community Hospital we found that food supplements were given to patients indiscriminately whether they needed them or not. Kitchen staff at the hospital were seen adding three scoops of Complan to the mashed potato without patients' knowledge or approval. Complan is a food supplement for under-nourished people. The kitchen staff said they were told to do this by the nurses to supplement patients' food. There was no evidence of dietitian referral or involvement in this decision-making process.
- Kitchen staff were observed at meal times and had a good rapport with patients, helping them make choices and completing their menus. Buckingham Community Hospital did not allow patients to bring in their own food, but staff said they would order something specific for them if possible. A patient fridge was seen at one of the hospitals that contained foods that had not been dated. We found out of date food at Buckingham Community Hospital. This meant patients were at risk of harm by eating out of date foods, that could also potentially belong to another patient.
- The three hospitals catered for all diets, including vegan, vegetarian, halal and kosher. There was a good choice of food available with a four week rolling menu. There were also supplements available for patients if necessary.
- At Marlow Community Hospital, patient food allergies were identified on a notice board. This meant that care and domestic staff were able to access the information quickly when helping a patient to order food or serving them their meals. This minimised risks of giving patients foods they were allergic to, as the information was easily accessible.
- We visited the kitchen at Thame Community Hospital where we observed good practices in food hygiene and food management. There were colour coded chopping boards in place together with guidelines in using the cook–chill oven. The daily task guidelines for the hotel services team had been completed daily. Staff completed the 'safer food, better business for caterers' booklet which included the temperatures of fridges and freezers as well as cooked foods. During our visit we observed staff using the food probe to ensure foods were at the correct temperature. We saw this was recorded daily.
- Marlow and Thame Community Hospitals showed good record keeping with patient's food and fluid charts that were completed after meal times. Kitchen staff were also seen to tell care staff what patients had eaten before taking trays away.
- At Buckingham Community Hospital there was a delayed process for referral and assessment by dieticians. Food and fluid charts were not completed adequately. This meant it was hard to tell if patients had eaten or drunk enough as their charts were not completed thoroughly by the healthcare staff. When patients were identified as needing to see a dietician they were referred, but the response time was slow. This meant that patients were not given professional advice or support on addressing their nutritional needs. Healthcare staff also lacked guidance on how to manage and support their patients.
- At Thame, we observed not all patients were able to reach their water. We asked what they would do if they needed water and they said they would have to call someone.

Requires improvement

Are services effective?

- At Buckingham Community Hospital we found 'thick and easy' drinks with no date of opening. This was brought to the attention of the nurse in charge who disposed of the drinks.

Approach to monitoring quality and people's outcomes

- We found that there was no evidence of goal setting and little measurement of patient outcomes at the three hospitals we visited. It was difficult to track the goals and outcomes from the notes, and no evidence was seen that this was audited. However, during the unannounced inspection, we saw improvements had been made, as some assessments of patients' needs were comprehensive and included the assessment of pain. We found that the outcome of treatment was now being monitored and reviewed at management meetings at Thame Community Hospital.
- On the unannounced inspection, assessment tool audits had been completed, for example the determining of patients' risk of inadequate nutrition. Staff told us the results of these audits were shared with them at team meetings.
- The records we read identified that staff completed the Barthel assessment. The Barthel scale is used to measure performance in activities of daily living.
- Patients' feedback was used to assess and monitor the quality of the service and the outcomes of the treatment provided. These were on display on the patient board within the wards visited.

Competent staff

- Appraisals at the community hospitals were 100% completed. However, there was inconsistent clinical supervision across the sites and staff had only occasional supervision sessions. Therapy staff said they had peer supervision and forged links with the community team for ad hoc supervision sessions. They said all their annual appraisals were completed.
- Many of the staff we spoke with told us there was little opportunity for professional development, due to lack of training opportunities, funding and staffing pressures. On the unannounced inspection, staff at Thame Community Hospital said they received annual appraisals with the opportunity to study for further qualifications and develop themselves. One staff member said they had been encouraged and supported to complete their National Vocational Qualification (NVQ) level 3 in health and social care.
- Staff told us they did not have training on mental health issues, learning disabilities, dementia and mental capacity. Staff stated that as they were now treating patients who were more unwell and with a variety of conditions, that they needed specific training. They mentioned this was not identified and supported by clinical leads as necessary.
- Thame had a new clinical leader in post, who had been in post for two weeks. The deputy sister and clinical leader posts had been vacant for six months, and the band 6 post was still not filled. The locality manager was off sick. We found that the new ward sister had yet to receive support and handover in her new role. This had the potential to impact on their understanding of the hospital.

