Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust	Inadequate
Are acute services at this trust safe?	Inadequate
Are acute services at this trust effective?	Requires improvement
Are acute services at this trust caring?	Requires improvement
Are acute services at this trust responsive?	Inadequate
Are acute services at this trust well-led?	Inadequate

Summary of findings

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Overall summary

Heatherwood and Wexham Park Hospitals NHS Foundation Trust has six sites. The two main sites are Wexham Park Hospital and Heatherwood Hospital. They also provide outpatient services at King Edward VII Hospital in Windsor, St Mark's Hospital in Maidenhead, Chalfont's and Gerrards Cross Hospital and Fitzwilliam House in Bracknell.

The trust provides services to a large and diverse population of more than 465,000. The area it covers includes Ascot, Bracknell, Maidenhead, Slough, South Buckinghamshire and Windsor. The trust has approximately 3,600 staff and a total number of 650 beds. The trust has recently increased the bed capacity at Wexham Park to meet increased demand following an increase in their catchment area for A&E, paediatrics and wards, and had plans to open more capacity later in 2014.

The trust's catchment area population includes a significant proportion of ethnic minority groups and 30 languages are spoken in the area covered by the trust. The most common (excluding English) include Hindi, Polish, Urdu, Somali, Romanian and Punjabi.

The trust became a foundation trust in 2007. At the time of the inspection, the executive team (based at Wexham Park Hospital) comprised members who were either interim appointments or relatively new in post, with only one member of the executive team in post for over three years. The chief executive had been in post for two years and four months (but had formally resigned, with a leaving date in March 2014).

We inspected this trust as part of our in-depth hospital inspection programme because it represented a variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Heatherwood and Wexham Park Hospitals NHS Foundation Trust was considered to be a high-risk service.

At the time of the inspection, Wexham Park Hospital was in breach of a number of regulations and, in many instances, it has been providing care below the essential standards, as found during two previous CQC inspections in May and October 2013. In May 2013, there were particular concerns about the care provided to patients in Accident & Emergency (A&E) and the impact this had on the ability of inpatient wards to provide the essential standards of care. At the inspection in October 2013, improvements in A&E were noted to have been made. However, we found that Wexham park Hospital was in breach of eight regulations. As a result we served compliance actions for breaches of two of the regulations (15 and 16) and warning notices for breaches of six regulations (9, 10, 12, 17, 20, and 22).

We gained views from partner organisations who expressed their concerns about the care provided at Wexham Park Hospital and the future sustainability of the trust.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust provides the following regulated activities, which formed part of our inspection; diagnostic and screening procedures, management and supply of blood and blood derived products, maternity and midwifery services, surgical procedures, termination of pregnancies and treatment of disease, disorder or injury.

We carried out an announced inspection visit on 12 and 13 February. We held focus groups and drop-in sessions for staff. We talked with patients and staff from many areas of the hospital. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We held two listening events when patients and members of the public shared their views and experiences of Heatherwood and Wexham Park Hospitals NHS Foundation Trust. Patients who were unable to attend the listening events shared their experiences via email or telephone. We carried out three unannounced visits, when we looked at how the hospital ran at night, the levels and type of staff available, how patients were cared for, and patient flow through the hospital.

The trust had a long history of problems. Financial shortfall and high turnover of senior leadership had resulted in poor outcomes in recent CQC inspections and expressions of increasing concern from multiple stakeholders. The trust we found was one that had a

Summary of findings

significant legacy from a history of financial challenges and the hospital had a culture which was not open with learning at its heart. Trust wide improvements were commencing with support from external agencies, however these were at very early stages and the trust remained challenged. The future sustainability of the trust was clearly a concern. Although efforts had recently been made in response to these concerns they were still very much in their infancy.

The culture was one of learned helplessness and accusations of bullying and harassment were heard throughout the organisation. Although the chief executive was reported to have high visibility and communicated regularly with the frontline, she had recently resigned and was due to leave in March 2014.

The trust was clean and wards that were heavily criticised in previous CQC reports showed evidence of improvement. However, staffing levels were still low in many areas and there was heavy reliance on agency staff to sustain both the medical and nursing workforce.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The hospital had recently undergone a deep clean and all areas inspected were visibly free from dirt. Most staff were seen to wash their hands appropriately.

Unsafe staffing levels were a consistent theme throughout the trust and were noted in almost all clinical disciplines including medical, nursing, and allied health professionals.

Escalation beds had been opened at short notice, which were staffed largely by agency. Many of these staff had not worked in the trust previously and there was evidence that induction to wards was not systematic.

Notes were found to be inconsistently completed in many departments throughout the trust. This was particularly notable for of falls assessments. At Heatherwood there had been four falls in the previous seven days, one of which had resulted in a fractured hip.

There was a lack of a genuine safety culture, with the exception of the critical care unit and the children's and young person's department. The culture in the trust did not encourage staff to report incidents as they perceived there was little subsequent change. This was consistently a lost opportunity to improve practice and outcomes. Although there were individuals and groups of staff who took the time to progress initiatives, there was no evidence that this was embedded practice.