Multi-disciplinary working and coordination of care pathways

- Medical cover was provided at the three hospitals through an agreement with local GPs. The agreement specified cover between 8am and 6pm Monday to Friday. All evening and weekend medical cover was provided by the out-of-hours medical provider.
- GP cover across the three hospitals was the same, with contracted hours on a rota basis from an identified GP practice. Buckingham had one GP allocated from a local practice, although this could be a different GP each day. Whereas Thame had the same GP each day for one week at a time. They all had the same contracted medical cover per day, Buckingham had more beds with a higher acuity of patient needs. GPs attended at a specific time and worked to a diary system. There was an expectation that a GP would review a patient on admission. At other times they were dependent on nurses identifying issues for them and notifying them of serious concerns.
- All three hospitals had daily handovers and weekly multidisciplinary team (MDT) meetings.
- All patients at Marlow Community Hospital had identified dates for discharge with clear goal setting. Evidence sharing was evident with a focus on patients' best interests. We observed a GP handover that reviewed a patient's medical conditions.

Requires improvement

Are services effective?

- We found disjointed MDT input at Buckingham Community Hospital. Although meetings took place and problems were identified, there was no medical input and no clinical decision making. A nurse, social worker and occupational therapist were present, but there was lack of leadership. There was no coordination of care pathways. MDT working was not documented in patient notes. This proved difficult for clinical staff delivering care as there were no set plans or guidance on specific patient needs and goals.
- At the unannounced inspection, patients' records we read indicated good multidisciplinary working at Thame Community Hospital. For example, we saw evidence of the intervention of a speech and language therapist, a physiotherapist and occupational therapists. During our visit we met with the out-of-hours doctor who was visiting at the request of staff to see a patient who was unwell. Specialist nurses were available to provide consultation when required. Staff said they worked within a supportive team and had good access to the tissue viability nurse, although this was a slow process. However, we found three records of patients with pressure ulcers with no tissue viability nurse input recorded and no evidence that a referral had been made.
- Support was available from a physiotherapist and occupational therapists but this was not a seven day service.

Referral, transfer, discharge and transition

- Patients were admitted from acute trusts, other community hospitals or home. Referrals could be made by GPs, practice nurses, adult community healthcare teams including district nurses and advanced case managers, community matrons, specialist nurses based in acute and primary care, acute trust discharge teams, the assessment unit at Wycombe General Hospital, and the Emergency Department at Stoke Mandeville Hospital .
- There were two main pathways that patients would follow. The first was the prevention of admission to the acute setting pathway, for example mild to moderate exacerbation of long-term conditions, which might include the need for short-term antibiotic therapy that cannot be appropriately managed at home. The second pathway was post-acute care, for example step down management of long-term conditions, which might include patients who had needed acute care to stabilise their exacerbation but now needed some inpatient care to support them back to maximum independence.
- There was an expectation that patients would only be accepted for admission if they met the pathway criteria. If there was capacity within the inpatient areas, and if there were agreed safe staffing levels within the inpatient areas to manage the admission, they would be eligible, however, review of existing dependencies of patients needed to be made first.
- Staff across the three hospitals said they were sometimes asked to admit patients who did not meet community admission criteria and whose needs could not be fully met in a community inpatient setting. They said this usually involved patients who needed complex or specialist care which community hospitals were not equipped to provide. They said they came under pressure from the trust's acute services and bed management team to take patients who were unsuitable for community care.
- Some patients had clinical needs that could not be met and staff told us this resulted in readmissions to the acute trust. Other patients, such as a mental health patient, were being cared for by staff who were not prepared for or trained on how to manage them. The trust dashboard did not include data on readmissions.
- Staff reported that inaccurate patient information was sent by the acute trusts or outside bed management teams, which resulted in inappropriate admissions of poorly patients. Staff told us one patient arrived with a fracture that had not been picked up in the acute trust and the patient was moved due to bed pressures.
- Staff told us that due to bed pressures, an unclear admission protocol, and an increasing acuity of patients, they did not always have the staff and experience to look after patients with complex care needs. There were many patients admitted that were not at the end of life or in need of rehabilitation as intended. Service leads said the acuity of patients admitted was appropriate, but this was contradicted by the clinical leads and ward healthcare staff in all three hospitals.
- Staff told us that patients at Buckingham Community Hospital could wait three weeks to see a specialist nurse, such as a tissue viability or incontinence nurse. This was the same at Marlow Community Hospital. There was an delayed referral process to specialist

healthcare professionals. It could take two weeks to see the dementia nurse for example, and decisions were made without patient or specialist involvement. There was also lack of response from urgent referrals made to diabetic nurses or to the community psychiatric nurse.