Governance processes were not seen to be robust enough to allow the trust board to gain assurance that they were providing safe care.

Are services effective?

Requires improvement

Although many staff told us that they followed national and local guidelines, during the unannounced inspection we found that a significant number of the policies and guidelines were out of date. In addition, the trust provided evidence confirming that 27% of the policies were out of date.

We were provided with a table of audit activity currently being undertaken, but with the exception of critical care and children and young people's care, we were not provided with evidence of the results for these audits or how practice had changed as a result. Although the trust provided evidence that it is good at undertaking audits, in some areas there was no evidence that this resulted in patient care being more effective or safe. We found the trust was not acting on the results of audits by identifying improvements, implementing or appropriately monitoring change. We found examples where performance was getting worse when repeat audits were undertaken.

There was a shortage of equipment on some wards and some of the ward areas were in need of repair.

Summary of findings

While we found good multidisciplinary working in many areas, there was a lack of consistency in multidisciplinary working trust-wide. Some groups of consultants were not working collaboratively.

Are services caring?

Requires improvement

The trust scored below the national average for the Friends and Family test. In the CQC inpatient survey, the trust performed worse than other trusts for eight of the areas of questioning.

Members of the public expressed their concern to us at the listening event regarding poor care and the loss of dignity that they and their relatives experienced during treatment at the trust. They were also concerned with the lack of communication they received from the trust.

We witnessed staff in some areas (children's and young people, critical care and end of life care) deliver kind and compassionate care. Heatherwood Hospital consistently received good feedback from patients.

Due to the pressures placed upon them, staff were not always able to provide the amount of emotional support that patients wanted and deserved.

Are services responsive to people's needs?

Inadequate

The trust was very busy and failed to consistently meet national targets to admit, transfer or discharge patients from the A&E department within four hours. The trust has been predominantly performing much worse than the England average, with patients waiting between four and 12 hours following the decision that they should be admitted.

In order to increase capacity, extra beds had been opened, but there was little evidence of initiatives to try to reduce unnecessary admissions. Patient discharges were being delayed in many cases due to a shortage of radiology, physiotherapy, and occupational therapy assessments being completed in a timely manner.

The lack of capacity and delayed discharges resulted in medical patients being placed on surgical wards. Some patients were moved numerous times, which resulted in delayed care or lack of continuity of care. The use of surgical beds by medical patients resulted in a significant number of patients having their operations cancelled on the day.

Discharges were not planned from admission, and there were significant delays due to lack of resources within the radiology department.

Vulnerable patients were not always a priority for the trust and translation services, though available, were not always used.

Complaints were not answered promptly and we were unable to find evidence that previous concerns had been learned from. Patient stories or complaints were not regularly reviewed by the board.

Summary of findings

Are services well-led?

Inadequate

The trust lacked a clear vision for staff to align or aspire to. The lack of clarity about the hospital's future left many staff feeling disempowered.

There had been a high turnover of executive team members and the chief executive had recently resigned. Staff referred to the trust as 'rudderless'

The governance arrangements and risk management structures throughout the trust were neither standardised nor consistent throughout departments or divisions. This resulted in the board receiving assurances which were not always robust. In addition, risks throughout the trust were not being progressed or actioned in a timely manner, with many missing their set target date for completion. Information governance needed further investigation to establish its accuracy. The trust had taken steps to source external support to review and improve these aspects.

Sickness levels were found to be under-reported and therefore not a true reflection of staff sickness figures. The trust performed poorly in both the staff survey and the GMC National Training survey. There was a widespread reference to culture of bullying and harassment.

The workforce was disempowered and disengaged. Nursing turnover was high with recruitment and retention being a fundamental concern. This resulted in high use of agency staff. The trust was taking steps to improve retention by schemes within HR, but these were not started at the time of the inspection.

While there were groups who were engaged with the holistic patient experience, some consultants were seen to prioritise their individual working practices and displayed dysfunctional behaviours to the detriment of patient experience in the trust.

Patient experience was not at the heart of everything that was done at the trust. We witnessed a mixture of 'firefighting' and learned helplessness from frontline staff and an executive team that had focused on financial improvement. As a consequence, innovation was not encouraged or rewarded.

Members of the executive team were unanimously concerned about the perceived instability in the future of the hospital and recognised the need for long term significant support in order to achieve a sustained and improved future for the trust.

Some of the executive directors did not have confidence that, as a board, they could make the required significant improvements within an acceptable period. We did not feel that there was the required skill and capability within the trust to make the complex and necessary changes trust-wide.

Summary of findings

What people who use the trust's services say

The Friends and Family test had been introduced in April 2013 to give patients the opportunity to offer feedback on the quality of care they had received and whether they would recommend it to their friends and family. Heatherwood and Wexham Park Hospitals NHS Foundation Trust scored below the national average for inpatient in December 2013 with a score of 66 against a national average of 71.

When analysed at ward level, 24 wards at Heatherwood and Wexham park Hospital NHS Foundation Trust were included in the December 2013 Inpatient survey. Fourteen 14 wards scored less than the trust average of 62 and all of these were at Wexham Park Hospital. Ward 17 scored the least of all wards at 25. Ward 20 and DSU had responses where people would be extremely unlikely to recommend them to friends and family.

In the A&E department Friends and Family test, the trust scored well below the national average for both the response rate and the score consistently. In December 2013, they scored 37 against a national average of 56, with a response rate of 11.4% against a national average of 15.3%.

Analysis of data from CQC's Adult Inpatient Survey 2012 shows that the trust scored worse than other trusts for eight out of the 10 areas of questioning. In the individual questions, the trust has performed worse than expected in 24 out of the 70 questions. Comparison to the 2011 CQC Adult Inpatient Survey illustrated an improvement in one question and a decrease in performance on three of the questions, including; cleanliness of toilets, speaking to staff to alleviate fears or concerns and whether patients were ever asked their views on quality of care.

The Cancer Patient Experience Survey is designed to monitor national progress on cancer care. The survey is made up of 64 questions. In the 2012/13 survey the trust performed 'better than other trusts nationally' in three questions. It performed 'worse than other trusts nationally' in 12 questions (which placed them within the bottom 20% of trusts for those questions). For the remaining 57 questions, it scored 'about the same' as other trusts nationally.

Patient Opinion (an independent non-profit feedback platform for health services) had 295 comments on the trust's section of their website with scores out of 5 stars for the following of 4.1 stars 'cleanliness'; 3.8 stars 'environment'; 3.6 stars 'information'; 3.7 stars 'involved'; 3.8 stars 'listening'; 3.9 stars 'medical'; 4 stars 'nursing'; 2.5 stars out of 5 stars 'parking'; 3.9 stars 'respect'; 3.4 stars 'timeliness'.

The NHS choices website had 215 reviews and gave Wexham Park Hospital scores of 3.5 stars out of 5 overall. There were 31 positive comments which were rated five star and 26 comments which were rated as one star.

Share Your Experience (a service organised by the Care Quality Commission whereby patients are asked to provide feedback on the standard of care they have received) received six comments for the trust, all of which were negative. The six negative comments included lack of communication, lack of patient respect & dignity, incorrect appointment, staff attitudes and waiting times.

The Patient-Led Assessment of the Care Environment (PLACE) scored Wexham Park Hospital below 90% for all four metrics, which include cleanliness, food, privacy, dignity and wellbeing and facilities; the lowest at 81% for 'Food'.

We held two listening events where patients, carers and relatives provided feedback about Wexham Park Hospital. In addition, those that were unable to attend emailed their experiences of the hospital to us.

Summary of findings

Areas for improvement

Action the trust MUST take to improve

- Ensure that patients are appropriately risk assessed particularly for falls and pressure ulcers including those patients who are in the A&E department for a prolonged period.
- Ensure that patient flow is addressed as a priority (and escalation procedures adhered to) to improve the poor performance in the four-hour A&E target, high number of surgical cancellations and delayed discharges from the critical care unit. This will require engagement with all departments within the trust, improvement to discharge planning, access to radiology and ambulatory care pathways.
- Ensure the estate is fit for purpose and that leaks, repairs and maintenance are planned and dealt with in a timely manner.
- Ensure that there is a robust system in place to assess the numbers and skill mix of medical and nursing staff for all wards. Ensure that establishments are increased to reflect this.
- Address workforce recruitment and retention plans to reduce the dependency on locum and agency staff.
- Ensure, where agency and locum staff are employed, relevant background and competency checks are undertaken and they receive appropriate local induction prior to commencing work on the ward.
- Encourage and support an incident reporting culture, so that it is seen as a mechanism to learn rather than attribute blame. This needs to be present throughout all directorates and at all levels of staff.
- Ensure that the investigation of incidents is carried out in a fair, openly transparent and consistent manner, regardless of the level of seniority of staff involved. Multidisciplinary involvement needs to be seen as essential. The outcomes and areas for improvement need to be developed and disseminated trust wide.
- Ensure the radiology service is able to meet the needs of people who use the service in a timely way.
- Ensure that all staff are able to respond to the needs of vulnerable groups such as people with dementia or a learning disability.
- Ensure policies and procedural guidance are updated so that staff have access to up to date evidence based guidelines. Ensure that audits are regularly undertaken to check clinical compliance (in particular medicine managements).
- Ensure that the governance structures are reviewed and standardised trust-wide.
- Improve staff engagement across clinical and managerial disciplines to promote a learning and safety culture where patient experience is paramount.
- Ensure that there is a consistent and standardised approach to multidisciplinary meetings and mortality and morbidity meetings trust wide
- Ensure that patients are not inappropriately moved (especially out of hours) for non-medical reasons.
- Ensure where escalation areas are opened that there are clear admission criteria that are strictly adhered to and audited. Senior oversight of the ward needs to provide assurance that patients are seen appropriately and in a timely way and that nursing staff are aware of individual patient needs.
- The trust must take steps to improve the booking and appointments system, waiting times and the cancellation of clinics to prevent delays and to improve access to treatment.
- Ensure that the World Health Organisation Surgical Safety Checklist is mandatory practice and consistently completed. Comprehensive audits must be undertaken regularly.