- There were delayed discharges from all three hospitals due to delays in referrals being actioned and care packages in the community being set up. One patient had been there for 71 days, waiting for their care package to be organised. This was supported by the trust's quality dashboard data which showed that community inpatient services continuously exceeded the target dates for discharges. The target was 20 days; Buckingham results were 23.4, Marlow 31.7 and Thame 29.7 for March 2014.
- Marlow and Thame Community Hospitals physiotherapy and occupational therapy input was limited due to staff vacancies. Community therapists would provide cover, but this caused delays to patients waiting for treatment.
- The patient records we reviewed at Buckingham and Thame Community Hospitals did not show evidence of active discharge planning. Patients said they had not been involved in any discharge pathway and were unaware of when they were due to leave the hospital. Two patients said this caused them anxiety as they wished to leave as soon as possible to support family at home.
- One patient said they were stuck there and waiting to go home but could not as they were waiting on their package of care to be set up. They were unhappy it was delayed and were keen to get home.

Availability of information

- A mixture of paper and electronic notes were used at all three hospitals. Occupational therapists told us they did not have access to all required computer systems and were waiting for training on one of the trust's electronic systems. Staff expressed concerns that the use of multiple computer systems caused duplication of notes and was time consuming.
- Care records did include information for staff to follow on treatment, for example risk assessment, care plans, case notes and test results. The information, however, was not always fully completed. There was for example, limited information on admission details or comprehensive risk assessments.
- Referral information was not always in the notes. For example, we saw a patient with a necrotic (black) heel wound. Necrotic tissue is dead tissue, which usually results from an inadequate blood supply. The wound was being dressed twice weekly, once by the ward staff and once by the podiatry service. We found no information/notes from the podiatry service within the records regarding dressing care for the ward staff to follow. The records did not identify the participation of the tissue viability nurse. This meant that staff may not have had the appropriate information to provide the correct care and treatment to the patient.

Consent

- Consent was not always obtained from patients before staff provided care and treatment. Consent was not documented in the patient records we saw. For example, at Buckingham Community Hospital, it was seen in the notes that a patient had refused the use of bed rails three times, which was documented, but they were still in place. This was discussed at the MDT and it was evident this was not a patient that lacked capacity.
- There was little evidence that patients were asked for consent to share information about them with other parties. The consent to information sharing and care and treatment was variable across Buckingham and Thame Community Hospitals. There was no evidence within the records at Thame of patients consenting to care and treatment and information sharing. Only two of the records we reviewed at Buckingham Community Hospital identified discussions with the patients and/or their family about consent to information sharing and care and treatment.
- Most staff demonstrated awareness of the Mental Capacity Act 2005. They were able to describe how they would support patients to make decisions for themselves wherever possible and the procedures they should follow if a patient lacked capacity.
- Staff knew about deprivation of liberty safeguards (DoLS) and best interest meetings, but told us that they seldom had patients whose freedom needed to be restricted. They explained that patients who met this criteria may not be admitted to the community hospitals as it may be an unsuitable admission as they could not meet their needs. Only a few staff across the three hospitals were trained officially in applying the DoLS.
- At Buckingham, we saw that a DoLS application was in place, for the administration of covert medicines. We observed the record identified the involvement of the

patient's relative. We saw evidence that a mini-mental score assessment had been completed to ascertain whether the patient had the mental capacity to make a decision about their own care and treatment.

- During our unannounced visit to Buckingham Community Hospital we saw staff had recognised a patient's risk of falls. We saw there were bed and chair movement alarms in place. However, the records did not identify consent to the use of the alarms by either the patient and/or their relative.

Requires improvement

Are services caring?

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

We rated 'caring' as 'requires improvement'.

There were concerns at Buckingham Community Hospital where we observed an incident of poor care and patients had reported that they were being woken and dressed too early, and being man-handled, mainly by agency night staff. The trust had taken action on this issue although this was not being monitored. At Buckingham and Marlow Community Hospitals there were examples where patients' dignity and privacy was not maintained. Staff hand overs happened at patient's bedside and this resulted in all neighbouring patients, relatives and visitors overhearing intimate details about the patients' conditions and circumstances.

Call bells were in easy reach of patients, although at Buckingham Community Hospital a patient complained about the length of time it took to answer their call bell.

Patients were not routinely involved in decisions about their care and treatment and communication with patients and relatives about plans of care needed to improve.

We found caring staff across the three hospitals, with a commitment to help patients recover. Overall, staff treated patients with kindness and respect and demonstrated that they had a good understanding of patients' different needs.