Action the trust SHOULD take to improve

- Ensure there is a robust system in place to review the decision when a caesarean section is to be performed.
- Ensure the recovery unit is used appropriately and that patients are not accommodated overnight in the recovery area.
- Ensure there are clear processes in place for the collection of patient feedback and responding to complaints.
- Ensure the nutritional needs of patients who are in the A&E department for prolonged periods are met and they are offered food and drink if appropriate.
- Review the food provision services to enable patients' cultural needs and preferences are respected.

Summary of findings

- Ensure patient records are complete and accurate to ensure the safe delivery of care and treatment.

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Detailed Findings

Hospitals we looked at:
Wexham Park Hospital; Heatherwood Hospital; King Edward VII Outpatients

Our inspection team

Our inspection team was led by:

Chair: Kathy McLean, Medical Director, NHS Trust Development Authority

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

Background to Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Heatherwood and Wexham Park Hospitals NHS Foundation Trust operates at two main sites an provides services to a large and diverse population of more than 465,000 which includes Ascot, Bracknell, Maidenhead, Slough, South Buckinghamshire and Windsor. The trust has approximately 3,200 staff and a total number of 650 beds, with 588 on the Wexham Park Hospital site, and 62 at Heatherwood Hospital. 61 of the beds at the trust are used are used for maternity, 57 for children, 103 for surgery, 12 for critical care and the remaining number for various medical specialities. The trust also has capacity for a further 51 beds to become available if required. Their indicative catchment increased as a consequence of the closure of an A&E to the north in November 2012. All maternity, critical care and children's services are based at Wexham Park Hospital.

The trust became a foundation trust in 2007. In 2008/9 the trust faced significant financial challenge and in 2009/10 they were officially placed into turnaround and Monitor appointed a new Chairman. At the time of the inspection the executive team were either interim or relatively new in post, with only one member of the executive team in post for over 3 years. The Chief Executive had been in post for two years and four months (having formally resigned with a leaving date in March 2014) and the Chairman had been in

post for one year and 3 months. This instability in leadership, financial challenge and absence of a consistent vision had evidently impacted on the trust's standard of care and culture.

Wexham Park Hospital has been found to be in breach of a number of regulations and, in many instances, providing care below essential standards in two previous CQC inspections in May and October 2013. In May 2013 there were particular concerns about the care provided to patients in the accident and emergency department (A&E) and the impact this had on the ability of inpatient wards to provide essential standards of care required by the regulations. Following that inspection we issued a warning notice to the trust against Regulation 10: assessing and monitoring the quality of service provision.

In October 2013, we followed up on the warning notice and found the trust had made significant improvements in some areas, particularly in managing capacity issues in A&E at Wexham Park Hospital. However, during this inspection we found a number of significant concerns and we found that Wexham park Hospital was in breach of eight regulations. We served compliance actions for breaches of two of the regulations (15 and 16). We also served warning notices for breaches of six regulations (9, 10, 12, 17, 20, and 22). All these warning notices stated that Wexham Park Hospital must become compliant with all the regulations by 31 January 2014.

Following our inspection in October, we referred our findings to local area team (NHS England), General Medical Council, Monitor, Health and Safety Executive and Local Authority: Commissioning. As healthcare regulator, Monitor subsequently put the trust under enforcement action. We followed up the warning notices As part of our planned inspection in February we followed up the warning notice we had issued in October

Why we carried out this inspection

We inspected this trust as part of our in-depth hospital inspection programme. We chose this trust because it represented a variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Heatherwood and Wexham Park Hospitals NHS Foundation Trust was considered to be a high-risk service.

How we carried out this inspection

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

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

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

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, the Local Area Team (LAT), NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Royal College of Surgeons, the Royal College of Obstetrics and Gynaecology, and Healthwatch.

We carried out an announced inspection visit on 12 and 13 February. We held focus groups and drop-in sessions on 11, 12 and 13 February with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all areas of the hospitals, including the wards, theatres, recovery, radiology

Detailed Findings

department, outpatient services and A&E. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We held two listening events, in Ascot on 4 February and in Slough on 12 February 2014, when patients and members of the public shared their views and experiences of the hospitals. Patients who were unable to attend the listening events shared their experiences via email or telephone.

We carried out unannounced inspections on Saturday 15 February, Wednesday 19 February and Thursday 20 February 2014. During these additional visits, we looked at how the hospital ran at night, the levels and type of staff available, how they cared for patients, and patient flow through the hospital.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Wexham Park Hospital.

Inadequate

Are services safe?

Summary of findings

The hospital had recently undergone a deep clean and all areas inspected were visibly free from dirt. Most staff were seen to wash their hands appropriately.

Unsafe staffing levels were a consistent theme throughout the trust and were noted in almost all clinical disciplines including medical, nursing, and allied health professionals.

Escalation beds had been opened at short notice, which were staffed largely by agency. Many of these staff had not worked in the trust previously and there was evidence that induction to wards was not systematic.

Notes were found to be inconsistently completed in many departments throughout the trust. This was particularly notable for of falls assessments. At Heatherwood there had been four falls in the previous seven days, one of which had resulted in a fractured hip.

There was a lack of a genuine safety culture, with the exception of the critical care unit and the children's and young person's department. The culture in the trust did not encourage staff to report incidents as they perceived there was little subsequent change. This was consistently a lost opportunity to improve practice and outcomes. Although there were individuals and groups of staff who took the time to progress initiatives, there was no evidence that this was embedded practice.

Governance processes were not seen to be robust enough to allow the trust board to gain assurance that they were providing safe care.

Our findings

Staffing levels

Unsafe staffing levels was a consistent theme throughout the trust and was noted in almost all clinical disciplines including medical, nursing, and allied health professionals. In addition there was no evidence of use of a consistent nursing acuity tool in place to establish the different numbers of nursing staff required on each ward. Some wards did display their ideal and actual staffing numbers but again this was not consistent throughout the trust, and when it was in place we saw that wards often had to function below establishment. There was a significant vacancy rate especially in midwifery which was quoted to us as 26.4 whole time equivalents.

Consultant cover for medicine was poor out of hours and little progress had been made towards seven day services, although we were informed that work was in progress. In A&E there were only seven consultants out of a trust target of 12 and the middle grade rota relied significantly on non-permanent members of staff. As a result of the vacancy rates, we found significant reliance of agency staff in almost all divisions. Of concern we found that there was no consistent process in place for the trust to assure themselves that staff were appropriately inducted and orientated and we found that some agency staff were unable to tell us where the crash trolley was on their ward. In addition we found staff working without having had their proficiencies confirmed prior to administering intravenous medication.

In total the trust's total agency spend in 2012-13 was 6.9% of total staff expenditure compared the regional comparator of 3.8%.

Use of escalation beds

Due to bed pressures we found that an escalation ward had had to be opened by the trust. There was a significant number of agency staff working on this ward, and when we returned for our unannounced visit out of hours we found that none of the staff working on the ward had worked there before. Furthermore they had received their handover and induction from the day agency staff. We found from looking at the notes that one patient had not been seen for five days by a doctor because their medical team was unable to locate them and had not been informed that their patient had been moved. In addition two patients (out of nine on the ward) had waited over 12 days to see a physiotherapist. Although there was an agreed criterion for admission to the ward we found that on most occasions this had not been completed or it had been documented that the form was completed on the ward after the transfer. Several of the patients who did have the form completed did not fit the criteria. When we questioned the staff about why they had been allowed to be transferred to the ward they did not know.

Completion of records

Notes were found to be inconsistently completed in many of the departments throughout the trust. This included

nursing risk assessments which were often found to be incomplete or absent, medical notes which were illegible in some cases and again incomplete, and handovers were not recorded or documented between shifts.

The low compliance in completion of the WHO surgical checklist was a significant concern during the inspection. The trust had carried out an audit to identify the low compliance but there did not appear to be any plans in place to improve the compliance despite the importance of this check being mandated nationally. During the inspection process we were provided with a policy regarding the WHO checklist stating this was not mandatory, however the policy available to staff on the intranet did state it was mandatory, although this policy was out of date. This concern regarding guidance to staff was raised during the inspection as a concern.

Learning and improvement: Incident reporting

Although staff told us that they knew how to report incidents staff in the majority of departments told us that they did not regularly receive feedback from these and thus they did not feel there was any benefit from completing the reports. The exception to this was within the Critical Care and children's and young person's departments, where we were told both incident reporting and learning from incidents was expected and common practice.

Learning and improvement: Information governance

We could not be assured that there were appropriate governance processes in place to ensure that the trust themselves knew that safe care was being provided. The trust was aware that this was an issue and had recently commissioned an external consultancy firm to support their development in this area. We also were given action plans (put in place in response to external reports) that showed that dates for completion regularly slipped and people were not held to account for this. Risk registers were lengthy and did not show evidence of progression.

Although there was some evidence of good local practice, for example, in the critical care unit, we were also informed that there was some very poor practice. For example, in some of the surgical departments where regular mortality and morbidity meetings were not being conducted. Our concern was that without robust governance arrangements the trust at executive level could not be assured that services being provided were safe.

Requires improvement

Are Services Effective?

(for example, treatment is effective)

Summary of findings

Although many staff told us that they followed national and local guidelines, during the unannounced inspection we found that a significant number of the policies and guidelines were out of date. In addition, the trust provided evidence confirming that 27% of the policies were out of date.

We were provided with a table of audit activity currently being undertaken, but with the exception of critical care and children and young people's care, we were not provided with evidence of the results for these audits or how practice had changed as a result. Although the trust provided evidence that it is good at undertaking audits, in some areas there was no evidence that this resulted in patient care being more effective or safe. We found the trust was not acting on the results of audits by identifying improvements, implementing or appropriately monitoring change. We found examples where performance was getting worse when repeat audits were undertaken.

There was a shortage of equipment on some wards and some of the ward areas were in need of repair.

While we found good multidisciplinary working in many areas, there was a lack of consistency in multidisciplinary working trust-wide. Some groups of consultants were not working collaboratively.

Our findings

Using evidence based guidance

Although we were told by many staff that they followed national and local guidelines, during the unannounced inspection we found that a significant number of the policies and guidelines were out of date. In addition, the trust provided evidence confirming that 27% of the policies were out of date.