Patients were involved in decisions around daily living and activities. At Thame Community Hospital, nurses and healthcare assistants spent time with their patients on a one to one basis. Staff reported that they had the time to give their patients personal attention, talking with them and forging good rapports with them.

We saw examples of staff promoting patient's self-care, and found there was access to pastoral and spiritual leaders from different faiths.

Detailed findings

Dignity, respect and compassionate care

- At Buckingham Community Hospital we saw a staff nurse who was abrupt and unkind while attending to a patient who needed the toilet. We addressed this with the ward sister, who reassured us they would speak to the staff member involved.
- Some clinical staff at Buckingham Community Hospital made allegations of bullying by the night staff and managers. They said there was a culture of night staff getting patients up early to wash them and patients had complained. They also said that some patients had being roughly handled by some staff, especially by agency nurses. Some agency staff had been suspended. However, staff feedback that some issues had not been addressed.
- During our inspection we identified two patients on one morning at Buckingham who were up and dressed by 6.45am. The notes did not record if this was appropriate or was the patient's wishes. One of the patients told us they were happy to be up. Some patients may not have had the mental capacity to decline an early morning wash, or be orientated to time, place and date.
- At Buckingham and Marlow Community Hospitals we saw detailed patient handovers been given at the bedside. This did not allow for privacy, dignity or confidentiality as all neighbouring patients and relatives could overhear intimate details about patients' conditions and circumstances. We saw staff engaged only with five of the 16 patients during the handover.
- One patient said that staff did not respect their privacy and entered without knocking. We observed this during our unannounced visit to Thame Community Hospital.
- We observed that the call bell was within reach of the patients. However, one patient, who preferred to sit out of bed, was not able to access the bell. The staff had given them a hand bell, but they reported they often rang the hand bell five or six times with no response from staff. They said they had to attend to their personal needs independently due to the lack of response.
- Patients at all three hospitals felt they were well looked after and treated with respect. People were positive about the support provided and used the phrase "very nice" to describe the nursing care they received. We spoke with a relative who was very positive about their experience and the care their relative had encountered. They told us that they found staff to be very caring and

supportive. However, not all patients and across all three hospitals were asked if they were happy and well cared for. Some patients may not have had the mental capacity to answer this question.

- Due to the high staff to patient ratio at Thame Community Hospital, nurses and healthcare assistants had time to spend with their patients on a one to one basis. Good interactions were observed and staff told us that because they were fully staffed and had only eight low dependency beds, they had the time to give their patients personal attention, talking with them and forging good rapports with them.
- During our unannounced inspection to Buckingham and Thame Community Hospital on 10 and 11 April 2015 we saw that staff treated patients with kindness and respect. Staff explained to us how they delivered care to the different patients who used the service. This demonstrated that they had a good understanding of patients' different needs.
- We saw good interactions between the nurses and patients during our unannounced inspection at Buckingham and Thame Community Hospitals. For example, we saw at Thame Community Hospital a patient asking to do their physiotherapy exercises. We saw a nurse supporting them, in the absence of a therapist, to ensure they were completing the exercises correctly.
- Patients' feedback was used to assess and monitor the quality of the service, and these were on display on the patient board within the wards visited. At Marlow we were shown 25 cards with positive feedback from the Friends and Family Tests. We saw that Buckingham and Thame hospitals had achieved 78% positive feedback from patients.
- The patient led assessment of care environment (PLACE) scores for all three community hospitals showed privacy, dignity and wellbeing scored 69%, which was significantly below the national average of 83%.
- The most recent NHS Friends and Family Test score (February 2015) for Buckingham was 77%, 88% at Marlow and 56% at Thame. The NHS Friends and Family Test is a survey that asks how likely inpatients would be to recommend the NHS service they received to friends and family as a place to receive care.