This was particularly the case in accident and Emergency, medicine, surgery and maternity. This meant that staff may not have been following best practice.

For example during our inspection we noted that departments were not following the trust antibiotic protocols and antibiotics were being written up for unspecified lengths of time and without documentation of the reason for why they were being commenced. This meant that patients may not have been receiving the appropriate antibiotic for their infection.

Performance, monitoring and improvement of outcomes

The trust had a central audit office to coordinate and support audits within the trust. We were provided with a table of audit activity currently being undertaken, however we were not provided with evidence of outcomes for theses audits or how practice had changed as a result. The trust did participate in some of the national audits it was eligible for, but again we could not see evidence of improvement to patient care as a result. The exception to this was critical care and children's and young persons which both held regular audit afternoon where results of audits were presented and acted upon.

Equipment and facilities

Provision of equipment was variable throughout the trust. During the inspection, we noted that there was a shortage of equipment on Snowdrop ward (which was the recently opened escalation ward). The trust responded quickly when we raised concerns during the inspection and equipment was found promptly.

The environment and facilities were not always fits for purpose although the trust had improved since our last visit. We did still find some wards where further work was needed, such as one ward which windows were leaking significantly.

Multidisciplinary working

Although in most departments we saw evidence of good multidisciplinary working we were aware that in certain areas such as maternity and pockets of surgery there was the potential for patient outcomes to be adversely affected as a result.

Requires improvement

Are services caring?

Summary of findings

The trust scored below the national average for the Friends and Family test. In the CQC inpatient survey, the trust performed worse than other trusts for eight of the areas of questioning.

Members of the public expressed their concern to us at the listening event regarding poor care and the loss of dignity that they and their relatives experienced during treatment at the trust. They were also concerned with the lack of communication they received from the trust.

We witnessed staff in some areas (children's and young people, critical care and end of life care) deliver kind and compassionate care. Heatherwood Hospital consistently received good feedback from patients.

Due to the pressures placed upon them, staff were not always able to provide the amount of emotional support that patients wanted and deserved.

Our findings

Compassion, dignity and empathy

The trust scored below the national average for the friends and family test. In the CQC inpatient survey the trust performed worse than other trusts for eight of ten areas of questioning.

Members of the public expressed their concern to us at the listening event regarding poor care and the loss of dignity experienced by themselves and their relatives following treatment at the trust.

However, we did witness that some staff did treat patients with respect and care, particularly in some departments such as the critical care team, the end of life care team and children and young person's division. Other departments such as A&E and some medical wards were very busy and this was clearly having an impact on the time staff where able to spend with their patients. In some areas (medicine) staff appeared to have become accustomed to patients being exposed and did not attempt to conceal their nudity unless it was bought to their attention.

Heatherwood Hospital patient experience was consistently considered to be good in feedback from patients both from and inpatient and outpatient perspective. Many patients who experienced care at both Heatherwood Hospital and Wexham Park Hospital stated that there was a significant difference in the care provided between the two hospitals, with Heatherwood Hospital being their hospital of choice.

Trust and communication

A clear theme at the listening events was that patients and relatives did not always feel that they were kept up to date with their (or their relatives) progress whilst an inpatient at the trust. Patients told us that doctors did not always introduce themselves prior to examining them or asking them questions.

In addition, of the formal complaints made to the trust, 14% related to issues around poor communication.

Again, some departments received good feedback, including children's and young persons, critical care and the end of life care.

Emotional support

Due to the pressures placed upon them, staff were not always able to provide the amount of emotional support that patients wanted. We heard from many patients comments such as 'the staff do try, but they are just very busy'. This varied from department to department and also on the time of day.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The trust was very busy and failed to consistently meet national targets to admit, transfer or discharge patients from the A&E department within four hours. The trust has been predominantly performing much worse than the England average, with patients waiting between four and 12 hours following the decision that they should be admitted.

In order to increase capacity, extra beds had been opened, but there was little evidence of initiatives to try to reduce unnecessary admissions. Patient discharges were being delayed in many cases due to a shortage of radiology, physiotherapy, and occupational therapy assessments being completed in a timely manner.

The lack of capacity and delayed discharges resulted in medical patients being placed on surgical wards. Some patients were moved numerous times, which resulted in delayed care or lack of continuity of care. The use of surgical beds by medical patients resulted in a significant number of patients having their operations cancelled on the day.

Discharges were not planned from admission, and there were significant delays due to lack of resources within the radiology department.

Vulnerable patients were not always a priority for the trust and translation services, though available, were not always used.

Complaints were not answered promptly and we were unable to find evidence that previous concerns had been learned from. Patient stories or complaints were not regularly reviewed by the board.

Our findings

Meeting people's needs and access to services

It was evident from at the time of our inspection and from what the trust told us, that Heatherwood and Wexham park NHS Foundation trust was very busy. They were consistently unable to meet the national target for admitting, transferring or discharging 95% of patients within four hours.