Patient understanding and involvement

- There was no evidence of patient involvement in decision making in any of the three hospitals we visited. In some instances a box had been ticked in patient records to indicate it had taken place, but this was not evidenced when reviewing the notes which covered patient interactions.
- An exercise class was observed with a therapist that had good staff and patient interactions. The staff knew the patients' ability and their limitations.
- Staff said they took time to ensure that patients understood their care and treatment and were involved in making decisions. However, we witnessed decisions being made at MDT meetings without patients or relatives being aware or involved.
- We observed a relative enquiring after the welfare of a patient at Buckingham Community Hospital who had arrived on the day of our visit. The patient had been in hospital for six weeks and was unable to care for herself due to her leg being in plaster. We spoke with the relative whom raised concerns that she needed to re-activate the self funded care received before admission. The relative was then seen asking the nurses if there were any changes to their relative's care, but the nurse replied there were no changes and would notify the relative accordingly. However, on reviewing the records we found that the patient's medicines had been changed by the diabetes nurse in the morning and the occupational therapist was due to make contact with the warden to assess the property prior to discharge. None of the above had been relayed to the relative during our visit.
- We observed patients being supported and given the choice of clothes to wear during the day. This meant that patients were able to make choices and decisions about their lifestyle.
- Most patients at Buckingham and Thame Community Hospitals said they felt able to talk to staff. One patient said "they were all very kind" and if they had any problems "they sort it for me." Two patients said that most staff were nice but some were "sharp." One patient at Buckingham Community Hospital said they did not want to say anything because of fear of staff reaction.

Emotional support

- There was a pastor that attended Buckingham Community Hospital every Wednesday afternoon to meet patients' spiritual needs.

Requires improvement

Are services caring?

- Patients also had access to other religious faith representatives, and referrals were made if requested.

Promotion of self-care

- We did not observe an approach to promote self-care across the community hospitals. We did however see some examples of this. At Marlow Community Hospital a staff nurse was promoting patient independence by teaching a patient to self administer insulin.
- At Thame Community Hospital, we saw that staff supported patients to manage their own healthcare and maximise their independence. For example, we observed staff supporting a patient to complete their physiotherapy exercises.

Requires improvement

Are services responsive to people's needs?

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

We rated 'responsive' as 'requires improvement'.

The trust was reviewing its community hospital provision but there was little evidence of monitoring of appropriateness of admissions or the current model of medical and nursing staffing, and the skill base to meet the needs of patients. Inpatient beds were not always used in the way originally planned. Patients requiring rehabilitation had long waiting times for admission. Inappropriate admissions extended waiting times and resulted in some patients needing urgent transfer back to acute services.

At all hospitals reasonable adjustments had been made so the premises were accessible. Staff demonstrated understanding of equality and diversity by ensuring that patients were treated fairly and given treatment specific to their needs. But there were delays in access to specialist support for patients in vulnerable circumstances, for example patients with a learning disability or mental health needs

We found staff, patient and relative awareness of the complaints process was inconsistent. At unannounced inspection there was improvement in both staff understanding of the process, and the availability of information for patients and their relatives.

Detailed findings

Planning and delivering services which meet people's needs

- At the three community hospitals we visited there was a GP-supported model of care. This had been designed to support patients with rehabilitation needs or those receiving end of life care. At Amersham Hospital (one of the community hospitals not inspected as part of this inspection), this had been changed to a medical model. We were repeatedly told of a change in the acuity of patients but it was unclear how the impact of this on the planning and delivery of the service was being monitored or reviewed.
- Patients' needs were not always met, as non-rehabilitation patients were being admitted that the staff were not trained to care for. We saw an example of this at Buckingham Community Hospital where a suicidal patient had been admitted and no risk assessments had been made, such as ligature points in their room.
- A review of the trust estates footprint was being undertaken and this would include a review of the management and use of the community locations. As part of this process there would be staff and public consultation and involvement.
- The inpatient community service was a bed-based model. There were plans for this to be reviewed to establish the best model for the different areas within the county. Consideration was being given to a mixture of inpatient beds in some areas, but day case for step down beds in others.
- Staff at Buckingham Community Hospital said they bought a minibus in order to take patients home to avoid delayed discharges. This was driven by the trust staff, and was an in-house initiative to help their patients get home quicker.

Equality and diversity

- During our visit, we saw that staff were able to demonstrate their understanding of equality and diversity by ensuring that patients were treated fairly and given treatment specific to their needs. This included areas of race, gender, disability and religion or belief.
- At Buckingham Community Hospital, equality and diversity staff training compliance was 91%, at Marlow it was 94% and at Thame 97%.
- We observed staff attending and supporting a patient who was blind. Upon their approach, they identified themselves and gave clear direction and information on the surrounding environment and what they were doing.
- At all the hospitals we visited, reasonable adjustments had been made to ensure that the premises were accessible to all.

Meeting the needs of people in vulnerable circumstances

- At all three hospitals vulnerable patients requiring assessment or support from specialist teams were being

affected by delays when referrals were made. There were frequent delays for referrals made to the learning disability nurse specialist, and also for mental health. We saw a patient at Buckingham Community Hospital with a learning disability who was waiting for assessment and input from both specialist nurses.