This was largely due to the fact that the hospital was very full – we saw that the trust had had to open extra wards to increase capacity (Snowdrop, a so called escalation ward) and that there were many medical patients on surgical wards (known as medical outliers). In addition we found that elective procedures (both surgical and cardiological) had to be cancelled due to lack of available beds in the hospital. We also saw the impact this was having in other departments, such as critical care, who were unable to discharge patients who know longer required the intensive treatment provided there, due to lack of beds elsewhere in the trust.

The trust's solution to this problem was centred on creating further capacity and we were told consistently by the executive team that 'things would improve' when further ward space was opened later in the year. We saw little evidence of innovative thinking around preventing unnecessary admissions to hospital – for example ambulatory care pathways. Patients with a suspected deep vein thrombosis (clot in the leg) where still being admitted for investigations, whilst in most other hospital these patients would be seen and treated as an outpatient. In addition we did not see evidence of working with local GP's, again to try and ensure that patients were only admitted if services could not be provided in the community.

During the unannounced inspection, there were inpatients that had been waiting for 12 days for an X-ray, 10 days for a CT scan, 10 days for an MRI scan and 8 days for ultrasound scan. The MRI machine was out of use due to the lift being broken and this had not been reported as an incident as it persistently caused problems and staff didn't feel it made a difference. These waiting times resulted in a delay to diagnosis and treatment for inpatients. It also added to the overall length of stay for patients.

Outpatient delays for an appointment for X-rays dated back to November 2013, ultrasound, and CT scans delays dated back to 5 December 2013 and MRI scans 1 November 2013. This resulted in patients attending for a follow up appointment in the outpatient department without their diagnostic procedure being done.

In addition to the delays in getting a diagnostic procedure carried out, there was then a subsequent delay in reporting

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

the result by a consultant. The trust had recognised this and set a target of seven days for reporting to be completed. They had started outsourcing reporting the results at five days to try to achieve the seven day target.

Leaving hospital

Discharge planning was not always proactive, and often was commenced only after the patient was medically fit for discharge rather than starting as soon as patients were admitted. In the CQC Adult Inpatient survey (Sept 12-Jan 13) the trust scored worse than expected for patients not being given enough notice about when they were going to be discharged. This was often because the staff had to look after a much larger bed base (especially medical patients) than previously expected. This contributed further to delays in discharge and poor patient flow from the accident and emergency department.

We were told of one initiative during our inspection – known as the Post Acute Care Enablement (PACE) team. This service offered medically stable patients the opportunity to be cared for either at home or in a community bed and was a joint initiative with Berkshire Healthcare NHS foundation trust.

A common theme within the trust was the delay in patients undergoing radiological investigation, and we saw many patients who were unable to be discharged until they had had certain tests. Other patients were waiting for their results, and we found evidence that there was a significant backlog in investigations waiting to be reported.

Vulnerable patients and capacity

We found care for vulnerable patients such as those with dementia to be mixed. Not all staff had undergone their dementia training, and although a dementia specialist nurse had been appointed, not all staff appeared to be aware of their presence. Initiatives such as 'This is Me' documents (a tool designed by the Alzheimer's Society to help staff understand patients with dementia and their likes and dislikes) was not used regularly. Although staff told us they were able to ask for 1:1 nursing for patients requiring extra support this was not always available.

On some wards we saw that patients were seen by a 'Learning disability' nurse, though we also saw in the trust risk register that the lack of provision of this service was a concern. Again, staff in the A &E department were not aware that this member of staff existed.

Although the trust was situated within a multicultural community, staff told us that on the wards translation facilities were not always available and they often relied on other staff members or relatives to provide this service. In outpatients and in the A&E reception however, both written information was available in different languages and telephone interpretation was easily available.

Learning from experiences, concerns and complaints

Many patients and relatives raised concerns at the listening event that their complaints had either taken a long time to be answered or were not resolved to their satisfaction. The trust has an initial response target of 10 days, but we noted that they were only achieving 18 days. We were told by some relatives that they had been waiting for up to a year for their complaint to be resolved. Trust data corroborated this.

We saw that many of the themes from the complaints were on the trust risk register. This meant the trust had acknowledged where the concerns were. However throughout our inspection we saw evidence that little had been changed as a result of the complaints and staff were not engaged with the process.

It was not regular practice for patient stories to be presented to the board, nor did we hear that trust staff would meet with complainants to understand their concerns

Are services well-led?

Inadequate

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

Summary of findings

The trust lacked a clear vision for staff to align or aspire to. The lack of clarity about the hospital's future left many staff feeling disempowered.

There had been a high turnover of executive team members and the chief executive had recently resigned. Staff referred to the trust as 'rudderless'

The governance arrangements and risk management structures throughout the trust were neither standardised nor consistent throughout departments or divisions. This resulted in the board receiving assurances which were not always robust. In addition, risks throughout the trust were not being progressed or actioned in a timely manner, with many missing their set target date for completion. Information governance needed further investigation to establish its accuracy. The trust had taken steps to source external support to review and improve these aspects.

Sickness levels were found to be under-reported and therefore not a true reflection of staff sickness figures. The trust performed poorly in both the staff survey and the GMC National Training survey. There was a widespread reference to culture of bullying and harassment.