- Buckingham Community Hospital had a 'tip tree' table which was used as a memory jogger. This included red distinction tables which aided people with dementia to recall familiar items.
- The service had access to the trust's speech and language therapists for advice and guidance to assist patients with communication difficulties.
- Some patients at Thame Community Hospital said they were bored as there were no activities to keep them occupied. One patient said that unless they got a visitor they were unable to go out into the grounds.

Access to the right care at the right time

- Out of hours cover and a direct line to ambulance services was available for patient emergencies. This was reported as effective for patients requiring rehabilitation with low acuity needs. However, patients did not always receive the care they needed because staff did not always have the skills to provide more complex care. We were made aware of two incidents during the inspection where patients had to return to the acute trust because nursing staff had not appropriately recognised and escalated the deterioration in the patient's conditions, and did not have the knowledge or skills to be able to provide the required care.
- Some patients with higher acuity levels were being admitted and they were not able to be reviewed promptly by a doctor if the GP had already visited the hospital on that day. These patients were either seen the next day or awaited an ambulance for acute care. We observed, during the inspection, two patients who were inappropriately admitted to Buckingham Community Hospital from the acute services who returned to Stoke Mandeville Hospital for medical review and treatment.
- On the unannounced inspection, we did see evidence of the appropriate use of the out of hours service. At Thame Community Hospital, a patient required medical review for a urinary tract infection, and the out of hours were called. This resulted in a Doctor's visit to assess and treat the patient.
- There was an electronic database called STRATA which created a list of patients waiting for admission to the community hospitals. Patients could wait for a long time on this list and we were told it was often bypassed by bed management teams from the acute trusts. We saw waiting times ranging from three days to 51 days. The last 10 patients on the list had been waiting 25 days for a rehabilitation bed in the community hospitals.

Complaints handling (for this service) and learning from feedback

- The monthly dashboard for the three community hospitals showed that there had been no complaints made since April 2014, and none were recorded for January and February 2015. However, when we checked with staff, we found Marlow had one complaint and Thame had three complaints in the last year.
- Locality managers told us complaints were put on the dashboards and discussed at their middle management meetings.
- Staff at all three hospitals said they did not receive information about complaints and that the Patient Advisory and Liaison Service (PALS) dealt with them all.
- One clinical lead could not explain the complaints process to us or how they reported complaints. They said the ward clerk dealt with them, and when we asked the ward clerk, they said the clinical lead monitored them. Two of the clinical leads said they dealt with complaints themselves , and did not report or escalate informal complaints through PALS – they were dealt with in house. They both confirmed that PALS contacted them if they needed to provide any information.
- During our announced inspection, we found that patients were not aware of how they could complain or raise a concern. There were no PALS leaflets on display in the hospitals, or details of how to make a complaint for patients and relatives. However, on our unannounced inspection, information was seen displayed for patients to report any 'concerns, complaints, compliments'; and there were systems for them to be investigated and given a response**.** When asked, patients said they knew how to complain and said they could approach staff if they had any issues.
- At one hospital, a patient said they had complained that morning when they felt they had to wait a long time for a wash. They said the matter had been resolved

Requires improvement

Are services responsive to people's needs?

efficiently and quickly. Staff said they supported people and carers to make complaints as required, and would refer complaints to PALS if they were unable to resolve the issue locally.

- At the unannounced inspection, one relative said they had made a complaint that morning as their relative had been moved to Buckingham Community Hospital without their knowledge. They confirmed they were the patient's guardian. They said they had received an apology from the hospital.

Requires improvement

Are services well-led?

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

We rated well-led as 'requires improvement'.

The trust wide vision and messages were not widely known or understood by staff. The vision and strategy for community inpatient beds was not well developed, and staff in the service had not been involved in the process.

The arrangements for identifying and managing risks did not always operate effectively. Not all issues and risks reported to leaders, on the risk register, reflected the concerns of staff. Not all identified risks had appropriate action plans or were dealt with in a timely way. There was monitoring of performance and quality using a trust wide dashboard but limited evidence of local audit of the service or patient care.

The quality of leadership varied across the hospitals, and affected in part by long term absences in the senior team. There were concerns about the skills and capabilities of leaders at Buckingham hospital, including allegations of bullying and harassment.

Staff were passionate and caring about their work but staff satisfaction was mixed. There was a positive culture and high morale at Marlow and Thame hospitals, with evidence of team working and staff engagement. Staff morale at Buckingham hospital was low, they reported a negative culture of lack of team cohesion and respect and staff not feeling listened to.

There was some evidence of the service seeking the views of patients and relatives through 'You said, we did' initiatives. There were also examples of innovative initiatives by clinical staff to improve the quality of patient care.

Detailed findings

Service vision and strategy

- The trust had a vision 'to be the first choice of hospitals for the people of Buckinghamshire and beyond, because in a Buckinghamshire hospital the needs of the patient always come first'. The trust had made five promises to its patients. These were clean and safe practice; clinics and hospitals having a caring, helpful and respectful attitude; respect for your time with care closer to home; easy access to comfortable and modern facilities; and the best clinical care. The aim was to ensure that all patients received the right care, in the right place, at the right time, first time, and the trust strived to deliver this by keeping its promises.
- The vision was on display at Buckingham and Marlow Community Hospitals, but when we asked one of the clinical leads about the vision, they were not able to tell us about it. They had limited knowledge of trust-wide messages and a lack of awareness and insight to support staff.
- The service strategy was unclear and service leads told us the trust board was devising a new one. The clinical leads and locality managers had not been involved in writing the new strategy yet. The service leads told us the future strategy was to decrease the reliance on inpatient community beds with more emphasis on community care delivered in people's own homes. They wanted to liaise with social care and create a virtual ward where GPs provided cover. This was to be supported by accessible beds in nursing homes which would decrease pressure on community inpatient beds.

Governance, risk management and quality measurement

- Dashboards were used to monitor specific quality indicators at the three hospitals, and discussed at management meetings. They included such issues as complaints, falls, medication errors, hospital acquired infections, serious incidents, pressure ulcers, staffing levels, NEWS scores and cardiac arrests. Safety Thermometer information was used at all three hospitals to monitor the quality of care.
- The community inpatient services risk register was analysed and six items were listed on it. Three were related to staffing levels and the inability to recruit staff. Staffing levels had been added to the register in February 2011, and once again added under a different heading in January 2012. High staff sickness absence rates were also added in January 2012. Another risk added in January 2012 related to the need to develop a pathway for step-up patients. These had been on the register for a number of years without clear resolution

Requires improvement

Are services well-led?

- The final risks were added in January 2015 and related to fire evacuation at Thame Community Hospital, and problems with broken beds that could not be fixed and did not fit through evacuation doors and corridors. The fire evacuation issue at Thame hospital and been addressed and managed and new beds had been ordered.
- The risk register did not include risks identified during the course of this inspection, for example, inappropriate admissions, he inefficient management of STRATA that aided in delayed discharges, the skill mix of nursing staff and delays in the referral and assessment to specialist service which impacted on patient care and recovery.
- Across the three hospitals we found little evidence that audits were being completed. At Buckingham Community Hospital there was an audit folder that we reviewed. This showed that the infection prevention and control action plan dated by the locality manager on 8 November 2014 was asked to be completed but there was no evidence to suggest this had been done. The medicines management security checklist had been checked on 25 February 2015, and before that it was last done in March 2014. Daily acuity checks had not been completed since 19 May 2014. Matrons rounds were carried out but were not documented consistently. These were checks completed by the ward sister or matron that checked the ward and patients against a criteria list. Issues checked were cleanliness and safety. This form said it was to be completed weekly, but it had last been completed on 26 February 2015 by the deputy sister, which was one month before our visit. It was numbered 1 to 10 with an entry for each of 10 beds, but there were 16 inpatient beds at the hospital. There were no audits of patient care.
- At Marlow Community Hospital, staff did not mention any audits that were undertaken. However, the service leads told us there was an end of life care pilot at present. No further information was supplied. When asked, therapists said they carried out audits on equipment, such as response times for accessing therapy equipment.

Leadership of this service

- Leadership concerns were identified at lower and middle management levels at Buckingham and Marlow. Staff said they were not supported and that clinical leaders did not engage with them. At Buckingham there were reported allegations of bullying and harassment against the management. We were approached by a few staff about this, and they explained they had raised their issues through human resources with little support or outcome.
- New link roles were created for healthcare staff at Buckingham Community Hospital, but protected time was not allocated and little developmental training was available, or planned, to support them in undertaking these roles.
- There was no visible leadership at Marlow Community Hospital. A band 5 nurse was the most senior nurse on duty and she was undertaking the ward manager duties. Senior management was covered by another manager from out of the area on a temporary basis due to sickness.
- At Thame Community Hospital we saw visible leadership from the clinical lead, despite only being in post for two weeks. Staff generally spoke highly of the hospital leadership. The locality manager was off sick, but this was covered by another manager who told us they had not been to the hospital for four months and therefore had limited current knowledge of this location.
- The service leads said that board members did walk-rounds and visited the community hospitals, which was supported by some of the staff we spoke with.
- Middle management staff said they did not feel listened to by the trust board and there was lack of action. When we interviewed senior management it was obvious that there was a lack of information sharing from the trust, and neither management teams were visible or accessible across the three hospitals.
- Some staff said that they found their role frustrating. They said that although they felt they were listened to, “nothing ever happens”. Some staff at Buckingham Community Hospital were concerned with the leadership and management of the wards. They felt the wards were “disorganised” and felt this could be due to the lack of permanent staff.