The workforce was disempowered and disengaged. Nursing turnover was high with recruitment and retention being a fundamental concern. This resulted in high use of agency staff. The trust was taking steps to improve retention by schemes within HR, but these were not started at the time of the inspection.

While there were groups who were engaged with the holistic patient experience, some consultants were seen to prioritise their individual working practices and displayed dysfunctional behaviours to the detriment of patient experience in the trust.

Patient experience was not at the heart of everything that was done at the trust. We witnessed a mixture of 'firefighting' and learned helplessness from frontline staff and an executive team that had focused on financial improvement. As a consequence, innovation was not encouraged or rewarded.

Members of the executive team were unanimously concerned about the perceived instability in the future of the hospital and recognised the need for long term significant support in order to achieve a sustained and improved future for the trust.

Some of the executive directors did not have confidence that, as a board, they could make the required significant improvements within an acceptable period. We did not feel that there was the required skill and capability within the trust to make the complex and necessary changes trust-wide.

Our findings

Vision, strategy and risks

The trust lacked a clear vision for staff to align or aspire to. The lack of clarity about the hospitals future left many staff feeling disempowered. Members of the executive team acknowledged the absence of vision and the impact that this was having on patient and staff experience.

At the time of the inspection, the executive team (based at the Wexham park site) comprised of members who were either interim appointments or relatively new in post, with only one member of the executive team in post for over three years. The chief executive had recently resigned and had a planned leaving date for March 2014. There was a long history of high turnover of the executive team which had led to a lack of consistent leadership for the hospital. Staff referred to the trust as 'rudderless'.

Also the issue of patient flow was not being managed from a strategic perspective. Changes made in one place were reactive e.g. escalation wards or outliers without an understanding of the knock-on effect it has on another part of the trust. e.g. the trust-wide impact of the lack of resources in radiology.

Governance arrangements

Governance arrangements and risk management structures in place were neither clear nor consistent throughout departments. This resulted in the board receiving assurances which were not always robust. This was acknowledged by the executive team which had commissioned external support. The number of external agencies supporting the trust at the time of the inspections

Are services well-led?

Inadequate

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

was itself a risk, as the leadership of the improvements in governance and risk management seemed to be the responsibility of the external agencies rather than the divisional management taking clear ownership.

Lack of reporting and learning from incidents and engagement with complaints resulted in a negative impact on the ability of the organisation to understand its risks, learn, and improve for the sustainability of the trust.

Leadership and culture

Data demonstrated that sickness levels were within the national average for the trust overall however on closer interrogation of the data during the inspection we found that there was under reporting of sickness in certain staff groups. This meant the trust was taking false assurance from their data. This was acknowledged by the HR department who are now taking steps to address this.

The staff survey from 2012 showed that for nine out of the 28 indicators were in the bottom 20% nationally. This included staff recommendation of the trust as a place to work or receive treatment and staff job satisfaction. A further six indicators were worse than the national average and only two in total were above average. In addition the GMC National Training Scheme Survey 2013 the trust was highlighted as performing worse than average in seven out of 12 clinical specialities.

There was a widespread reference to a bullying and harassment culture among many staff groups at various levels. Again this was acknowledged at board level and an independent panel was going to be commissioned to both review current processes in place for responding to allegations but also to speak with staff members in order to understand their concerns.

We spoke to many staff who felt that their concerns were not listened to. This had resulted in a disempowered, disengaged workforce. There was a very high nursing and management turnover which meant instilling a positive culture had not been possible. Many of the consultants had been at the trust for the longest of all staff types, but had lacked consistent and effective performance management. They were not held to account for their attitude or performance and ownership of patient experience at trust level was poor.

The overall culture did not support improvements that could be sustained or built upon.

Patient experiences, innovation and sustainability

We did not see evidence that patient experience was at the heart of everything that was done at the trust. This was more prevalent at Wexham Park Hospital, as there was a more patient focussed approach at Heatherwood Hospital.

We witnessed a mixture of 'firefighting' and learned helplessness from frontline staff and an executive team that had focused on financial improvement. This combination had both had detrimental effects on the quality and experience of care received by patients.

Innovation was not evident or apparently encouraged as the staff were too busy with the increased number of beds that had been opened and because of staff shortages. Although the newly appointed ward matrons demonstrated that they were starting to understand the challenges they faced and how they might overcome them, it was too early during our inspection for us to evidence any sustained change.

The executive team acknowledged that the trust had multiple challenges to overcome in order to take the trust forward. In addition, they acknowledged they had been unable to make significant improvements within an acceptable period in many cases, although they had changed as a response to the last CQC report. They had repeatedly commissioned outside help to support them, but again this had failed to achieve any sustained change.

Some executives stated that they did not feel able to hold people to account properly and this had impacted on their ability to evoke change. Members of the executive team were unanimously concerned about the perceived instability in the future of the hospital and recognised the need for long term significant support in order to achieve a sustained and improved future for the trust. Some of the executive directors did not have confidence that as a board they could make the required significant improvements within an acceptable period. We did not feel that there was the required skill and ability within the trust to make the complex and necessary changes trust wide.