Culture within this service

- At Marlow and Thame community hospitals, staff told us there was a good team spirit and a positive atmosphere. There was good team work and support from the locality manager so the morale was high with

Requires improvement

Are services well-led?

professional respect evident between team members. Staff said there was a 'no-blame' culture, with a supportive team and management that had an open door policy.

- Staff morale was low at Buckingham Community Hospital. Staff described tensions between qualified and unqualified staff, and feelings that the use of agency staff strained relationships further. Some staff reported they were unhappy working there. Staff reported being threatened with suspension if they did not comply with management requests. Some staff reported that certain agency staff had refused to return to work because of the culture in the hospital. Staff at Buckingham Community Hospital made allegations of bullying and harassment against management to us. They spoke about favouritism and cliques which tended to exclude members of staff. Some staff reported abuse of power and a culture of not being listened to or respected.
- An example was given of when a staff member went off sick. They were scrutinised about their reasons, and a return to work date was requested by management. They said they had been required to provide proof that their sickness was genuine on the day they went off sick by showing a medical certificate.
- Staff at all the hospitals we visited were caring and passionate about the service and the care they provided to people.

Public engagement

- The hospitals used the NHS Friends and Family Test but these were not always completed. We saw some examples of public engagement across the three hospitals. At Buckingham Community Hospital they had 'coppers for cupcakes' where relatives gave donations for cupcakes which staff bought so patients and relatives could have tea and cake together.
- We saw 'You said, we did' on the notice boards. For example at Thame Community Hospital the feedback from patients said the "care is fantastic and the food very tasty". The response was for the feedback to be reported to the kitchen staff.

Staff engagement

- There was little evidence of staff engagement across the three hospitals. Staff at Buckingham Community Hospital said they felt isolated from the rest of the trust, and that their concerns were not listened to or taken seriously.
- The trust-wide staff survey was recently completed and showed staff felt there was a lack of support from immediate managers, poor job satisfaction and motivation at work. There were also concerns raised about fairness with, incident reporting and feeling secure about raising unsafe practices. The survey indicated that staff were not satisfied with the quality of patient care they were delivering, the work pressures they had, and the extra hours they worked. The survey also reported on staff experiencing harassment and bullying in the work place.
- Staff at Buckingham Community Hospital said they were unhappy the staff rota came out late and at short notice so they were not able to make plans with their family.

Innovation, improvement and sustainability

- A webcam was introduced at Buckingham Community Hospital to improve the prescribing and reviewing of medicines. This was connected to Stoke Manderville Hospital Pharmacy department.
- We were told of a clock that was devised by the clinical lead at one hospital to remind staff to give patients a regular drink. This occurred from a lessons-learned approach after a review of the frequency of urinary tract infections.
- We saw a 'Tip tree' interest table at one hospital which was on a red background and helped patients with dementia identify and touch familiar things.
- Marlow Community Hospital won an award for student nurse support, which was highlighted in the local press.
- The trust was developing a strategy for community inpatient services to deliver services in line with the NHS Five Year Forward View. This was to support independence, increase health promotion and ill health prevention

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Staffing (staffing)** **How the regulation was not being met:** The trust did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Supporting workers (staffing)** **How the regulation was not being met:** The trust did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying out the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to patients safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal. Regulation 23(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Respecting and involving people who use services (dignity and respect)** **How the regulation was not being met:** There were unsuitable arrangements for ensuring patients' dignity, privacy and independence. Regulation 17(1)(a)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Records (good governance)** **How the regulation was not being met:** Patient records were not always accurate and were not always securely stored. Regulation 20(1)(a)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Assessing and monitoring the quality of service provision (good governance)** **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The trust did not have an effective operation of systems to enable it to regularly assess and monitor the quality of the service provided in the carrying on of the regulated activity.

- Admission criteria
- Incident reporting
- Audit
- Leadership
- Review of access to equipment
- Review consent procedures

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Care and Welfare (safe care and treatment)** **How the regulation was not being met:** The trust did not take proper steps to ensure that each patient was protected against the risks of inappropriate and unsafe care. • Completion of national early warning score Regulation 9 (1)(a) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.